CONTENTS

John Edvalson, anthropology major
They Have No Respect: The Impact of Youth Gangs on the Community of Nahuala, Guatemala ................................................................. 3

Cherie Farnes, community health
Antenatal Care Options Among Asante Women in Mampong, Ghana ......................... 13

Jacob R. Hickman, anthropology major
Forced Migration and Health Syncretism: The Changing Nature of Hmong Health Beliefs in Alaska ................................................................. 35

Angel Kirkham, anthropology major
Medicalization in the West: Psycho-Social and Political-Economic Causes .............. 51

Michael Searcy, graduate archaeology major
The Daily Grind: An Analysis of Maize-grinding Times in Mesoamerica ............... 73

Colin Smith, English major
Telling Stories: Past and Present Heroes .................................................................. 83

Justin C. Wheeler, anthropology major
Cough it Up: Anthropological Perspectives on Respiratory Infections in Antigua Santa Catarina Ixtahuacán .......................................................... 91

ISBN 0-8425-2643-9
They Have No Respect: The Impact of Youth Gangs on the Community of Nahuala, Guatemala

John Edvalson

Abstract

In the Maya community of Nahuala, Guatemala, youth gangs have become a growing public health problem. Once considered primarily an urban phenomenon, gangs have gained a foothold in this rural community. According to many members of the community, gangs have formed in Nahuala as the result of unemployment, familial disintegration, and the breakdown of traditional Mayan culture. This research examines the reaction of community members to gangs, discusses the context of the local gang culture, and looks at how local people would go about finding a solution to the problem.

Introduction

In the highland Mayan community of Nahuala, Guatemala, a survey was conducted among 102 community members, asking them to list the five most serious social problems in the community. Gangs were mentioned by 81 percent of the people interviewed—the highest percentage of any of the social problems listed. This would come as a surprise to many scholars who see gangs as primarily an urban phenomenon.

According to community members, gangs are a threat to public health in Nahuala because they jeopardize the well being and safety of the people through violent and destructive behavior. They set themselves up in opposition to cultural restraints that were once the salient feature of social control in the community, especially those associated with what local people call “nuestro costumbre” or our custom. The three factors mentioned by the Nahualense people that contribute to the existence of gangs in their community were unemployment, familial disintegration, and the fusion of two cultural systems—one Mayan and the other Western.

Unemployment “Here there is no work”

Unemployment is generally seen as one of the main factors in the formation of gangs in Nahuala. In the survey conducted for this research, unemployment was listed by 25 percent of the consulted, followed by gangs, alcohol, and theft. According to one local former gang member, available employment would do a lot to alleviate the problem of gangs in Nahuala:

It’s that there is no existing solution, because the truth is that the lack of work is the thing that makes them [gang members] join. Not only here in the town, but at a national level, there is not a source of work. Because of this young men have nowhere to entertain themselves, a place to pass the time; I say that is why people join gangs.¹

Many local youth have to travel to major metropolitan areas like Guatemala City or Quetzaltenango to find work, while a few manage to raise the money to travel and find employment in the U.S. Those that go to the capital city often are not able to find work, so
they incorporate themselves with gangs and are recruited to be founders of gangs in small towns like Nahuala. What happens is that many travel to Guatemala City, and because here there is no work, they stay there for a while. There they notice that there are gangs in the capitol, so somehow those gangs came and formed in Nahuala.

The problem of unemployment is reflective of larger national concerns that have been a constant source of anxiety to the people of Nahuala. The people feel that the officials they elect are corrupt, which in turn limits economic opportunities for the people. In one interview, this sentiment was made very evident:

The government has a lot of responsibility. In this case [the government] needs to see the way to provide a source of employment for society and that they do not spend unwisely. This is a very important point: it all boils down to employment—if there is none, nothing good will happen.

If current rates of unemployment continue in the community, it is difficult to imagine how poorer young men in the community will avoid being pulled in by the local gangs.

**Familial Disintegration “A Gang Member is a Person with Family Problems”**

Another contributing factor to the rise in gangs is the breakdown of the family structure. With more and more fathers traveling to the United States to look for work, many youth find that joining a gang is unavoidable. A former gang member offered this as a cause for gang formation in Nahuala:

A gang member is a person with family problems. From his childhood, he does not receive affection from his mother or father. And in conclusion, this is a person that does not feel remorse when he does damage to a person.

Families form the basic support unit for people in this community, and when that unit ceases to work, gangs lure them in. According to one of the teachers interviewed, this was a common cause for gangs:

For me, a gang member is a person who is frustrated in their life, which is not a normal life. It is a person who has formed as a result of familial disintegration. When the family is disintegrated, then boys lose themselves; it is then that they incorporate themselves with the gangs.

By incorporating themselves with a gang, youth find the structure that serves in the place of a stable family environment. This is especially the case when young people are orphaned and raised by other family members whom they feel less connected to. One former gang member related this story:

We helped each other. . . . There were two other youth that I knew—the mom died from drinking. Their father died as well, and the two children were left as orphans. In the gang, they felt like they were a family because we were very united then. That is how it starts; many times I have noticed that the majority of the youth who become gang members do not have a father. They might have a mother, but she cannot do anything for them.

When asked what the largest contributing factor to the gang problem was in Nahuala, fifty-three out of 102 people listed family problems as a reason for joining gangs. This is the most
common answer when people are asked what the cause of the problem is; the other prominent
two are media and unemployment. According to one member of the community, the reaction
of gang members toward parental authority is very troubling:

Now they [gangs] want to have authority over parents, and our culture is not that. In Maya
culture, we respect the father, we respect the mother, even if we are married, we should
always have respect.

A lack of respect was a common attribute of gangs pointed out by community members.
This lack of respect is the result of the breakdown of social control in the community. As
Irving Spergel stated, “Gangs operate as a residual social institution when other institutions
fail and provide a certain degree of order and solidarity for their members.” In the case of
Nahuala, the breakdown of the family unit seems to be the most prominent institution being
replaced by gangs.

Cultural Fusion “What We have is the Fusion of Two Cultures,
One Indigenous, the other Ladino”

Gangs are perhaps the most obvious example of cultural transformation in Nahuala, and
the most obtrusive and sometimes violent in nature. Spergel argued that “youth gangs tend
to develop during times of rapid social change and political instability.” Social change is
evident all over Nahuala and can be seen in the market and on advertisements on buildings.
Television has started to take hold in the community, with many violent programs available
on the local cable network. When parents are gone or intoxicated, it is difficult to control
the behavior of their youth. Political situations have been difficult over the past two decades
in Guatemala. This has had an effect in Nahuala, where the people have noted a legacy of
corruption and inability on the part of government officials. This is not likely to change in
the near future.

The local gang situation in Nahuala is a reflection of what is going on throughout
Guatemala. According to Presna Libre, a national newspaper, Guatemala City was declared
the most violent capitol of Central America in 2003, with 1,185 deaths of youths younger than
twenty-two years old. This contrasts sharply to a report by Dennis Rodgers, which stated
“the Guatemalan maras are little more than neighborhood friendship networks that revolve
around more or less legitimate pursuits—such as playing sports, listening to music, drinking,
or consuming drugs—and engage only in low-level violence, such as street brawls, muggings,
and pick pocketing.” This example from a 1999 study shows that much has changed in
Guatemala in the last five years.

During the time this research was conducted, there were a total of six murders reported
in Nahuala. Although a connection to gangs has not been officially confirmed, the crimes are
often blamed on them. Five of these murders were drunks found hit or stabbed to death on
the street. While no serious investigations were conducted, the general sentiment is that gang
members were involved. Locally, there is no statistical information about the murder rates in
the community and the percentage of them that are gang related.

A teacher in the community defined gangs as “youth that fight over territory.” More and
more gang violence has become a problem in Nahuala. The gangs that are active locally are
Mara 18, Mara 13, Salvatrutas, Los Batos Locos, and Los Rockeros, with a few additional
Inquiry

minor gangs that are aligned with Mara 13. Mara 18 and Los Rockeros appear to be independent entities, while Mara 13, Los Salvatrutas, and Los Bandidos Locos are united. All of these gangs engage in territorial disputes that are well known in the community.

Mara 13 and Salvatruta gangs have particular popularity and are found throughout North and Central America, with little centralized control. A recent Newsweek article identified Mara Salvatruta, or MS-13, as “the most dangerous gang in America, with a possible total of seven hundred thousand members worldwide.” This example demonstrates the negative impact globalization is having on Nahuala.

Much of the gang activity in Nahuala seems to be centered on finding alternative forms of lifestyle that appeal to the town’s youth. One former gang member commented, “In my case, it was pure rebellion. I felt uncomfortable in the house, and I went to find something to entertain me.” This comment is typical of what many former gang members felt. It seems gang membership is a search for alternative forms of entertainment and an opportunity to form groups, where they feel comfortable and can pursue those interests.

One of the most prevalent activities for youth gangs is to drink. Alcohol is a primary pastime for gang members, especially on Sundays and evenings. When asked what the maras did together, one member commented, “In the first place drinking, but before you drink you need to find money. To find money, some people work, but there are others who do not. So they go out and rob at night.”

One of the most evident pastimes for the local gangs is to paint graffiti on the walls of town buildings. The graffiti is concentrated in the cemetery and in the central market enclosure. The central market is an obvious choice because it is where most people in the area congregate. As in other parts of Latin America, the gangs of Nahuala are very territorial. According to one former gang member, gang territory was determined by the local soccer team boundaries. Most of the graffiti depicts the name of the gang, often written in English. Short phrases and words are written both in English and sometimes in Spanish. “Smokin” is a common one, along with many misspelled curses in English, probably learned from television.

Gangs are highly organized and provide an alternative structure that is every bit as rigid as a Maya home. In order to join a gang, local youth are jumped in, or put in local terms they are “bautizado” or baptized. This is a process where members of the gang beat up someone for a period of time called the “eight seconds,” but according to a former gang member, it is more like eight minutes. During this time, members are not allowed to hit the face or genitals, and once a person is jumped in, they are never supposed to leave the gang again. The gang becomes that person’s family, and their sole purpose in life. These behaviors seem congruent with many classical definitions of gangs. W.B. Miller defined gangs as:

A self-formed association of peers bound together by mutual interests, with identifiable leadership, well-developed lines of authority, and other organizational features, who act in concert to achieve a specific purpose or purposes which generally include the conduct of illegal activity and control over a particular territory, facility or type of enterprise.  

Gangs represent a new and appealing alternative for many youth, who are looking for something different, and they form economic and social support groups for youth, who find little of what they desire from home environment. Gang life, in many ways, is set in opposition to the
social norms people want to establish. With change occurring so quickly in the community, it is little wonder that the local population feels ill equipped to deal with the problem.

**Methods**

In this study, I employed the field methods of direct and indirect observation, unstructured and semi-structured interviewing, a focus group, and a questionnaire administered to one hundred local consultants. Observations were recorded walking through town and talking to local people, who were willing to discuss gang-related issues. In the questionnaire, I used free-listing as well as a Likert scale to get a better understanding of the situation.

Unfortunately, I was not granted access by Brigham Young University’s Institutional Review Board to interview gang members to get their perspective as to why they chose to engage in gang activity. Fortunately, there were plenty of local people, including youth above eighteen, who were former gang members and who were willing to discuss what they saw as causes to the problem as well as possible solutions. From interviews with parents and former gang members, I obtained the local perspective on how the presence of gangs affected people’s lives in the community. The focus of this research was two-fold: first, to find out what local people believed to be the causes of gang activity, and second, to find out how the population felt the problem could be dealt with effectively.

**Solutions “To Do the Things that are Good”**

Over the past decade, Nahuala has experienced rapid changes in the local culture. The end of the civil war in the 1990s brought new commodities and foreign media influences to the once isolated mountain village. While modernity has expanded the view of what is available to the people of Nahuala, their ability to obtain these goods and services remains limited. A shortage of available land for corn farming (a convenient sample of one hundred people had an average of only eleven *cuerdas* or acres of corn) and limited local employment opportunities have forced many local men to search for employment in urban areas of Guatemala and, more recently, the United States. This migration has altered local perspectives and changed the local culture. Young men no longer seek to be identified with things that are considered indigenous; rather, they are choosing to adopt Western dress, music, and attitudes.

As a result of these changes, the Maya of Nahuala find themselves increasingly torn amid two worldviews, between the traditional Maya agricultural system of self-subsistence corn farming, and the ever-expanding global system, here in Ladino form, which is becoming entrenched in community life.

In this process of cultural transformation, the willing recruits of modernity appear to be the young men in the community. No longer satisfied with the farming life that has long been the staple of the community, where little land is left to be inherited, young men are increasingly turning to other sources of employment. The rapid influx of media as well as the availability of modern products has created a sense of disparity within Nahuala. This disparity has caused many to seek out education or travel to outlying areas, especially the United States, to search for work and what is believed to be a better way of life. While this is the goal for many young men, many are frustrated in their attempts. One alternative to gaining the economic and social support young men in Nahuala are seeking is found in the local gang culture.
Many people in Nahuala are becoming very frustrated with the local gang situation, and in many ways, the situation is coming to a boiling point. When asked about the gang problem, one local shopkeeper said simply, “There is no peace; there is always fear.” The fear is evident in the timidity of the people, in the way people interact with gangs. One local bartender related how he often had to pay a tribute to gang leaders who came to his bar, so that he would not be robbed. Gang members are seen harassing elderly people in the plaza, something that is normally unheard of in a culture where respect for elders is very important. A thirty-five-year-old teacher remarked on this change:

Included in the Maya culture, we are always taught that if there is an old woman in the path, and I come as a youth the other way, out of respect I should always step aside and give the old woman the right of way. This is part of our culture, but those that are in a gang now do not do that. When an old woman comes, they push her, “Get out of the way and let us pass,” they say. So you can see, now they have no respect at all.

Having “no respect at all” was a common term used by people to describe gang behavior in reaction to the social changes taking place in the community. People are aware of the change in social norms; those comfortable with the cultural system have trouble understanding the view of local gangs.

Youth gangs in Nahuala represent a minimal presence in Nahuala. They are neither fully Ladino nor Indigenous. This type of behavior was documented in the United States among Native Americans, where bi-culturation caused a crisis of identity among Native boys of the Mesquakie tribe. Gang members no longer see themselves as part of the culture their parents grew up with. They are rapidly adopting behaviors, including styles of dress, language, and attitudes that are foreign to their parents and other members of the community. This combination of cultures was expressed by one local man, “What is happening here in Nahuala is a fusion of two cultures, one indigenous, the other Ladino.” With the culture gap between the older and younger generation continuing to expand, youth gangs will likely remain until the process of cultural fusion slows.

It would be difficult to sum up what could be done for gangs in these rural communities. Much of the effort should be concentrated on empowering the people and the institutions that have already been set up. The development community must understand local values and beliefs before they can implement positive change.

According to one teacher, much of the change that needs to take place involves the families of the gang members themselves, and the attitudes that they are taught in relation to their role in society:

To speak of a youth who is a gang member, we say that there is now a lack of morals. Having morality is to have good attitudes, to have respect, to be obedient, do the things that are good, not only for just yourself but for all of society.

This lack of maturity, as evidenced by the consultant, displays the perceived disconnect between gang members and other members of the community. Symbolic structures are being established to differentiate the two. This is evident in language, religion, and in cultural norms.

During the time this study was conducted, a situation occurred where gang members from outside of Nahuala had come to pick a fight with gangs in the community. According to
accounts from members of the community, word got out that members of a gang had come to the community with handmade guns. There were accounts that a number of them had come, but the community members gathered only three of them together. In the trio, there were two young men and a young woman. Members of the community apparently took the clothes off the gang members and proceeded to beat and pour water on them. All three had been carrying handmade guns. At one point some members of the community suggested that they burn the three for threatening the community, rationalizing their actions because of claims that the police are ineffectual. Luckily, cooler heads prevailed, and some members of the community convinced their neighbors to let the police arrest and remove the offenders from the plaza.

It is evident that the community is getting very tired of the ineffectual way that the problem is being dealt with. Community leaders need to get together and see what can be done about the situation before fear takes over and community members start to take matters into their own hands in vigilante fashion.

Solutions to gang problems are not simple. As in other places where gangs are present, in Nahuala, gangs are a symptom of social disease rather than the disease itself. If socio-economic conditions in Guatemala continue to spiral downward, it is most likely that gang problems will continue as well. In the study done by Rodgers, he examined the three types of intervention programs that have been used with gangs. While he cited that there is little information on programs in Latin America, he used programs implemented in the United States as his model. Following are programs he outlined in his report.

The first two approaches are preventative in nature:

- **Suppression** attempts to reduce youth gang activities through punitive means, usually involving police action.
- **Community organization** aims to change the context within which youth gangs operate by mobilizing and organizing gang-affected communities, thus reducing the scope for gang activities.

The following two approaches are rehabilitative or corrective and seek to affect youth gangs and their members directly:

- **Social intervention** includes outreach and counseling aimed at preventing youth gang delinquency and reducing gang membership through face-to-face contact with gang members.
- **Opportunity-providing** seeks to re-channel gang activities into more constructive pursuits and includes job training, employment, and education programs.

Of these methods, the communal nature of Nahuala would allow for a very effective community organization program. According to Rodgers:

- Community organization programs can take a number of forms. All, however, take as a basic premise that youth gang violence is at least partly a result of social disorganization and that if local-level social institutions or networks were created or strengthened within these communities, youth gangs would become less of a problem. Such a conceptual approach is also implicit within initiatives that aim to build social capital within violence-affected communities as a means of mitigating the effects of this violence.

Members of the community have suggested several approaches to the gang problem. The
first seems to always be family centered and then later, community meetings are discussed. One community leader tried to suggest to the mayor that a psychologist should come in and set up a rehabilitation program, but so far no action has been taken. People in the community are generally frustrated about the way the police handle the problem and claim "the police don’t do anything." It is evident that because of the nature of the community, small and fairly united, community organization would be the best way to go. The gangs do belong to local families and are known in the community. Gang problems have been curbed in other outlying areas with meetings, where the gang members are gathered together and warned that if their actions continue there will be consequences. Such committee systems are already in place in the community and could be easily organized, thus reducing the problems of gangs in Nahuala.

**Conclusion “This is the Reality”**

The people of Nahuala are now active players in the global economy rather than an isolated village of corn farmers. Globalizing forces present in our world today have some influences that haunt our postmodern world, by destroying much of what is unique about the multitude of cultures that inhabit our planet. As Brett Greider put it, “One would be hard pressed to claim that Indigenous cultures around the planet face Twenty-first Century globalization with divergent trajectories toward survival, yet most are in the perilous process of modernization, assimilation, and degradation of traditional identities.”

In his analysis of Baudrillard, Edward Fischer asserted that many Maya are becoming representative of capitalist societies who “define themselves through what they consume rather than what they produce, a process brought about by the culmination of alienating workers from the means of production and the concomitant fetishism of commodities.” According to Fischer, commodity fetishism is applicable to the Maya world, as the agrarian roots of their society have been disturbed by the influence of a more consumerist culture. He asserted that “most Maya today would be decidedly modern or pre-modern—maintaining strong affective ties to the means of production—while simultaneously integrated into post modern economies of symbolic consumption and creation.”

While this seems to be true in Tecpan, where Fischer did his research, in Nahuala, the local population has become consumed with obtaining the kind of wealth more congruent with what they see on television and in Guatemala City. While evidence of a resurgence of ethnic pride, stemming from the Pan-Maya movement exists, this movement is embraced primarily by academics; most people generally seem unaware or unconcerned with the phenomenon. By and large, the town seems to be distancing itself from a life of agricultural farming and cultural isolation into the Ladino world of soft drinks, cable television, and automobiles—a lifestyle that few can afford.

As a public health issue, gangs also cause harm to local businesses and jeopardize the safety of the people within the community. However, it is the encroaching materialism that comes with unchecked political corruption that drives up the levels of unemployment, familial disintegration, and cultural disintegration. Recent political history makes it evident that the problems with gangs will continue if dramatic action is not taken. The last presidency robbed millions of dollars from the national treasury, an occurrence all too common in this country.
Corruption has reached all levels of government and especially the local level. One teacher described the situation this way:

The government can add more soldiers and more police, but if there is no plan, they cannot do anything. This is like a sickness—the sickness is now in the people, what it needs is to be really healed, to cure all of it, so that it does not return again. If [the government] only tries to sort of calm things down, it does not help anything. The government is very influential in this case, but how we are now is a little difficult. It’s not that one is a pessimist, but this is the reality.

The sad reality is that gangs will most likely continue to increase in these communities unless local people decide to take action for themselves in conjunction with political leaders finding policies that will help improve the countries that they govern. Development programs would be well-advised to understand these factors. It is doubtful that anything large-scale can happen to the gang problem unless nations unite and find effective crime solving solutions. Meanwhile the people of Nahuala will do what they can to organize as a community and find local solutions for this vexing problem.

NOTES
1. Pues, una solucion no habria, por que la verdad la falta de empleo es lo que hace que ellos se integran alli, No solo aqui en el pueblo, pero a nivel nacional no hay una fuente de trabajo, por eso no tienen donde entretenirse donde pasar el tiempo, yo digo que por eso se integran a las maras.
2. Bueno lo que pasa es que muchos viajan a Guatemala, y porque aqui no hay trabajo a veces quedan un tiempo. Alli se dan cuenta que hay maras en la capital, entonces de alguna manera, fue asi que vinieron aqui para formar maras en Nahuala.
3. Un joven mara es una persona con problemas familiares, desde su niiñez no recibio algun afecto de su mama o de su papa. Y en conclusion, es una persona que no siente remordimiento cuando hace algun daño a una persona.
4. Para mi una persona mara es una persona que quizás esta frustrado en su vida, que no es una vida normal. Es una persona que prácticamente se ha formado a través de la desintegración familiar. Cuando la familia esta desintegrada entonces los muchachos se pierden, entonces se incorporan con las maras.
5. Nos ayudábamos ... Habia otro dos jóvenes que conoci—La mama murió de tanto tomar. Su papá pues murió, los dos niños quedaron huérfanos. Allí en la mara se sentían como era una familia, porque estábamos muy unidos en ese entonces, asi comienza, muchas veces me he dado cuenta que la mayoría de los jóvenes que se integran a una mara no tienen papá, solo tiene mama, y como la mama no puede hacer mucho por ellos.
7. Ibid.
8. Presna Libre, 13 July 2004, p. 3.
11. El caso mío fue puro rebeldía. Yo me sentí incomodo en la casa, y fui a buscar algo que me detuviera.
12. En primer lugar a tomar, pero antes de tomar necesitan conseguirle dinero. Para conseguir dinero, hay unos que trabajan, pero hay otros que no trabajan. Entonces, se dedican a robar de las noches.
14. Ladino is the local term for any person of non-Maya origin.
15. Ahora no hay paz, siempre hay miedo.
16. Ya quiere tener autoridad sobre sus padres, y nuestra cultura no es esa. En la cultura Maya respetamos el padre, respetamos la madre aun que seamos mayores de edad, aunque seamos casados, siempre debemos
estar respetando. Incluso dentro de la cultura maya siempre se nos dice los mayores nos dicen si en el camino si nos encontramos con una anciana, y vengo como joven yo por respeto tengo que salir del camino y darle paso a ella para que pase, entonces es parte de nuestra cultura, pero los que estan en la mara ya no lo hagan, viene una anciana la empujan, fuera! Yo voy a pasar dicen ellos, entonces ya no tienen respeto.

18. Lo que esta pasando aqui en Nahuala es la aleación de dos culturas, uno indígena la otra ladino.
20. Ibid.
21. La policia no hace nada.
24. Ibid.

REFERENCE

Antenatal Care Options Among Asante Women In Mampong, Ghana

Cherie Farnes

There is Tanzanian folklore that tells the account of an expectant mother and accurately portrays the danger of childbirth within developing countries. The mother tells her older children, “I am going to the sea to fetch a new baby. The journey is dangerous, and I may not return.”

Introduction

In the sixty seconds it will take you to read this introduction, one woman will have died of a pregnancy-related complication, a calculation roughly equaling 600,000 deaths every year. Ninety-nine percent of these deaths occur to women living in developing countries— their lifetime risk is approximately one in forty-eight. However, for those living in developed countries the lifetime risk is one in eighteen hundred. The risk is highest for African women.

It is believed that many of these deaths can be prevented with increased problem awareness and appropriate interventions aimed at increasing the chance for survival. “In the modern set up, as soon as pregnancy is established, the woman is advised to report at the nearest antenatal clinic for a thorough physical examination.” This woman would then be advised in matters of nutrition, food, and environmental hygiene, rest, exercise, and activities that should be avoided. Improving the quality of prenatal care (prenatal and antenatal care are used synonymously) for at-risk individuals can do much to make pregnancy and childbirth safer. Research has shown that effective prenatal care improves birth outcome for both the mother and her infant. When the basic functions of prenatal care are realized, a favorable outcome will result.

“A contemporary approach to antenatal care views pregnancy as a normal, healthy event under favorable conditions that only requires a minimum of skilled care.” Anthropologists Carole H. Browner and Nancy Press conducted prenatal research among women living in the Los Angeles area and found that the goals of these women mirrored those of their practitioners: most wanted to give the physician access to their bodies for monitoring. Others desired to learn how the doctors thought they could best care for themselves during pregnancy. Furthermore, a strong theme among almost all women emerged: antenatal care (ANC) provided strong emotional reassurance in addition to concrete services. Prenatal care has three basic functions:

1. Provide basic care for uncomplicated pregnancies
2. Identify and diagnose women at risk for pregnancy complications or emergencies
3. Eliminate risk factors and/or triage these women to higher level facilities for appropriate care

It is precisely these functions that I sought to identify through research conducted among the Asante people of Mampong, Ghana, West Africa. My primary objective was to answer two questions. First: within the different existing medical systems, what antenatal services
are available to the expectant mother? Second: What are the reasons behind the selection of a particular medical system?

Research Methods

The opportunity to study maternal health and midwifery originally drew me to West Africa, and the Brigham Young University (BYU) program that facilitated my research. Ghana has a rich heritage of both traditional and biomedical medicine. I lived in Mampong, a small city in central Ghana from May to July 2004. The country of Ghana is divided into regions, which are then further divided into districts; Mampong is the capital of the Sekyere West District and is home to the district hospital.

Contacts made in previous years with hospital personnel by both BYU students and faculty members provided a solid foundation for my exploration of biomedical antenatal care. I built on these relationships as I met and interviewed many of the doctors, nurses, and midwives associated with the Mampong District Hospital. A midwifery school with hospital affiliations additionally provided me with many excellent students, who were an outstanding source of
help and information. The outpatient department of the maternity ward is host to an antenatal clinic three days a week. The nurses employed there trained me in how to conduct prenatal checkups and histories and taught me much about health care for the expectant mother. I am indebted to their service and time.

The Sekyere West District is further divided into seven subdistricts. Most days after completion of hospital rounds, I found myself climbing into the back of a dusty taxi, sometimes with a goat, and traveling long bumpy roads to rural health clinics. There I became acquainted with midwives, traditional birth attendants (TBAs), and public health workers that expounded upon the disparity that exists between rural and urban health services. I observed them in their responsibilities and interviewed them as they provided care for individuals whose hospital attendance is restricted by distance, money, and lack of adequate transportation.

I came to know and appreciate the services of many of the traditional practitioners including the akomfo (witchdoctors), herbalists, Christian healers, bonesetters, and a Muslim mallam. Through interview and participant observation, I began to understand the importance that traditional healing plays and will continue to play in holistic healing.

Additionally, I interviewed several women living in both the urban neighborhoods and the outlying villages; their narratives regarding antepartum behaviors, how prenatal care was sought, and who provided what care helped me to understand their vital role in society.

Maternal Health Care in Ghana: A Background

In September 1995, the Ghanaian Ministry of Health published a landmark health policy known as “The Medium Term Health Strategy,” with the purpose of increasing access to health services, particularly among rural populations. The end-term evaluation of the programs established by this policy acknowledged improvements in several areas of public health care delivery. However, it cited a need for continued advancements and created “The Second Five-year Programme of Work, 2002–2006” with a goal to “consolidate gains made . . . and apply the lessons learned to finding solutions.” This document exists as the current national health policy, and lists reproductive and maternal/child health as one of its priority health interventions.

Ghana’s Ministry of Health (MOH) oversees the care provided within the public health care system. In November 1997, MOH completed the development of its first comprehensive Reproductive Health Services and Standards. The Reproductive Service principles incorporated the “Safe Motherhood’ protocols,” an initiative set forth by the World Health Organization, whose emphases include: antenatal care, safe delivery and postnatal care (especially breast feeding), and infant and women’s health. The Republic of Ghana National Reproductive Health Services Protocols handbook sets forth these reproductive health protocols and includes four volumes:

- Vol. 1—Safe Motherhood Protocols
  a) Clinical Management Protocols
  b) Health Education Guide
- Vol. 2—Family Practice Protocols
- Vol. 3—Other Selected Reproductive Health Service Protocols
- Vol. 4—Other Procedures

Antenatal care protocols can be found in Volume (1), Section (a). [see Appendix 1]
Options for both public and private health care expenditures exist for Ghanaian individuals, although most depend on the public sector for their needs. Reproductive services are offered at basically every level within the general health care infrastructure. Most rural communities rely on a TBA, who may or may not be formally trained. Generally most services provided in the public clinic setting are provided for a fee. However, prenatal care is offered free of charge (as are postnatal services).

**Sekyere West District: The Research Setting**

The Sekyere West District, one of eighteen districts in the Ghana Kumasi Region, is located fifty-seven km north of the regional capital in Kumasi. The district constitutes 5.2 percent of total region. The district has 220 settlements, seventy of which are rural. The district is divided into seven subdistricts: Mampong, Nsuta, Kofiase, Kwamang, Birem, Asubuasum, and Oku. Access to the northern part of the district, the Afram Plains, is difficult during the rainy seasons between April and September. The 2003 district population total was 158,315, the population of Mampong, the district capital, constituted 49.5 percent of the entire district population.

Only Mampong and part of Nsuta enjoy pipe borne water. Many of the southern communities depend on boreholes, rainwater, wells and rivers as their sources of water. The shortage of water supply to the capital, especially to the hospital, is a major problem.

Some communities do not have electricity; therefore the community health care workers must rely on liquid petroleum gas to run the equipment needed to ensure that immunization vaccines remain potent.

Mampong, and the nearby towns of Nsuta and Kofiase are the only villages with telephone systems. Communication networks have yet to be extended to other parts of the district. This is a critical problem when patient histories and high-risk cases need to be communicated between health facilities. The main road from Kumasi to Mampong is tarred, as are roads from Nsuta, Kwamang, and Beposo; the rest of the district roads are compacted dirt.

The majority of individuals residing within the district are of Asante tribe origin. Most engage in commercial and subsistence farming of peppers, tomatoes, garden eggs, plantains, groundnuts, corn, yam, cassava, and cocoyam. Every Wednesday, Mampong is home to a large market. People from various local communities gather to buy and sell produce grown on the farm and textiles purchased from merchants. Secondhand shoes line the pathway up to the main market. It is always a rich, colorful scene.

There are 101 primary schools, fifty-eight junior-secondary schools, four senior-secondary schools, two teacher-training colleges, one technical school, one midwifery training school, and one university campus located within the district.

**Antenatal Care within the Sekyere West District**

Pregnancy related diseases continue to increase within the Sekyere West District; 33.4 percent of all hospital admissions in 2003 could be attributed to a pregnancy related disorder (In 2002, the percentage was 23.1; in 2001 it was 22.4 percent.) Additionally, maternal deaths continue to rise (there were eight maternal deaths at the hospital in 2003), although antenatal
care services within the facility are rising. Pregnancy related disorders are listed as number two, just under malaria, in the top ten causes of morbidity.

The following is a table adopted from the Sekyere West District: District Health Directorate 2003 Annual Performance Reviews written by the District Health Director, Dr. Felicia Amoo-Sakyi, a brilliant, dedicated woman. The table lists the statistical data for the year 2003 in regards to antenatal care (ANC) services:

Woman in fertile age (WIFA): 36,729 (23.2 percent)
Expected pregnancies: 4,438 (2.8 percent)

<table>
<thead>
<tr>
<th>Indicators</th>
<th>District Total Achievement</th>
<th>Percent Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANC registrants</td>
<td>6,852</td>
<td>154.5</td>
</tr>
<tr>
<td>ANC attendance</td>
<td>19,777</td>
<td></td>
</tr>
<tr>
<td>Average # of visits</td>
<td>2.8</td>
<td>43.5</td>
</tr>
<tr>
<td>Teenage Pregnancy</td>
<td>914</td>
<td>13.3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Supervised deliveries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Midwives</td>
</tr>
<tr>
<td>TBAs</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Percentage Antenatal Care Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>129.9 (2001)</td>
</tr>
<tr>
<td>157 (2002)</td>
</tr>
<tr>
<td>154.5 (2003)</td>
</tr>
</tbody>
</table>

The district reports that 154.5 percent of pregnant woman are receiving prenatal care. This statistic was calculated by dividing the number of expected pregnancies for the year 2003 (4,430; 2.8 percent of population) into the number of ANC registrants (6,852). The number does not accurately portray the actual percentage of women that are receiving care. The miscalculation is due to the fact that some women are double counted (registry in two different cities) and many women living outside the Sekyere West district come within district boundaries to receive antenatal care. Although the data suggests the percentage of woman receiving ANC has decreased from the 2002, it is difficult to accurately assess what is occurring given the misrepresentations of data.

Despite the pessimistic outlook that the data may communicate, most practitioners were very positive about the services given and the future of prenatal care. I was very impressed with the services and the overall organization of care, especially within the public health domain. District Director of Health Dr. Felicia Amoo-Sakyi discussed maternal services with me and related that the district is focusing on improving the care given to women and encouraging women to receive an adequate amount of care.

“They always come,” said Helena, a midwife of thirty-eight years. Helena currently works in the Assam Health Clinic, a rural clinic situated in a small village a few miles outside of Mampong. She explained that most woman do receive antenatal care in some form or another. At times this care is given by the physicians at the hospital, at times by the midwives and nurses employed at the rural clinics, and at other times antenatal care is provided by the public health workers during what is referred to as a “child welfare clinic.” This collection of practitioners forms the biomedical realm of antenatal care.
Africa has a rich culture of traditional healers that also provide care for the expectant mother. Often the etiology of the sickness is attributed to a spiritual matter. Witchcraft, taboo violation, curses, and lack of ancestral worship all contribute to sunsumyare, or spiritual sickness. A person will manifest signs of an illness and, despite biomedical treatment, the disease will not depart. Paul Adje, my translator, described it this way:

I think spiritual sickness is a sickness that one cannot find solutions to it. They go to the hospital. The doctor cannot even find a solution or a cure to it. And when they say physical sickness, it is the same; but just that, that you go to the hospital, you’ve been given medication and you’re okay.  

Sunsumyare can affect an unborn fetus. One woman explained:

. . . we have some people who have that bad spirit and that disease . . . if they are passing along, and they heard the baby cry in this room, they can give them through the window, intrude a disease through the spirit . . . and it comes on the baby directly.

To prevent sunsumyare and the consequential harm of the fetus, many West African women seek remedies from traditional healers trained in effective treatment and prevention. Frequently this treatment involves the use of herbal medications. The aforementioned woman continued, “Yeah, it can affect the baby in the womb. That is why some people went to some places to get the herbal, the traditional medicine to prevent the baby from bad diseases.”

The remainder of this paper will focus on describing antenatal care in both the biomedical and traditional sectors of medicine.

**Biomedicine in the Sekyere West District**

It is important to get antenatal care because you are carrying two souls. Two persons: the mother and the baby. You have to take care of them because to prevent some different types of sickness such as anemia, bleeding.

I think that it is important for a woman to receive antenatal care so that any complications from being pregnant and when she meets any complications the care can be given before she delivers.

**The Mampong District Hospital**

The word Mampong comes from an Asante word that means literally “a great town.” The account is told that over two hundred years ago the personal hunter of the chief of Akronfonsu, a nearby town, returned from a night of hunting with the news of his discovery of a “great town.” The land was taken over and the descendants of these Akronfonsu migrants have been dwelling in the land to date.

Mampong, the Sekyere district capital, is truly a great town with a large hospital that serves as the referral point for all district health institutions, including those in the private sector. In 1973, the General Wing of the hospital began operation; nine years later it merged with an older specialist maternity hospital. Today they share administration. The Maternity Wing is located three-fourths km from the General Wing. There is a dirt road that connects the two wings and facilitates the movement of medication and laboratory work. The Maternity Wing of the hospital includes the outpatient department (OPD), antepartum ward, labor and delivery
ward, postpartum ward, newborn intensive care unit (NICU), and subdepartments of laundry, medical records, dispensary, and catering. I spent the majority of my time in the outpatient department; every Monday, Wednesday, and Friday the antenatal care clinic is head in the OPD. (Tuesday is postpartum day, and Thursday is gynecology day with Dr. Nicolas, a Cuban gynecologist resident). The antepartum protocols at the OPD clinic follow suggestions set forth by the Safe Motherhood Initiative and can be found in the Republic of Ghana National Reproductive Health Services Protocols. [see Appendix 1]

When an expectant mother arrives at the clinic, she takes a seat on a bench in a semi-organized line. A nurse provides a short lecture on hygiene, nutrition, exercise, or infant care, depending on the day. The mother gradually moves through the line, attending the various assessment stations. When her turn comes and if gestational age indicates appropriate, laboratory work is obtained.

Blood is drawn to assess hemoglobin which serves as an indication of anemia, a very common ailment among Ghanaians. Urine is evaluated for protein and sugar, primary indicators of preeclampsia and gestational diabetes. If this is her first visit to the clinic, she is provided with the “Maternal Health Record Book,” and is instructed to bring the book to all subsequent clinic visits. This book traces the important events of pregnancy: growth of the fetus, changes in height and weight, and changes in blood pressure. The first page of the book lists a short personal history. Lucy, an OPD nurse, explained to me the need to inquire about marital status (first or second wife) and religious preference (Jehovah’s Witnesses won’t consent to a blood transfusion), when filling in the history portion of the book. Blood pressure and weight are assessed at the next station, and then the mother is directed into a small room with a bed in the corner. She is instructed to lie down while the nurse conducts a prenatal exam: first looking at the hair for lice; then the eyes and tongue for anemia; a breast exam for lumps; a search for edema along the spine and ankles; and finally an abdominal exam to verify the fetal presenting part (head or buttocks), the position of fetus, and fetal heart tones. It is interesting to note that the fetal heart tones are not counted; merely the rate and rhythm of the heart are assessed using a fetoscope. The patient is then referred to a station where the tetanus-toxoid immunization is administered and medications including prenatal vitamins and Chloroquine tablets for malaria prophylaxis are dispensed. During this time the nurse answers questions and gives appropriate counseling.

At times a patient will arrive with a pregnancy related complication, such as antepartum hemorrhage (APH), malaria, severe anemia, preeclampsia, or preterm labor. She is triaged at the clinic and then referred to the doctor for a consultation. The Mampong Maternity hospital is fortunate enough to have in their possession an ultrasound machine to more accurately diagnose problems. If the attending physician feels the situation deems necessary, the woman is admitted to the hospital antenatal ward for further treatment and follow-up. The antenatal ward has up to twenty-two beds.

Maternity Clinics: Rural and Private

Distance is often cited as a barrier to antenatal care. More than half of the district population lives in rural communities outside of the city of Mampong. Road conditions are poor, and many taxi and tro-tro (passenger van) drivers are reluctant to drive such harsh
conditions. Those that will travel the dirt roads, often only do so once or twice a day. One midwifery student explained to me, “Their villages are very far and sometimes it is very difficult to come [to the hospital].”

The disparity that exists between the rural and urban areas has often been mentioned as one of the largest problems facing health care in Ghana. For this reason, the government has promoted the construction of health clinics situated within the outlying communities. These clinics are run by nurses, midwives, and an assorted mix of accounting and maintenance personnel. One clinic I visited was run by the records keeper; she had no formal medical training. Most of the staff members live in a small compound adjacent to the clinic. The Sekyere West District is divided into seven sub-districts, each run by a supervisor and a health team; they oversee all the rural health clinic activities.

Antenatal care is provided at the clinics and follows district protocols. [see Appendix 1] All services are provided with the exception of blood transfusions and some laboratory work (the equipment is not available for the procedures). Any complications pre- or post-term are referred to the district hospital. I asked many of the health care staff who and what constitutes a referral. “The risky ones,” Helena, the midwife over the Assam Health Clinic told me. I laughed, “Okay, the risky ones.” Anthony, the Kofiase subdistrict supervisor informed me:

Normally when a person comes, and the person is within the risk group, for example a person’s height is less than five feet, and then the person is sitting there for the first time, and we realize the person is manifesting eclamptic condition: rising BP, edema; we can refer.

District protocol states that in cases of severe anemia, sickle cell disease, diabetes, deformity of the pelvis, grand multiparous (five or more pregnancies), preeclampsia, previous history of preeclampsia, unexplained intrauterine death, a previous stillbirth, repeated miscarriages, renal or heart failure, a previous retained placenta, a previous postpartum hemorrhage (PPH), a previous cesarean section, prolonged pregnancy, prolonged infertility, and previous pre-term delivery, referral to the hospital is necessary. Staff members are trained to look for these problems and to refer when required.

Some women choose to receive antenatal care at private clinics located both within and without the city of Mampong. These clinics are run for profit, but still report directly to the District Director of Health Services and the District Health Team. They too refer any complicated cases to the district hospital. Josephine, a midwife at Quality Health Clinic, a private clinic just outside of Mampong, informed me that one of the primary reasons a woman chooses the private sector over the public is related to time.

You see some people, you go there [to the hospital], and it is a very long line. If an antenatal mother comes here right now within five, ten, fifteen minutes I finish. So some of them are thinking of the time. This is the reason, they are thinking if I go to the other clinic I will finish short, and then I can do my work. So I can’t tell you this place is better than the other side, but they are thinking of the time factor.

Some private clinics are managed with and depend on funds from religious or philanthropic organizations. They also report to the District Director of Health Services and refer problematic and potentially problematic situations to the hospital.
Public Health Efforts

The public health efforts were the most impressive of all the biomedical services provided. Several years ago, Ghana Ministry of Health created a program designed to access a larger percentage of the rural population; the program is currently in effect within the Sekyere West district. \( ^{46} \) This plan entitled “Community Based Health Planning and Services” (CHPS) is composed of a systematic hierarchy of health personnel and is designed to identify community members in at-risk categories, especially those living within rural populations. Dr. Amoo-Sakyi oversees the efforts within the district and reports to the District Assembly. Her committee includes a biostatistician, a Disease Control /Surveillance officer, a supply officer, an accountant, a nutritional officer, a public health nurse, an estate manager, and a secretary. These individuals make up what is referred to as the District Health Management Team. Their primary responsibilities include overseeing all activities of the district and sub-districts, planning and budgeting program activities, and supplying essential medical supplies to the sub district health team.\(^{47} \)

Each sub-district employs at least one Community Health Officer (CHO); usually this individual has a university degree in public health or epidemiology. He or she is an essential member of the Sub-District Health Team and is equipped with a motorbike, important drugs, and family planning supplies. Each subdistrict has designated “outreach points.” The CHO travels via motorbike to each outreach point at least monthly to provide education, immunizations, nutrition information, and family planning services. The CHO additionally supervises sanitation efforts and observes for cases of diarrhea, malaria, acute respiratory infections, wounds, and skin diseases.\(^{48} \) There are 123 total outreach points within the entire Sekyere West District. Some of the outreach points serve multiple communities (there are 207 total district communities).\(^{49} \)

The services and information supplied in the outreach points are provided on what has been designated as the “child welfare clinic days.” The primary purpose of the “child welfare clinic” is to weigh and monitor the growth of children. Mothers bring their infants monthly to the clinic to be weighed. The mothers are taught nutrition and sanitation, and their children receive the scheduled immunizations. Antenatal care is provided as well. Michael, the CHO of the Kofiase sub-district, explained that he often has to provide antenatal care by assessing the mother and providing proper immunizations:

> We have about eight mothers who are preparing to deliver, and they came for the TTN [tetanus-toxoid immunization], so I have to do antenatal clinic for them.\(^{50} \)

If there is any indication of a pregnancy related complication, Michael will refer the mother to the hospital.

Each community additionally has a Community Health Volunteer (CHV), a trusted member of the community who donates time in assisting the CHO with their responsibilities. He or she is almost always literate, but many times has little formal education. The CHV monitors the community for any at risk situations, provides services for malaria and diarrhea, offers family planning counseling, identifies children lacking immunizations, and refers any problems or serious cases to the CHO and clinics. CHV men and women are recruited by chiefs and elders within the same community. There are 141 CHVs currently working in the district. Michael explained the role they play in assisting him:
When . . . the time comes [sic] for these child welfare clinics, he will go and announce [it]. We have what you call the Gong-Gong, the Gong-Gong beating in the town. That is the work of the CHV, to announce that coming this Friday there is going to be a child welfare clinic, so every mother, if you know that you are traveling, you are going to be some place, you should try and attend the child welfare clinics. So the CHV are very helpful. And yes, when there is an antenatal clinic, we work hand in hand with them.\textsuperscript{51}

Michael went on to describe, “it is a volunteer work, they are not paid, but right now the district is trying to give something to them, because they put a lot of work actually.”\textsuperscript{52}

**Traditional Birth Attendants**

Michael explained that because he can only get to the outpost clinics once a month, TBAs carry out the majority of antenatal care given in rural villages. Again, factors of distance influence when and how a woman receives care. He described, “We have traditional birth attendants in every community. They are specially trained; they are trained traditional birth attendants. So I work with them.”\textsuperscript{53} Every month Michael visits these indigenous midwives to collect data regarding the number of deliveries they have assisted and to see if they are in need of medical supplies. “I have to go there every month and collect things from them; the number of births. I have to submit it to Mampong.”\textsuperscript{54}

Most of the TBAs received their knowledge of childbearing by way of their mothers and grandmothers who practiced midwifery years ago. Most feel their practice is a calling from God. Ruth, an elderly TBA, shared with me that prior to becoming a TBA, she had a vision in which she delivered a baby. She recounted this dream to a friend, who was a medical assistant. This friend felt the dream was a sign from God and referred Ruth to the district for formal training. Within recent years, the district has attempted to train many of these birth attendants. There are currently 117 TBAs practicing in the district; sixty-two of these women have received government training.\textsuperscript{55} Anthony, the Kofiase sub-district supervisor, clarified: “First we give them the knowledge about the sanitation, personal cleanliness, and the environmental set-up, and then the examination of the expectant mother. Second is when they should refer.”\textsuperscript{56} TBAs are trained to refer to the clinics or the CHO for any complications, women younger than eighteen and older than thirty-five, and if the woman is pregnant with her first child. The clinics in turn refer to the hospital if necessary. Kwame, the husband of Akosua, a TBA practicing in Mprim, a small village north of Mampong, explained, “Well, when you come, she exam you and feels that you can bring forth, and she does that. But when she feels the difficulty in the child’s birth, then she refers you to district.”\textsuperscript{57}

Many of the TBAs use herbal remedies in their care. Akosua, the Mprim TBA, shared a bit of her extensive herbal knowledge with me over the course of several mornings. Akosua has been a practicing childbirth assistant for thirty years (between 1998 and the summer of 2004 she assisted in over four hundred births). Akosua lives in a bright pink house with her husband Kwame, several chickens, and a few goats. She works on the farm for most of the day, attending to her antenatal duties in the morning. She has a room set aside in her home for women who come to her for assistance.

Akosua’s mother was a TBA and taught her much of what she knows today. About forty years ago, her first husband fell ill, and they sought medical assistance from a traditional
herbalist/Christian priest in Makuro, a township near Kumasi. This herbalist/priest recognized Akosua’s “gift” and often recommended her skills to pregnant women within his community. In the two years that she lived at his shrine, he taught her his knowledge of herbs. In 1998, she attended Sekyere West District TBA training and was given an official records book, which she uses to this day.

Herbs are picked fresh from the bush. Each woman is expected to bring her own plastic bag. Akosua fills the bags with the appropriate herbs and gives instructions regarding the herbs. Most are ground and mixed with water and palm oil to form a soup; some herbs, however, are ground and mixed with water to be inserted rectally as an enema. The following is an excerpt from my field notes. I arrived at Akosua’s house early one July morning. The sun was beginning to rise and mothers were beginning to arrive to collect their herbs. [see Appendix 4 for a short list of herbs Akosua uses]

A young woman has arrived. She is seven months pregnant with her first child. Kwame said that she is probably about seventeen years old. She comes weekly to get the herbs. Today she is here to collect the usual herbs that will “bring her strength to the womb and to the baby as well as facilitate a safe and easy journey.” Akosua goes to the bush, to a plantain tree located near her home. The flower of a plantain is cut from the tree and brought to a small table in the middle of the “patio” area. The flower is sliced down the center and the outer husk removed. The woman is instructed that she must boil the remaining part of the flower, mash it, grind it, drain it, and use the juice to make a soup for drinking. When I questioned as to why the young woman thought it was important to come here for the herbs, she replied, “For safe delivery.”

A twenty-year-old primip, nine months pregnant has just arrived. She has come to Akosua only four times, having relocated about one month ago from a village near Accra. Her mother delivered twins with Akosua and consequently sent her here to receive herbal care. She becomes “free, light in the sense that she has no pain during delivery,” while taking the herbs. Akosua gives her an herb by the name of bonhon. The preparation for the herb given is the same as above.

A twenty-year-old primip, who is also nine months pregnant, has just arrived for herbs. She states that she receives prenatal care at the hospital as well. Akosua gives her odjuma, an herb that she is to take and make a palm soup with for easy childbearing and to protect against fever, etc.

Akosua doesn’t perform any type of physical prenatal check-up, although many other TBAs do. Kwame told me, “Physical exam, women go to the hospital for this type of treatment.” And they do. Many of the women I spoke to see Akosua in addition to the care they receive at the hospital. They find the herbs vital to their well being and the health of the baby.

Not all TBAs use herbs in the antenatal care they give. Salama, a Muslim TBA practicing in Mampong, related to me that she used herbs prior to receiving government training. Jones, my translator, explained, “She said before she went to the workshop, that time she was practicing the herbs, so after she get the experience of the government side she is no more using the herbs.”
Asante cosmology is described as monotheistic, although certain elements of polytheism exist. God, or Onyame, is omnipresent, omnipotent, and omniscient.\textsuperscript{60} To ensure a harmonious existence for His children, He has assigned all governmental responsibility to local gods and goddesses referred to as abosom. Onyame punishes those who break taboo or commit offense by way of the abosom. These beings live in rocks, shrines, brass pans, groves, rivers, trees, and other places. They “carry out their respective assignments through human intermediaries.”\textsuperscript{61} These intermediaries, termed “witch doctors” in Western civilization and known as akomfo in Asante culture, often serve as chiefs for their respective villages and spend considerable time in consultation with the abosom. Through special ceremonies, dubbed “possession ceremonies,” the abosom spirits physically possesses the akomfo (singular: okomfo); they communicate to them problems that are occurring in the communities or the presence of witchcraft. Many individuals who are experiencing some sort of problem consult with the abosom via the akomfo in search of solution during these ceremonies. Many times there is a suspected “spiritual” etiology that is attributed by the individual to the problem.

In addition to the akomfo, herbalists present another facet of traditional medical care. These skilled men and women are trained in herbal knowledge and prescribe treatment for specific ailments. They treat both physical and spiritual forms of illness, as do the akomfo.

Religion preference prevents some individuals from seeking the assistance of an okomfo. Both Christianity and Islam prohibit their followers from obtaining any services from these “fetish priests.” They do, however, provide their congregations with alternate forms of spiritual healing through the Muslim mallam and the Christian priest. The akomfo, the herbalist, the mallam, and the priest all provide forms of antenatal care.

The Akomfo

Many women seek the care of an okomfo throughout their pregnancy. Several of these women attend the antenatal clinics of the hospital and health posts in addition to the herbs and spiritual protection they receive at the hands of their local okomfo.

Gyasi, a local okomfo in Pentang, a small community outside of Mampong, has been divining and consulting for eight years. His uncle, the previous okomfo, died in August of 1995. After consulting one Friday, the uncle took ill. The community members took him to the hospital but he said that it “wouldn’t matter”; his illness wasn’t “hospital illness.” They took him home and he died the next day. In June 1996, Gyasi was a student of accounting at Mampong Senior Secondary School. The abosom began to possess him. He felt that they were calling him to be the next okomfo. He resisted the call of the abosom until his father began to lose his eyesight. Gyasi believed that his father’s blindness was a direct result of his opposition to the call of these local gods. He felt culpable and returned to Pentang. The shrine workers poured libation in restitution of his resistance and Gyasi began to work as an okomfo. His father’s sight was restored. The abosom comes to him in his dreams, when he is in possession, and when he is sitting. They teach him about herbs and medication that he gives to those who come to consult.

Gyasi consults or holds “possession ceremonies” three times a week. During the consulting ceremony the Pentang abosom, who inhabit a nearby river, possess Gyasi. His clients come from far away villages in search of his services and to communicate with the abosom through
Gyasi. He helps them determine the origin of their problems and sicknesses. The following is an excerpt from my field journal of a possession ceremony I attended in early May 2004.

Gyasi emerges from his compound, which is about one hundred yards from the consulting area. He is wearing a white tunic. He mingles with the consulters for a couple of minutes. His workers pour libation. One taps the ground with a shot glass; another rings a bell. All this is done to attract the abosom spirits. Gyasi walks to the chair and sits down. The workers are barefoot. One worker pours libation into a small glass cup (like a shot glass). Gyasi dumps half of it out; the glass remains in his hand. Gyasi drinks it, and begins to have small convulsions. Suddenly, he stands up. A man brings him a bowl of talc powder. Gyasi spoons the talc on the ground with a large knife and walks into a small room on the shrine property. This room is home to all the various robes and clothes Gyasi puts on in representation of specific abosom. There are different clothes for each abosom. He emerges one minute later in a red tunic (the clothes of the consulting abosom) and continues to spoon the talc onto various places around the compound. He walks to the shrine and sprinkles talc onto it. There are some cowry shells lying on the altar; he picks them up and hits the shells against the knife, throws them onto the shrine, throws talc on the grave of his uncle, and then enters the consulting house. Men and woman enter the consulting house one by one to inquire about their various plights. The men and women sit down and a possessed Gyasi begins a question and answer session. He questions, they answer; he throws cowry shells on the ground to interpret the answers. When the last consultant has left, he comes out of spirit possession. He is very tired.

After this particular consulting ceremony I had the opportunity to question Gyasi, and he told me that he had consulted with two pregnant women during the ceremony. The first woman, probably in her first trimester, had started bleeding. She had been to the hospital but the bleeding continued. Gyasi prescribed an herb he called *popopopo*. The second woman, now nearing full term, had seen Gyasi throughout her pregnancy. She originally sought the care of Gyasi because she did not “feel pregnant.” She was concerned that her baby wasn’t growing properly. Gyasi had given her herbs throughout the pregnancy to strengthen the infant and prohibit him from developing sunsumyare.

Gyasi does not charge for his services, but asks that his clients pay what they can. Many of the local akomfo do ask a fee for their assistance; sometimes they can charge more than the hospital.

Madam Saewa is the okomfo of a shrine in Daaho, a small community just north of Mampong. Her abosom inhabit an object rather than a place (like the river as in the case of Gyasi’s abosom). She dances to call and attract the abosom to her shrine. While possessed, she holds a small mirror in her hand. She can see the abosom in the mirror, and they speak to her by means of a bell that she holds in her other hand. She understands the messages they want to communicate to her by the ringing and tones of the bell.

Afreyem, a forty-three-year-old woman with six children is from Beposo and came to Pentang because she was suffering from sunsumyare. She had tried different healers without avail and was finally referred to Gyasi. With his help, she was restored to health. She married a Pentang community member and settled. She related to me that she delivered her youngest in
the hospital, and went to the clinic monthly to receive prenatal care. With every pregnancy she additionally consulted with Gyasi to receive fortification against disease and spiritual sickness. He gave her herbs for bathing and for oral intake.

Naomi, a twenty-nine-year-old mother of four, delivered with the village TBA, but did receive prenatal care from the hospital. She took herbs given to her by Gyasi throughout her pregnancy to protect against sunsumyare and explained that the hospital can’t detect spiritual sickness, nor can they treat it. For this reason it is important to also see an okomfo.

The skilled men and woman that call themselves okomfo are important providers of antenatal care. They prescribe herbs and other forms of curative therapy to prevent the spiritual sickness of both mother and infant.

The Herbalist

Mampong is home to numerous herbalists. Many women seek out the care of these knowledgeable individuals; they provide herbs that help to fortify the fetus, provide a source of strength for the mother, and protect against spiritual illness. One woman explained to me, “I went there for protection of the baby in the womb.”

Alex Mensah, known to all as Dr. One-Man, has been a licensed herbalist for fifteen years. His grandfather was an herbalist many years ago and taught Mensah much of what he knows and uses today. He worked with his grandfather for fifteen years and then went to work for the Ministry of Agriculture. In 1985, Mensah retired from the MOA and began farming and working part-time as an herbalist. It was during this time that he was approached by a neighbor to request a healing of this man’s grandson, who had some eye ailment. Mensah helped the grandson. The neighbor was so pleased, he encouraged Mensah to use his medicine to “help the nation” and went as far as to finance the license needed for a legitimized practice. “If you don’t have a license, you can’t practice,” Mensah told me. (There is an office in Kumasi that grants these types of traditional healer licenses to those who can pass a verbal herbal exam.) He was a traveling herbalist for five years before finally settling down in Mampong. As a traveling herbalist, he would stay one week in a village and then move on to the next. “They invite me to come to help them,” he said. He currently is the district chairman of the Herbal Association.

During my interview with him, Mensah commented on the medicine used for pregnancy and told me that he has medicine “for women so that they may deliver per vagina when they have had [a] previous [child].” His herbs protect against spiritual sickness. “There are some leaves and if you take the leaves the devil can’t affect you.” He also has medicine for those who can’t eat and sleep and for those who are bleeding prior to delivery (antepartum hemorrhage). I questioned him on his beliefs surrounding biomedicine or “the hospital,” and he responded, “It is important to go to the hospital depending on the nature of disease.” In the past, he has referred women to the hospital before treating them with herbs.

Muslim Mallam

One afternoon I was taking a taxi back from Pentang with a few fellow students. Our driver was a devout Muslim and we had the opportunity to interview him about his faith and how these beliefs affect his attitude towards traditional and Western healing. He stated that as a Muslim, he would never go to an okomfo—it is prohibited by the religion. Muslims however,
do have their own traditional healer, the mallam. Jones, my translator, explained during an interview with a Mampong woman, “Yeah, she went to a certain man called a mallam who is a healer. He can cure some spiritual disease. She went to that person to collect the herbs. They are called mallam.” Mallams function in the way that the akomfo do; they provide herbs and treatment for both physical and spiritual ailments.

One such Mampong mallam that I had the opportunity to interview began his practice eighteen years ago. Although he is completely illiterate, he has his clients write their name on a piece of paper, when they come for a treatment. He looks at the paper, the spacing of the letters, the form, the letter shape, and the spacing between each letter and deduces the problem and solution. He explained that he received much of his training through his dreams. Often he has a series of dreams for several days. He ponders and prays over the knowledge and questions presented in the dream; if he feels it is divine, he incorporates this new information into his practice.

Many Muslim women come to him with various pregnancy-induced complications. He told me that he can discern that they have problems with their pregnancies, even if they do not complain of symptoms, by simply looking at this piece of paper. He goes to the bush and collects herbs, which he then gives to the women with instructions regarding how to take them. Different herbs are given for different periods of pregnancy. Herbs are given to facilitate delivery and to strengthen the fetus, “So he will be a strong African baby.” At times, the mallam uses the Koran to teach his clients the correct path if their sickness is the result of a transgression.

**Christian Healer**

Christianity, as well as Islam, rejects the practice of visiting okomfo. Therefore, many Christians rely on the services of a Christian Healer. The following is an excerpt from my field journal. Julie, a fellow student, Paul, our translator, and I had the opportunity one morning to visit the temple of a Christian healer.

We took a taxi just down the street from where Comfort Phillipah’s Clinic is located. The taxi dropped us off, and we walked down a dirt road until we reached a small thatched building. We took our shoes off, entered the structure, and took a seat in the corner. Paul sat by the Christian healer’s wife, and I interviewed her for a moment using Paul as my interpreter. She told me that about fifteen years ago this healer began to have problems with his eyes. He went to a priest for a healing, and although he didn’t receive a remedy at this time, he did receive a call from God to become a healer. He founded the Glory Be to God church and is currently the pastor and healer for his congregation and any other individuals that come to him for healing. Women come to him for blessings that they will have a safe pregnancy and that they will have no complications. They come with help with their “spiritual pregnancy.” I note that he is dressed in a long royal purple robe and is noticeably blind. His assistants guide him around the room and to those in need of help. They sing and chant with him. He slaps his patients a lot in the forehead and on the chest. Sometimes they flinch. He often yells Jesus when he hits them.

Several pregnant women were present that morning to receive help for their spiritual pregnancy. The first woman came because her infant was not growing. The baby was “on the wrong path of the womb.” The Christian healer approached her and said that she needs
a “spiritual operation.” All formed a circle surrounding the woman and began to dance and sing while she uncovered her stomach. The priest took metal rod of about 1 1/2 ft. long and poked and prodded her stomach while all sang and danced. He repeated Jesus and stamping his foot several times during this “spiritual operation.”

The second woman came complaining that she was spotting blood. She had a history of miscarriages and was concerned with this baby. She in turn exposed her stomach and the healer rubbed consecrated water on her stomach.

After the ceremony the women collect herbs from the priest for their various ailments.

**Conclusion**

I found that the most significant variables in the choice of antenatal care were distance, time, transportation limitations, and religious preference. The distance to a hospital is often too far, and it is difficult for many women to leave their work behind, spend hours traveling due to lack of transportation and bad road conditions, only to then wait many hours in long lines for the hospital antenatal care. The government has consequently constructed rural health centers that provide services for those living in areas where distance presents a barrier. Furthermore, public health efforts have been extended to those who live in these rural areas and find it difficult to seek care even in the rural health centers.

Many women seek care from those who function in the traditional sector of health service. Their preference for the type of care they receive is largely based on personal and religious partiality. Some women find traditional medicine to be “outdated” and “non-progressive” and therefore attain care primarily within the biomedical domain. However, there are some women who prefer to receive antenatal services only from traditional practitioners. A large number of women seek out care from both the biomedical and traditional spheres of medicine.

There are a number of services available for expectant mothers. As the services become more widely available, it is my hope that journey of childbirth will be less perilous for all.

**NOTES**

3. Ibid.
4. Ibid.
6. Ibid.
12. Ibid.
16. Mensah, Frank Opoku. A Review of Safe Motherhood Initiative Including Definition of Abbreviations and Terms, Kwame Nkruman University of Science and Technology, Kumasi School of Medical Science, Department of Community Health, Kumasi, Ghana, July 2000.
17. Ministry of Health.
18. The Center for Reproductive Law and Policy, p. 35.
19. Ibid.
22. Amoo-Sakyi.
23. Kofi Appiah.
25. Ibid.
26. Ibid.
27. Ibid.
32. Mother #5, personal interview, 2 May 2004.
33. Ibid.
34. Nursing Officer, personal interview, 31 May 2004.
39. Ibid.
40. Midwifery student.
42. Helena, personal interview, 4 June 2004.
43. Anthony, personal interview, 10 June 2004.
47. Ibid.
48. Ibid.
49. Amoo-Sakyi.
51. Ibid.
52. Ibid.
53. Ibid.
54. Ibid.
55. Amoo-Sakyi.
58. Farnes, field notes, 6 July 2004.
61. Ibid., p. 4.
62. Mother # 5, personal interview, 2 May 2004.
63. Mensah, personal interview, 8 July 2004.
64. Ibid.
65. Ibid.
66. Ibid.
67. Ibid.
68. Mother #4, personal interview, 2 May 2004.

REFERENCE

APPENDIX
Appendix 1—Reproductive Protocols

I. ANTENATAL CARE

A. OBJECTIVES
Antenatal care (ANC) is the health care and education given during pregnancy. Antenatal services are an important part of preventive health care. The objectives of ANC include:

- To promote and maintain the physical, mental and social health of mother and baby by providing education on nutrition, rest, sleep and personal hygiene.
- To detect and treat high-risk conditions arising during pregnancy, whether medical, surgical or obstetric.
- To ensure the delivery of a full term healthy baby with minimal stress or injury to mother and baby.
- To help prepare the mother to breast feed successfully, experience normal puerperium and take good care of the child physically, psychologically and socially.

A safe delivery and postpartum health depends on good antenatal care.

B. ROUTINE MANAGEMENT

Number of Visits: The number of times a client needs to be seen during pregnancy may vary. The standard recommendation is that ANC visits should be made according to the following schedule:

- Up to the 28th week of pregnancy: monthly
- From the 28th–36th week of pregnancy: every two weeks (fortnightly)
- From the 36th week to delivery: every week

If for any reason the woman cannot make the recommended number of visits, then a minimum of four visits should be made as follows: at the 10th, 20th, 30th, and 36th weeks. At each visit the client should be categorized into risk group A, B or C, as outlined on page 4. Apart from routine visits, the client should report to the clinic anytime she feels unwell or has any complications.
1. **FIRST VISIT:** The first antenatal visit should be made as early as possible; that is, as soon as the woman thinks she is pregnant. A comprehensive history is taken. The purpose of the history is not merely to record facts and statistics, **but to assess the health of the woman and identify any problems which could adversely affect childbearing.** The routine steps of antenatal care during the first visit include:

a. **Registration (name, address, age, occupation, etc.)**

b. **Comprehensive Medical History:**
   i) Personal medical and surgical history, including any known allergies to medication
   ii) Family medical history
   iii) Past obstetric history (whether any complications were experienced)
   iv) History of present pregnancy (including date of last menstrual period)

c. **General Examination: The following assessments should be carried out**
   i) Temperature
   ii) Pulse
   iii) Blood Pressure
   iv) Weight and height
   v) Gait or deformity

d. **Physical Examination:** A thorough examination should be performed from hair to toe, with an emphasis on examination of the conjunctiva and nail beds for pallor (anemia). The breasts and abdomen should also be checked, and the pelvis for any sign of deformity.

e. **Obstetric Examination:**
   i) Inspection for scar, deformities, etc.
   ii) Palpation for fetal maturity
   iii) Auscultation of fetal heart

f. **Vaginal Examination:** To confirm pregnancy; detect the position of the uterus (anteverted or retroverted); and detect fibromyoma or any extraterine abnormality such as ovarian cyst. Done during the first trimester.

g. **Laboratory Investigations (where the capacity to carry out these exists):**
   i) Test urine for:
      * Proteins (albumin)
      * Sugar.
      * Midstream specimen of urine for bacteria and puree (pus cells)
      * Prognostic test to confirm pregnancy (first trimester)
   ii) Test stool for worms
   iii) Test blood for:
      * Hemoglobin level (Hb)
      * Full blood count FBC
      * Sickling
      * Grouping and Rhesus factor
      * VDRL
      * HIV (on request; must be accompanied by counseling)

h. **Routine Administration of Drugs:**
   i) Oral iron/folate
   ii) Chloroquine tablets weekly for malaria prophylaxis; daraprim as backup option
   iii) Tetanus-toxoid immunization (from 20 weeks, with second dose four weeks later)

i. **Client Education:** Education is an essential part of antenatal care; through education, women learn what they can do to protect their health during pregnancy, why medical care is important, and what danger signs to watch out for. In order for education to be effective, health workers should follow these principles:
• **Courtesy and kindness**: Clients should be treated with respect and, especially if they are unsure or frightened, with sympathy.

• **Listen and ask**: Many women already know a great deal about pregnancy and childbirth: before telling them what they should do, the health worker should ask questions to find out what they know and what they want to learn.

• **Answer questions**: In addition to providing the basic information outlined below, health workers should be sure to respond to any questions or concerns women may have.

• **Give personal attention**: Every woman is different and has different problems and needs both in terms of the medical care she needs and in terms of the information she needs. Therefore, every woman should be given information and counseling as an individual.

The following topics should be covered during client education:

i) **Care of her health**
   * Diet and nutrition: Good nutrition during pregnancy and lactation is extremely important. The key message is that the woman’s diet should include foods from the following food groups, with a special emphasis on body-building and protective foods:
     - **BODY-BUILDING FOODS** fish, meat, beans, groundnuts, seeds, dark green vegetables;
     - **ENERGY-GIVING FOODS** cereals, starchy foods, fats and oils; and
     - **PROTECTIVE FOODS** fruits and vegetables
     The client should be given a list of locally available foods within each of these food groups, and balanced diets based on these foods should be promoted
   * Rest and exercise: A pregnant woman should get between 6–10 hours of sleep each night, and try to rest for one hour during the day. She should also be encouraged to undertake moderate exercise regularly, if her daily activities do not entail much physical exercise.
   * Personal hygiene: Pregnant women should be advised to keep their bodies clean, especially the genital area and breasts, to minimize chances of infection.

ii) **Danger signs during pregnancy**
   * Swelling of feet, hands, or face
   * Severe headache or blurred vision
   * Severe abdominal pain
   * Persistent vomiting
   * Jaundice
   * Rupture of the membranes
   * Pale conjunctiva, tongue, palms, nail beds
   * Offensive or discoloured discharge from vagina
   * Bleeding from the vagina
   * Fever

iii) **Education on drugs**
   * Their effects and why they are given
   * Abuse of drugs and alcohol
   * Harmful consequences of smoking

iv) **Explain the purpose of antenatal care, as well as**:
   * Timing of next visit
   * Total number of visits
   * What to expect at subsequent visits

v) **Briefly explain physiological changes and events in Pregnancy** (e.g., changes in the breasts, growth of the fetus, onset of labor, etc.)

vi) **Explain effects of exposure to sexually transmitted diseases and AIDS**

j. Treat complications, if any *(see pages 3–24)*

2. **SUBSEQUENT VISITS**: At every subsequent visit, reference ought to be made to the previous particulars and the following routines carried out:
a. Medical History:
   i) Assess general health status
   ii) Ask whether any complaints or complications have developed since the last visit
b. General Examination: Assessments of weight and blood pressure should be carried out.
c. Physical Examination: as appropriate.
d. Obstetric Examination: as in first ANC visit
e. Laboratory Investigations:
   i) Test urine for sugar and albumin
   ii) Test blood for Hb (at 28 weeks and 36 weeks, or earlier if indicated)
f. Routine Administration of Drugs:
   i) Resupply iron/folate as necessary
   ii) Tetanus toxoid immunization (first dose from 20 weeks, second dose 4 weeks later)
g. Client Education: See principles of client education, as outlined above
   2nd Trimester
   i) Diet: in general, weight gain should not exceed 0.5 kg weekly, although this depends on the
      woman’s weight before pregnancy
   ii) What to expect during labour, preparations for delivery
   3rd Trimester
   i) Where to deliver (depending on whether she has any risk factors/complications: see below)
   ii) How to recognize that labour has begun, signs of complications during labour
   iii) Preparation for breast feeding
   iv) Family planning: child spacing and methods
h. Treat complications, if any (see pages 3–34)
   Clients are categorized into risk groups based on their previous obstetric history, medical conditions,
   age, parity, weight, and results of laboratory investigations. This allows health workers to identify
   obstetric patients who will require special attention, and also determines the optimal place of delivery
   (see below).

Appendix 2—Herbs used by TBA Acosua

- **toantini**—taken from the bush for ante partum. It causes “the joining of the muscles” or uterine contractions.
  Taken as palm nut soup.
- **kwatemaa**—APH, taken as palm nut soup.
- **asusumasa**—taken for constant reports of waist pains—possibly resulting from “for fear of having a
  miscarriage.” The herb is taken from the bark of a tree and is used to prepare a soup.
- **nsansotiae**—herb is taken for lower abdominal pains if the woman believes the pain is resulting from a
  possible miscarriage. She grinds leafs and stem, mixes them with ginger (akakaduro); used as an enema.
- **akandedua**—for retained placenta. The woman will chew the bark and swallow water with a little bit
  of salt.
Forced Migration and Health Syncretism:
The Changing Nature of Hmong Health Beliefs in Alaska

Jacob R. Hickman

Abstract

Due to the emphasis within the Hmong folk health system on spirituality and non-physiological etiologies, there has been a significant degree of conflict between Hmong refugees in the U.S. and the Western health care system. This conflict has been well documented in the literature. The present study, however, seeks to explain how and why the Hmong health system is developing into a syncretism of the folk beliefs and elements of the Western medical paradigm. This syncretism has lead to an intricate system of physical/spiritual diagnoses that significantly affects the way health-care decisions are made within the Hmong community. Susan Irwin and Brigitte Jordan’s model of the authoritative construction of medical knowledge is utilized to implicate local discourse concerning Western medical hegemony (including consequent legal intervention) as a significant factor in this syncretism.

Introduction

America’s secret war in Laos during the late 1960s and early 1970s displaced hundreds of thousands of Hmong refugees, who would, after years in Thai refugee camps, eventually resettle in various Western and Latin American countries, after the communist takeover of Indochina in 1975. Even as recently as summer 2004, the United States granted resettlement to up to 15,000 Hmong, who have been living in Wat Tham Krabok since the end of the war in Laos, a refugee camp in Thailand. By the end of this most recent program, a total of approximately 145,000 Hmong will have been officially resettled in the United States alone.

In a short number of years, Hmong communities and kin-groups have moved from their mountaineous farming communities in the highlands of Laos and resettled in inner-city U.S. neighborhoods. Consequently, they have gone from little or no contact with Western customs to being immersed in and forced to live through a Western paradigm. Some Hmong will portray this experience as progress, while many others will emphasize the difficulties of living in the United States and long for the time when they can return to their mountain homes in Laos and to their traditional way of life.

One of the most difficult aspects of displacement and resettlement for the Hmong has concerned health practices and beliefs. In their Laotian villages, the Hmong were familiar with the local spirits, had free access to shamans who were not politically limited in their curing techniques, and were not subject to an alternative, hegemonic view of health and illness such as that experienced by many Hmong in the United States. Some of the literature suggests that the Hmong, previous to intervention by American and Pathet Lao military forces, were not deeply affected by Western culture, merely because of the distance between their villages and the cities. While some contact was inevitable, major influences into areas such as health care were not rampant, except for communities who had converted wholesale to Christianity and rejected the former worldview.
Having been uprooted and relocated, however, the Hmong health system has been directly challenged and influenced by Western medical practices, and many traditional practices have been questioned by U.S. citizenry (particularly regarding animal sacrifice) and government agencies. The resulting confrontation between doctors, U.S. citizens living in communities with large Hmong populations, and the Hmong themselves have been well documented in the literature.

However, as the Hmong have interacted with health care and political systems in Western countries, they have also begun to adopt aspects of Western biomedicine and scientific rationalism. This syncretism of health beliefs has been mentioned briefly in some research on Hmong health beliefs but has gone largely untreated as to its nature, extent, and prevalence. The present study seeks first to document how a group of Hmong immigrants living in Anchorage, Alaska, have integrated various Western concepts, diagnoses, and rationale with the traditional health system. Second, this study describes how syncretism bears heavily on the manner in which health care decisions are made and how the Hmong interpret interactions with both Western health care providers and traditional healers, including negative experiences. Finally, this study implicates discourse in the Hmong community surrounding Western medical hegemony as a major factor in the development of this syncretism, utilizing Irwin and Jordan’s model of medicalization in this analysis.

The Hmong and Western Medicine: A Literature Review

The medical and anthropological literature is well developed in terms of documenting many of the traditional beliefs of the Hmong health system and their incongruence with the Western biomedical paradigm. Researchers have described a great number of case studies where such cultural differences have led to legal, physical, cultural, and psychological problems from medical encounters. These studies typically portray the Hmong system as mutually exclusive from the Western paradigm. Many researchers briefly mention the syncretism of Hmong and Western medical ideologies, but only in passing, as if it were a relatively infrequent or unimportant phenomenon. This may occur because the main purpose of many of these studies is to delineate the differences and make suggestions for overcoming problems in intercultural health situations. In such a context, it would be more important to explain the differences between the two systems than to explain how certain groups are integrating the seemingly opposed systems, but an understanding of the syncretism offers insights into health-care-seeking behaviors of the Hmong that might otherwise be overlooked.

One of the most commonly cited articles in Hmong health literature is Xoua Thao’s chapter in the *Hmong in Transition*. Thao is both a member and student of the Hmong–American community and cultural practice. His research was carried out in the context of the aftermath of the original migration of Hmong to the United States, and his work represents one of the founding studies. His main objective is to describe traditional Hmong health practices, which he does primarily in order to inform medical practitioners of the most significant cultural differences. He describes the various herbal and spiritual remedies and how the Hmong view them as solving health problems. Thao also refers to natural causes (i.e., non-spiritual) as a specific possibility in the Hmong paradigm, but these are not conceptualized in the same way *natural* biomedical etiologies are described in the Western
system. Physical explanations of sickness in Thao’s description of the Hmong system focus on seasonal or climate change.

Mary Jo Beghtol seeks to further facilitate this intercultural understanding between U.S. doctors and Hmong patients. Her conclusions include the assertion that “the Hmong who enters the U.S. medical system often does so only when all traditional curing methods fail. At this point, the patient is usually extremely ill, sometimes critically.” This suggests that Western health care is perceived as only a last resort to the Hmong. While this may have been the case in the latter 1980s, when the Hmong were relatively new to the United States, adopting such an assumption in the present would negate the prevalent syncretism of Western and folk health ideology in the community and underestimate the extent to which many Hmong rely on Western health care as a primary resort.

Sharon K. Johnson’s work represents a more recent treatise of similar matters. Once again, the focus is delineating the Hmong cosmology in an attempt to suggest ways that medical professionals can better accommodate the Hmong. Johnson includes additional perspectives on communication such as clan decision making, the collective nature of the Hmong lineage, and general principles of intercultural communication. To this end, she explains several case studies with negative medical and social outcomes. The Hmong system is portrayed here (albeit implicitly) as static and mutually exclusive to the Western system.

Another recent study by Rebecca R. Henry explains the medical metaphors used by the Hmong in describing illness, particularly the etiological development. Henry delineates the differences between the symbolic representations of illness held by Hmong and individuals in the U.S. The Hmong do speak of the natural world when talking of measles, but they attribute volition and will to that world, unlike the Western medical paradigm which does not. This reflects the spiritual nature of the traditional Hmong system, again delineating the differences and avoiding the syncretism.

Dia Cha and Lisa L. Capps, who deal most directly with the medical syncretism in the Hmong community, do so mainly from an analysis of the way Christian indoctrination has lead to the wholesale rejection of traditional Hmong cosmology. Cha also deals with non-Christian Hmong. She even goes so far as to list some conditions that are better treated by doctors than by shamans and vice versa. Sickneces more successfully cured by American doctors include gout, blurred vision, kidney problems, gall stones, appendicitis, broken bones, illness of the internal organs. Sickneces more successfully treated by Hmong healers included the common cold, flu, broken bones, sprained ankles, chicken pox, back pain, stomach ache, stress or shock, miscarriage or child birth problems, or soul loss. “Hmong herbalists and massage therapists can treat physical ailments quite well, while shamans, soul callers or performers of magical ritual can effectively treat the spiritual aspects of illness.” This syncretism is only briefly mentioned in her book-length treatise of Hmong health and remains underdeveloped.

Capps’ study dealt solely with Christianized Hmong. Consequently, her findings dealt primarily with the way Christian doctrine nullifies the perception of beliefs, such as soul loss, as valid causes of illness. Capps describes how such explanations are modified to coincide with Western and Christian cosmologies. Unfortunately, Capps did not have a non-Christian Hmong population against which she could compare her findings because of the homogenous nature of the Christian Hmong group in Kansas City, where she conducted her study.
The present study deviates from the course of this literature in its emphasis on the actual integration of Western concepts in the health-related worldview of Hmong Americans. Members of the community in Anchorage have merged aspects of both perspectives and have come to develop the necessary rationale for adopting seemingly contradictory philosophies. This elucidates how the Hmong are more holistic than typical Americans in their medical reasoning. They do not see their traditional health system as mutually exclusive to the Western biomedical paradigm, whereas many Westerns view the two systems as just so. In order to begin to delineate the changes in the folk system, I will first outline the basic nature of traditional Hmong health practices and beliefs. Subsequently, I will describe how diagnoses are made in the syncretized system.

Methods

The qualitative data used in this study was collected through in-depth interviews with twenty-five Hmong individuals living in Anchorage, Alaska. The participants came from several different clans, including Lis, Moua, Vaj, and Yaj. I interviewed specialized healers, clan leaders, Hmong medical staff and translators, and non-specialists. I cross-validated information among my sample of informants as I drew conclusions, using the saturation sampling and “sufficiency redundancy” technique. Additionally, I observed several healing rituals (both shaman and magical healers) and interviewed American medical staff who frequently work with Hmong patients.

Overview of Traditional Hmong Concepts of Health and Healing

The lack of a hierarchal, standardized structure of any type of religious belief or practice in Hmong society, coupled with the diaspora over the past four hundred years, has undoubtedly lead to geographical idiosyncrasies with regard to spiritual beliefs and healing practices. Therefore, one must be careful in generalizing characteristics of one community to the entire group of ethnic Hmong.

Given this consideration, however, my informants throughout the Anchorage community seemed to come from a fairly homogenous background of religious and spiritual beliefs. Even with regional and communal variations found in the intricacies of the Hmong worldview, typically only old men are expected to understand the system in great detail. Consequently, the most important considerations for the average Hmong person are the aspects of the worldview that are generally understood by most individuals as well as generally accepted as Hmong. In other words, idiosyncrasies in specialized practice are less important in a general analysis of the status of the folk health system because of the small sector of the population (old men, magical healers, and shamans) who maintain access to them. The average Hmong person only understands the generalities of the traditional system and is equally, if not more, exposed to modern American medicine. I interviewed both lay Hmong and specialized healers and will describe the traditional outlook of the typical Hmong person, as well as some of the more generalized practices of traditional healing.

The Spiritual Root of Physical Sickness

Animism is central to this generally accepted traditional Hmong worldview. Every person has a sprit or spirits, but the exact number varied by informant. The natural world consists of
benevolent, malevolent, and ancestor spirits. The physical and spiritual welfare of the Hmong depends heavily on their relationships and interactions with these spirits.

*Spirit Loss*

One of the most common sources of spiritual and, consequently, physical problems concerns the loss of one’s *ntsuj plig* (soul). *Tim ntsuj plig* or *poob plig* (to loose one’s spirit) most commonly results from extreme fright—such as from a car accident, as a result of offending a spirit in the environment, or from the mere malevolence of a *dab* (evil spirit) who holds the soul for ransom (*tim raug dab*). When the soul is lost or strays from the body, the victim will become physically sick.

*Ancestor Spirits*

The status of one’s ancestors, particularly recently deceased kin, is also intimately related to an individual’s health. If one’s parent or grandparent, for example, is wandering in the spiritual realm without food or money, one can become sick as a sign that the ancestors are in need of food offerings. This was described as *cov laus yuav noj yuav haus* (the elders want food and want drink). This problem can be ascertained when the sickness is accompanied by dreams in which the hungry or poor ancestor visits the sick person or is seen wandering without food or money. Alternatively, a shaman might diagnose this as the cause of the illness even in the absence of dreams or other spiritual manifestations.

*Menacing Spirits*

In addition to stealing a soul, malevolent spirits can also cause sickness from mere molestation (*raug dab*). In this case, the actual soul of the victim has not left the body, but the presence of the *dab* affects the victim, such as giving them a very painful headache, because the sick person has offended the spirit or entered its domain. These spirits can thus inflict physical illness on people, but this condition is mutually exclusive from *poob plig* or *cov laus yuav noj yuav haus*, because of the differences in the spiritual causes of these conditions.

*Healing Practice*

Hmong healing practice revolves around four central practices: *ua neeb* (the practice of shamanism), *khawv koob* (magical healing), *fiv yeem* (supplicating powerful spirits), and *hu plig* (soul calling). These are qualitatively differing techniques, some of which are preventative while others are curative. *Ua neeb* is the central practice, and the term is also often used to refer to the healing system as a whole. *Ua neeb* in its specific sense is the Hmong practice of shamanism, which is performed by a *txiv neeb* (a shaman or spiritual interpreter/spokesman).

There are as many brands of *ua neeb* as there are *txiv neeb*. This relates to the aforementioned lack of standardization but also stems from the nature of *ua neeb* itself. There are varying levels of *ua neeb*, as one informant, a prominent *txiv neeb* in the community told me. He classified *txiv neeb* into two groups—those who wear a red head covering and those who wear a black head covering. The former is said to be more powerful. A *txiv neeb* learns the practice from an ancestor who is a *txiv neeb*, and the power skips one generation and is passed on to a descendant of the same gender as the predecessor. Various practices will pass down certain lines, while other lines may teach different techniques. Additionally, the *txiv neeb*
learns a large part of the practice from shamanic spirits, who will accompany the shaman in his or her travels to the spiritual world during a shamanic performance. This spiritual guidance inevitably leads to variability as well.

These differences aside, I learned certain aspects of ua neeb from various informants, including several txiv neeb and respected elders, which were described as general principles upon which ua neeb functions. This philosophical basis will provide the platform against which I will compare syncretism with the Western health system.

**Ua Neeb**

This is specifically selected as a method to cure soul loss. When the txiv neeb is called upon to perform a healing ritual, he or she will enter into a trance state in which one chants in a spirit language that is not always intelligible with vernacular Hmong. During this trance, the txiv neeb is communicating with a dab neeb (shaman’s spirit companion) through spiritual means as the dab neeb retraces the footsteps of the lost soul of the victim. In doing so, the dab neeb encounters various spirits with whom the txiv neeb talks, both to gain information on the lost soul and to negotiate its recovery from the evil spirit that has taken it away from the sick person. The ultimate objective is to find out what happened to the soul of the sick person and devise a means of returning the soul to the victim’s body.

There are typically two phases of the ua neeb ceremony. The first is diagnostic and is referred to as *ua neeb saib* (to do spirit rites and see). The txiv neeb is seeking to make deals with spirits and entice them to return the lost soul. After this stage, the family and the sick person wait to see if health is restored. If it is, then a second phase must be performed—*ua neeb kho* (to do spirit rites to fix the problem). During this ceremony the txiv neeb pays the ransom promised to the spirits, which typically consist of the sacrifice of a pig, some chickens, fake money, or a combination of these. Should the victim not recover, the family does not carry out the ransom payment ritual and will likely seek out a different txiv neeb and start the process over.

**Khawv Koob**

As opposed to ua neeb, one does not need a special calling such as that endowed on a txiv neeb in order to master *khawv koob*. Anyone can learn it from a khawv koob practitioner, but it is a supplementary healing method with its own techniques. Bilingual Hmong often translate khawv koob as magic, but it is not parallel to the Western concept of magic. Khawv koob is a spiritual method of communication (using the same spirit language as the txiv neeb) and healing in which the practitioner chants or speaks magic formulas on the sick person to affect the cure. There are no spirits involved. For example, khawv koob is widely believed to fix broken bones much quicker than the cast that one might get at a hospital.

A khawv koob practitioner explained to me that if one says the right formula into a bowl of water and uses the water to wash over the area with the broken bones, the latter will work themselves back together and can heal in as quickly as seven days. I witnessed the same man use a completely different form of khawv koob to chase off several dab that were inflicting migraine headaches on an elderly woman. This type of healing is diverse, depending largely on from whom one has learned the formulas, and will vary significantly from practitioner to practitioner.
This is a preventative method of spiritual contract in which various spirits are promised certain dues in the form of animal or monetary offerings in exchange for services, usually protection. Any knowledgeable person can perform *fiv yeem*. Once the services are rendered (for example, a person is protected during a journey and returns healthy and safe or a student passes her exams), then the responsible party must follow up with *pauj yeem* (the sacrificial debt payment).

**Hu Plig**

Soul-calling, or *hu plig*, is also a very common healing technique. Once again, anyone who knows the method can perform a *hu plig*, but txiv neeb’s perform it often as well. I observed *hu plig* performed as a preventative measure at several happy occasions, including a one-month birthday celebration and a graduation. Informants also describe it as a healing method, however. This is typically the preliminary curing technique for *poob plig*—the soul loss described earlier. During the *hu plig* ceremony, the soul caller may go to the spot where the soul was thought to be lost and try to retrieve it. If the soul caller finds it, then the soul is brought home, and a *hu plig* is performed to welcome it home and invite it back into the body of the sick person. If the soul can be retrieved easily, *hu plig* will suffice, while in more complicated situations the txiv neeb must solve the problem through *ua neeb*.

**Tshuaj Hmoob and Other Practices**

Finally, the Hmong also use *tshuaj* (herbal remedies) to cure certain ailments. These remedies are usually used for stomach problems, and they typically involve roots and plants that were common in the mountains of Laos. Families still order them from Laos, but one must know how to cook the medicine properly in order obtain the desired effect. *Kws tshuaj* (herbalists) are still practicing and are typically female, but I never met or interviewed one during my fieldwork. *Kws tshuaj* also use Chinese herbs, and many Hmong consult Chinese herbalists. Informants indicated that neither brand of herbalism was superior, but both are used for different sicknesses. Additionally, the Hmong have adopted many other homeopathic practices, such as Chinese cupping. The mother and father of the family with whom I stayed during my fieldwork were sought out often to perform cupping on sick Hmong throughout the community, because they received specialized training on the technique in California.

*“Tus Dah Ua” and “Lub Cev Ua Xwb”: Health Syncretism*

This description of health practices serves as a traditional baseline against which I will compare changes in the health beliefs of Hmong refugees. Beghtol and Capps speak of the sudden shift from almost no contact before the Vietnam War era to immersion in Western influences that the Hmong refugees have experienced during resettlement. The previous lack of access to Western medicine made the traditional healing system extremely important. One female informant stated:

There is a lot of things that Hmong believe that like sometimes, . . . when we live in Laos, and we don’t have a doctor, and all we have is *ua neeb*, and natural herbs medicine, and they
don’t have any doctors to tell them what is wrong with them, so they just use their own medicine.

Thao asserts that, beyond the spiritual causes of sickness in the traditional health system, physical explanations in Laos were based on “the equilibrium of men and nature.” Fluctuation in weather and seasonal change can be seen as the causes of symptoms such as coughing, runny nose, fever, or a cold. “The shifting of the man–nature relationship” is seen as causing these momentary conditions, but nothing akin to patho-physiological explanation was present in this scheme. The Western medical philosophy was completely novel to the Hmong upon first contact. Other Hmong scholars argue that Western medical influence among the Hmong in Laos stretches back to the 1950s.

Many Americans expect the Hmong to abandon their traditional system in favor of the “more advanced” scientific medicine available in the United States, but this is clearly not the case. As they came into contact—often forcefully—with Western medical practice in the refugee camps in Laos and Thailand in the 1970s, the Hmong have developed an integrated health system that relies heavily on the traditional cosmology and incorporates Western explanations for some sicknesses. This has led to a dual diagnostic system in which various criteria are used to assess the spiritual or physical root cause of a given health problem. While Westerners often see the Hmong system as incompatible with the scientifically based medical practice of the United States, the Hmong see the two systems as complementary.

**Diagnosis**

Throughout my fieldwork I attempted to form lists of spiritually and physically based sicknesses. The results were fairly standard across informants, but all conceded that certain conditions may classify a typically physical sickness as spiritual, or vice versa. Therefore, these divisions are not impervious to alternative classification. Epilepsy, chronic headaches, exhaustion, stress or shock, paleness, and any sickness where one sees a dab is typically seen as having spiritual causes. Diarrhea, cough, fever, gout, diabetes, high blood pressure, stomach ache, headache, vomiting, and (for some informants) exhaustion are commonly perceived as purely physical conditions. In Laos, before the Hmong gained access to Western medicine and explanations, many of these conditions would have been attributed to spiritual causes. Presently, headaches and exhaustion are commonly perceived as both spiritual and physical conditions. The context surrounding the condition is an essential consideration in making these distinctions, however, and may even change the status of the condition from physical to spiritual, especially after treatments by Western medicine fail, which I will discuss below and illustrate in Figure 2.

Regularity, longevity, and spiritual visions or manifestations can indicate the spiritual basis for nearly any condition. First, if a headache, for example, occurs at the same time every day, then a dab is probably causing it. I witnessed a khawv koob practitioner chase away the dab that were inflicting migraine headaches on an elderly woman. She explained that, due to the regularity with which her headaches appeared, it must have been dab wanting some offering from her. The practitioner burned ritual money and bargained with the dab to leave her alone. She sought khawv koob services and consumed herbal remedies to resolve the problem.
Second, longevity of any condition is indicative of a spiritual cause. The spirits have power to inflict sickness that physical medicine cannot resolve. Through descriptions of the powers of medical and spiritual healers, Hmong informants indicated that, even if the proper treatment is applied to a physical condition, it will yet persist due to the spirits causing it until its debt demand is met. Informants could not explain how the spirits can enact physiological changes in humans. It seems that this is an irrelevant consideration—the fact of the matter is that they can. In one case, a stroke victim was left debilitated and unable to care for himself. Informants clearly saw this illness as stemming from eating habits and blood conditions. One woman stated, “High blood pressure is caused by the things that we eat.” However, the same woman also indicated that the family still needs to ask a txiv neeb to perform an ua neeb saib in order to see the spiritual reason that his condition was so persistent— to find out what is wrong with his spirit or soul.

The third set of indicators of a spiritual cause, regardless of the seeming physical nature of a condition, include visions of dab or visitations from the spirits of ancestors, usually in dreams. In the context of ancestor problems, sickness generally indicates their lack of food or money in the spirit world, which would necessitate an offering on their behalf. If the victim sees a dab while sick, than they must enlist a khawv koob practitioner to scare it away, or, if the dab stole the person’s spirit, a txiv neeb must retrieve it.

**Diagnosis and Treatment**

These three criteria positively indicate the spiritual causes of illness. Treatment is another essential consideration in making the ultimate determination of the root cause of an illness. If one of the aforementioned criteria is present but the spiritual healer is unable to fix the problem, the family will consult a modern doctor. On the other hand, if the sickness is determined to be physical but the doctor manifests doubt in his or her diagnosis or the treatment regimen is ineffective in the short run, the victim’s family will likely deem it a spiritual sickness. Thus, treatment plays a practical role in determining the nature of any condition. This practice requires the assumption that a cure will be found in one of the available treatments, whether Hmong or American, but does not seem to pose a problem to the Hmong who believe it.

As they have integrated Western concepts of health, many Hmong have developed a sense of scientific rationalism. This is narrower than the average Westerner’s view of science in that there is no blind faith that science will eventually solve all medical problems. If there is no cure available, the Hmong are less likely to expect one to emerge—they will rather attribute a spiritual etiology to the condition. In the same vein, if a surgeon feels that surgery is the best course of action to correct a health problem, most Hmong require empirical evidence that there is a physical problem and how the surgery would correct it. This is often requested in the form of an x-ray or some sort of visual portrayal that proves the condition.

**Health Care Decisions: Implications for Medical Professionals**

Thao and Beghtol state that the Hmong will exhaust all traditional healing techniques before consulting a Western physician. Nearly all Hmong I interviewed suggested that such was not the case. On the contrary, some indicated that they more commonly consult a doctor before performing ua neeb or khawv koob. Most commonly, however, these decisions are based on the aforementioned diagnostic system. Thao and Beghtol’s assertion, while it may have
been true more immediately after the initial resettlement in the late 1970s, can be misleading to medical professionals, who currently work with Hmong patients. It is important to note that some Hmong do not consult Western medical treatment until the condition is more critical, which perplexes medical professionals and seems to validate Thao and Beghtol’s claim. There are other explanations for this behavior which, if understood by medical professionals, could be utilized to overcome misunderstandings in the future.

Figure 1 illustrates the possible causes of sickness in the current syncretic system and the likely courses of treatment. In sum, treatment decisions are made in consideration of the typical perceived causes of the illness, the victim’s personal and family history (and, therefore, the state of his or her ancestors), any recent spiritual encounters, longevity of the condition, and past treatment experience.

Poob plig, or soul loss, is initially resolved with hu plig or soul calling. If this doesn’t work, the victim’s family will resort to ua neeb saib—shamanic diagnostic rite, and, subsequently, ua neeb kho—the actual fixing ritual—if the problem is resolved in the interim. Raug dab (spirit molestation) is resolved through the khawv koob (magic) practice of scaring dab away from the home of the daws dab (victim). If the problem relates to one’s ancestors (e.g., they need food or money) then one must ua neeb (contract a shaman) in order to fix the problem, which will likely result in a pauj yeem, or payment of promised dues to the spirits. Physical ailments are more difficult to diagnose because they are only physical if the doctor can resolve them. Some physical ailments are also treated by khawv koob (magic), which many Hmong believe to be superior to Western medical techniques for burns and broken bones. Herbal remedies are often considered as well.

Figure 2 represents the process of diagnosing a core physical or spiritual cause to any illness. The Hmong have no reservations about trying different healing methods that are based upon different healing philosophies. The common perception indicates that if one method does not work, perhaps another will. This is true for many Hmong who are not strictly Protestant. Those who convert to Orthodox Protestantism will leave behind all traditional healing practices as worldly and unholy. It is interesting, however, that these Christian Hmong do not negate the underlying philosophy of the traditional Hmong healing practice, but they prefer prayer as a better, or more righteous, means of healing. They see shamanism and khawv koob as sinful without negating the fact that they are real practices based on a valid view of the physical and spiritual world. For example, one of the leaders of the Hmong community in Alaska sought out a traditional healer, Mormon missionaries, and Western medicine to resolve the same physical ailment. None of them were able to heal his condition, but this did not negate the underlying philosophy of any of the systems he consulted. The Hmong tend to be more holistic and inclusive in their health beliefs and practices than their Western peers.

Hmong Experiences in Western Health Care

As I investigated how Hmong make health care decisions, accounts of communication difficulties and legal problems arising from interactions with U.S. health care frequently emerged. These problems constitute an important factor in the analysis of the development of syncretism in the folk health system. Among these intercultural difficulties, the most common among my informants (also well documented in the literature) result from the
perceived intentions of medical professionals. One Hmong woman and her son told me that American doctors only care about Americans and, therefore, treat Hmong and other Asian patients as research subjects for experimental procedures or investigation of the body. Many Hmong hold similar feelings, although it is sometimes reinterpreted on economic
Inquiry terms—if one does not have health insurance, one is more likely to be a research subject than a real patient. Similarly, many Hmong indicated a fear that student doctors perform the operations, with the real doctor watching and giving guidance (the implication was that the student doctor would not know what he or she was doing).

A second issue for many Hmong regards communicating traditional beliefs to doctors. If the doctor asks how a Hmong person got sick and he or she responds that his ancestors are hungry or that they ran into a ghost, then the doctor could label them as mental and prescribe tshuaj xiam hlwb (crazy medicine). Consequently, many Hmong are afraid to discuss the real issues of the illness with medical professionals. Stories circulate within the community in Anchorage that one of the neighborhood health clinics frequented by Hmong gives out a lot of crazy medicine to Hmong patients when they tell them what they think about spirits and illness.

In addition to the fear of divulging traditional beliefs and being taken less seriously, some Hmong believe that their traditional medicines and curing practices are themselves illegal in the United States. This probably is the result of stories about child abuse allegations and sentences that have resulted from Americans’ misinterpretations of traditional healing techniques (i.e., cupping and coining) leaving bruises on the skin. One family I interviewed had to explain away some bruises the father had during a medical examination from such practice—had it been one of the children, the doctor would probably not have been as passive about the issue. Nearly all informants also expressed a fear of divulging information about traditional medicine to health care providers. They were afraid that the doctor would not allow them to take the herbal remedies, and many would sneak them into the hospital in the form of tea or herbal drinks.

Stories about other Hmong families and their hospital experiences are widely circulated and have a tendency to shape ideology profoundly. For example, I documented one family’s account of a widespread incident—a standard endoscope procedure that went horribly wrong and resulted in the Hmong patient’s death, as the local narrative goes. The mother explained that the doctors sent the tube down the man’s throat to see what was wrong with his stomach, but the tube poked a hole in his stomach. After that point, all of his food leaked into his body, and he became bloated until he died. She understood this procedure to be experimental, believing that doctors commonly experiment in medical practice (and more often on Hmong refugees or other disadvantaged groups) without warning patients. I recorded several other versions of the same incident, but this family was deeply affected. The father of the family was scheduled for a similar procedure, as the doctors thought he had a stomach ulcer. When they learned of the incident from a cousin, he immediately cancelled his appointment and ordered medicine from Laos to cure the problem. They feared that the doctor would force him to go through with the seemingly unsafe procedure, but no confrontation occurred.

Fadiman documents a poignant case that is well known across the Hmong–American community. This account is parallel to others experienced firsthand by informants in this study, in which children are court-ordered by state agencies such as the Division of Child and Family Services to receive medical procedures deemed necessary by their doctors. The widespread nature of these types of accounts instills a fear in the Hmong that the government or hospital will force them or their children to undergo a procedure against their will. Knowledge of these instances, realistic or confabulated, affects the way Hmong interact with medical professionals and the extent to which they disclose important medical information to medical
workers (I must note here that the present purpose is not to advocate change in the legal system nor cast blame on the medical community.). The importance of these accounts is found in the perceptions that they create in the Hmong community. These perceptions have resounding effects on communication and interactions between medical practitioners and the Hmong, as well as their continued reliance on their folk health system.

**Medical Hegemony: A Mechanism for Social Change**

Irwin and Jordan offer a useful model for explaining how Western medical hegemony develops through the systematic legitimation of the biomedical paradigm and the opinions of practitioners. They describe how “pedagogy” is wielded to support medical authority, how this benefits the medical community, and “how medical knowledge is constituted as authoritative” through the construal of Western medical beliefs “not as socially constructed, relative, and coercive, but as natural, legitimate, and in the best interest of all parties.” This primary establishment of scientific, biomedical knowledge as superior has led to the legal reinforcement of medical prescription, such as the court-ordered cesarean sections described by these authors. In fact, one of the case studies dealt with a Hmong patient, whose reasons for denying the procedure were parallel to those discussed in the aforementioned accounts—fear of invasive medical procedures. The legal imposition of cesarean sections in Irwin and Jordan’s view further legitimizes medical authority within the social system, thus reinforcing the initial pedagogic establishment of the superiority of American medical knowledge. Alternative curing techniques and opinions are naturally invalidated by this process. Individuals are encouraged and rewarded for adhering to the tenets of the superior system.

This model is helpful in the present analysis. The stories that circulate about the state requiring Hmong parents and children to undergo medical procedures, the construal of Hmong medicine as illegal, and the medicalization of Hmong beliefs as psychiatric conditions serve the pedagogic function of Irwin and Jordan’s model. This leads Hmong refugees to accept the Western medical system as a natural part of life in the U.S., however reluctantly. One elderly Hmong man stated that, “In my country we ua neeb first, but in this country we go doctor first [sic] . . . it’s the law.” This can, in turn, reinforce the initial notions of the illegality of Hmong medicine or traditional healing techniques. As a natural consequence, Hmong will participate more fully in the Western medical tradition and biomedical concepts will become more familiar to Hmong individuals. Participation in the system will be sanctioned (formally by the legal system and informally by the circulated stories) and reinforced by medical staff, completing the circle of legitimization. This process is a probable factor in the integration of Western concepts of health and healing in the Hmong community.

The Hmong are not, however, completely discarding traditional beliefs in favor of a purely Western medical paradigm. Instead, the hegemony of the overarching system has inculcated Western concepts into the folk system, resulting in the present syncretism—Hmong maintain the philosophical foundation of the traditional worldview, while contemporaneously adopting the scientific, rationalistic foundation of the Western biomedical paradigm. The diagnostic system described here is a direct result of this interaction. Further research will be necessary to reveal the final course of this syncretism and the extent to which Western medical hegemony will eradicate the philosophical basis of the traditional worldview.
Conclusion

As the Hmong have migrated from the mountains of Laos to various locations in the United States, they have inevitably interacted with a medical system that is based on a scientific, rational philosophy that was foreign to and seemingly incompatible with their animistic worldview. A copious body of anthropological and medical literature documents traditional Hmong practices as compared to the Western medical paradigm and the confrontations that have arisen as Hmong refugees have attempt to continue traditional life ways in the United States. However, this literature rarely mentions the syncretism of health concepts that is taking place in the Hmong community.

Through this paper I have shown how Hmong refugee health ideology has been adapted to include biomedical concepts of etiology and pathology, while retaining the core aspects of the traditional folk health system. This has led to a diagnostic system that must account for social, spiritual, and physical contexts, as well as changes and constancies in the course of the sickness or condition. Consequently, it is often difficult to assign an appropriate treatment to an illness, and the efficacy of the healing technique reveals additional information about the source of the problem. The integration of spiritual and biological causes constitutes a diverse, holistic medical perspective in the Hmong community, leading the Hmong to seek both traditional and modern medical practitioners as primary health care providers.

Additionally, I have documented some common perceptions that Hmong hold of the Western health care system and related government agencies. The stories that circulate in the Hmong community affect perceptions of both health systems and motivate many Hmong to participate in the Western system, in addition to traditional treatments. It is likely that this process plays an important role in the acculturation of the Hmong into American society, which has resulted in the present syncretism of health beliefs and practice.

Ultimately, recognition of this syncretism, the resulting health care seeking behaviors, and the commonly held perceptions of health care provides an awareness that is essential to health care providers who work with the Hmong. Understanding the spiritual emic diagnosis will aid medical professionals in understanding why Hmong do not behave like their American counterparts in their interactions with health care institutions. Further, this knowledge facilitates a cultural understanding of the Hmong community that accounts for the dynamic nature of concepts of health and healing.

NOTES


8. See Johnson.


10. Cha, p. 60.

12. See Capps.


23. See Johnson, p. 129 and Fadiman.
24. See Fadiman.


Abstract

There are two main causes of the growing trend of medicalization in the west: psycho-social and political-economic causes. The tendency to only look at the physical factors of illness fulfills a psychological function of healing by absolving patients of responsibility for behavior. Assigning “disease labels” to social problems also provides a stabilizing function for society, because deviants are not alienated but are allowed to re-enter society when “cured.” These two factors make up the psycho-social cause of medicalization. The political-economic cause is that political and economic forces (such as capitalistic market forces) have led to biomedical hegemony in the west. Biomedicine has a strong tradition of viewing health solely in physiological terms. This paper examines these factors cross-culturally, to see if the forces that have led to medicalization in the West are present in Ghana. Though there is evidence that the psycho-social cause of medicalization exists in the healing practices of Ashanti healers in Ghana, medicalization per se is not prevalent in Ghana. I argue that this is because of differences in the political-economic cause (Ghana has a higher degree of medical pluralism) and because of the holistic practices of the Ashanti healers.

Introduction

The medicalization of social problems has been examined by experts in a variety of disciplines for more than three decades, yet the causes of medicalization and its effects on society are still very much contested. “Medicalization” refers to a process “in which personal and social problems and behaviors come to be viewed as diseases or medical problems that the medical profession has a mandate to treat.” I suggest that there are both psycho-social and political-economic causes of this phenomenon in the United States. The psycho-social function of medicalization absolves patients of responsibility by distancing the person from the deviant behavior, or, in other words, separating the individual from his or her actions by labeling the condition a “disease.” This type of treatment response is becoming increasingly common for patients with health problems that have both physical and social components.

The political-economic cause of medicalization relates to how political and economic forces have molded the healthcare system in the United States into a hegemonic, biomedical system that favors physiological analysis and promotes drug therapy. “Biomedicine” is a term used interchangeably with western medicine to denote the medical system that focuses “primarily upon human physiology and even more specifically on human pathophysiology” and that “constitutes the predominant ethnomedical system of European and North American societies and has become widely disseminated throughout the world.” This superstructure has emerged as a result of developments such as “industrialization, urbanization, secularization and the transformation of social welfare by the rise of modern capitalism.” In order to better understand the role of both the psycho-social and political-economic components in the
medicalization of social problems, this study examines how healers outside the reach of the biomedical system identify the sources of illness and treat patients whose problems fall in the uncertain area of physical/social illness.

The three healers in this study are from the Ashanti region in central Ghana. One is an *okomfo*, also called a diviner or fetish priest, and the other two are Christian prophet-healers. These healers were chosen because their practices are representative of common healing methods used throughout the predominantly Christian and animist Ashanti region. However, even though their healing practices are representative of healers in the region, the treatment methods themselves cannot be easily lumped together and be said to represent “traditional” medicine as opposed to biomedicine.

Each healer has a very different motive, belief, and personality that are reflected in the healing practices. In fact, their specific treatment responses to physical/social problems, and the sources they identified as the cause of illness, lie on a continuum. The continuum ranges from identifying personal actions as the source of illness, to citing unknown supernatural causes, to blaming others for the patient’s illness. Even though each had markedly different methods in treating physical/social illnesses, there was a theme common among all three. All three treated patients holistically; that is, they gave equal attention to physical, social, and spiritual causes of disease.

The continuum of treatment methods offered by these healers gives an interesting insight into humankind’s attempts to maintain social order through healing. Healing methods that assign “labels” and “cures” to social problems and, in the process, whether wittingly or not, absolve patients of responsibility (achieve “quick fixes” to these social problems) most often reflect the western practice of medicalization of social problems. This study examines medicalization cross-culturally, using ethnographic examples to form the basis of my conclusions. The results of this study show that despite similarities in the psycho-social function of healing methods in Ghana and the U.S., there is no medicalization in Ghana for two reasons: 1) traditional healers are part of a pluralistic medical environment instead of a larger, capitalistic, biomedical system that is subject to political and economic forces such as corporate interests, and are consequently free from the restrictions inherent in biomedicine, and 2) healers have not created artificial boundaries between the various components of health, and their holistic methods are well suited for working in the uncertain area between social and physical illnesses.

**Background on Healing Systems in Ghana**

Ghana is an example of a nation with a high degree of medical pluralism. Three main healing systems exist in Ghana: traditional healing, Christian prophet-healer groups, and biomedicine. People may choose the system that best fits their needs or use each of them simultaneously. Like many other African countries, Ghana has a strong history of traditional healing practiced by herbalists, okomfo, midwives, and other healers. In this study, I observed an okomfo, Nana Gyasi, in order to understand the main elements of pre-Christian traditional healing practices in Ghana. Interestingly, Gyasi does describe himself as a Christian, and in his cosmological worldview he sees the Christian God as above the *abosom* (lesser gods). In his healing methods, however, Gyasi communicates only with the abosom, and it is their will and good favor he seeks in order to find cures for his patients.
The advent of Christianity in Ghana resulted in the blending of traditional healing and Christian faith-healing practices. The Christian missionary movement began with the arrival of the Portuguese as far back as the fifteenth century, but it was the Basel/Presbyterian and Wesleyan/Methodist missionaries who established a permanent Christian presence in Ghana in the nineteenth century. Since that time, traditional religions and Christianity have combined and influenced each other, resulting in many new churches that incorporate both Christian elements and elements of traditional Ghanaian religion and culture. These new religious movements are often focused around one leader, the Christian prophet-healer, and many develop large and devoted followings. In this study, Pastor Peter Oppong is the most typical example of a Ghanaian prophet-healer. Prophetess Hannah Dwomah also falls under this category.

In addition, biomedicine also has a strong and growing presence in Ghana. Biomedicine first appeared in Ghana with the arrival of the Christian missionaries (missionary work and western medical services often went hand-in-hand in colonial times) and currently occupies a firmly established place in the healthcare practices of nearly all Ghanaians. Medical services are provided by the “central government, local institutions, Christian missions (private nonprofit agencies), and a relatively small number of private for-profit practitioners” and operate under the mandate of the Ministry of Health. There are also two medical schools in Ghana: the University of Ghana Medical School in Accra and the Kwame Nkrumah University of Science and Technology School of Medicine in Kumasi.

Thus, people in Ghana are not without the option of seeking biomedical care (except in the case of financial restraints, which is a frequent occurrence). However, many who can afford to be treated in the hospitals and clinics also visit traditional healers or Christian prophet-healers. The co-existence of different medical systems creates a positive atmosphere for holistic healing among the healers because they are free from the restrictions of being a small part of a one dominant system; namely, biomedicine.

Numerous studies have examined what leads to medical pluralism in African countries and what affect that has on the people. Many in Ghana have found that biomedicine is often effective in treating physical illness but lacks the ability to deal with more complex health issues, such as those that have both physical and social components. In this situation, many people turn to traditional healers and Christian prophet-healers to help in the total healing process. This study argues that it is this pluralistic framework that offers healers freedom in treatment methods and keeps social problems from becoming medicalized.

**Background on the Medicalization of Social Problems**

Ever since the 1980s, but especially over the last decade, both public and scholarly interest have increased in the connection between physical health and other aspects of well being, such as social, mental, and spiritual health. This phenomenon is an outgrowth of an increased merger of the social sciences and medical sciences in academic thought, and the consequent reevaluation of the American medical system that has evolved. Evidence of this synthesis of thought is manifest in the U.S. in a variety of ways, such as the increase in requiring religion and spirituality courses at medical schools, and the explosion of the alternative medicine movement on the Internet and in bookstores across the nation. This study examines all of the connections between the various aspects of health, but focuses specifically on the interplay of physical health and social health.
Physical health and social health are interrelated and can influence each other. Physical health refers to all the physiological processes that govern an individual’s sense of well being. Social health refers to the establishment and maintenance of healthy relationships, adherence to societal “norms” of behavior to promote group unity and order, and fulfillment of a productive role in community life. Physical and social health have an important relationship, but what many healthcare providers perceive as an ambiguous boundary between the two often leaves them unsure of their course of treatment, when something goes wrong in the uncertain area of overlap. In fact, there are no boundaries at all, but rather the many components of total health are connected in a seamless continuum. Attempts to artificially create boundaries can lead to the emphasis of one set of health needs over another and result in the neglect of other needs necessary to the healing process.

The over-emphasis of a person’s physical health needs can lead to the medicalization of social problems. When Kaufman and other anthropologists were researching medicalization in the late 1980s, there were already numerous well documented cases of how medicine had permeated many aspects of a person’s life. As a result of this phenomenon, “social deviance, behavioral eccentricities, or moral problems are transformed into medical concerns, or . . . ordinary life processes (especially birth and death) are reinterpreted as events requiring medical intervention.”

More than twenty years after Kaufman pointed out this growing trend, nearly every current social issue (from racism to hyperactivity to homosexuality) has been recast in a medicalized light. For example, in 1987 Howard Shaffer administered a survey about perceptions of disease and addiction and, according to his findings, 35.4 percent of the people surveyed viewed racism as a disease. Fred Newman, a philosophy professor and founder of the East Side Institute for Short Term Psychotherapy, stated in 1990:

If this test has any validity at all, what it suggests is that one out of every three Americans no longer identifies racism as a fundamental social problem, but regards it as a disease, on par with pneumonia and heart disease . . . I think [this is] interesting because it shows how effective the medicalization of America has been.

Anthropologists working in the sub-discipline of medical anthropology, as well as those in other fields, have continued to study this issue, and their work illustrates how the medicalization of social problems has increased since the 1980s.

Another problem that leads to medicalization is the tendency for people to look for quick fixes to their problems. In the United States, this is manifest by the explosion of prescribing drugs for what used to be considered behavioral or social problems for both children and adults. For example, Lawrence Diller, a doctor and author of the book Running on Ritalin, is a critic of the over-diagnosis of Attention-Deficit/Hyperactivity Disorder (ADHD) in children and of the rise of “cosmetic psychopharmacology.” In an interview with Frontline, Diller spoke about social causes of this “disease,” such as the influence of two working parents in a home, and other factors including:

[A] continuing erosion of parental discipline that probably began 150 years ago . . . we had the self-esteem movement in the 1980s that basically said that conflict is not good for children, that it further erodes their self-image. There was a misreading of Freud in the
1950s that said to reduce stress and your child will be neurosis-free. . . . All these things were going on through the 1970s and 1980s. And yet, Ritalin production remained stable all through the 1980s.\(^{12}\)

The spark that ignited the Ritalin explosion, he contests, was “the administrative change in the educational laws guiding our country’s accommodations to children. In 1991, it began to include children with the diagnosis ADD or ADHD . . . when [parents] found out that they could get special services and accommodations by getting the diagnosis, they flocked to their doctors. Word spread, and along the way, you also got Ritalin.”\(^{13}\) This is one example of a disorder that has been medicalized because people are searching for easy and quick solutions to their problems, even though the actual causes are more than physical and relate to social factors as well.

In the following sections, I will present a description of my fieldwork among the Ashanti people in Mampong, Ghana. Nana Gyasi’s treatments are truly holistic in the sense that he emphasizes changing personal behavior, taking medicine, and healing oneself spiritually by sacrificing animals to the gods as a means of currying favor with the gods and symbolizing a personal act of contrition. His methods are based more on personal responsibility than the other two. Hannah Dwomah also treated people with a variety of physical/social problems (alcoholism, aggression, etc.), which she grouped under the larger heading of “madness.” Her methods are the closest to providing the same psycho-social function as medicalization does in the U.S., in that she effectually separates the person from his or her behavior, so that they have an opportunity to reenter society again after they are “cured.”

Finally, I present the third case study as a cautionary example of the dangers of over-emphasizing social rather than physical causes of disease (the opposite of medicalization). Pastor Peter is holistic in the sense that he looks for social causes of illness; but, in general, he does not do so in order to help the patient solve the social problems underlying the illness. On the contrary, he seeks out social problems in order to assign blame to a family member or neighbor for “causing” the disease. Some of his healing methods could be considered manipulative, and I argue he preys on the fears of vulnerable people, especially women. This example addresses the concern that holistic healing practices can be used as a method of social control to gain power and status. Although the healers’ practices in this study each fall in a different part of a continuum of accountability responses, each found success in holism and acknowledging the social components of illness.

It is also important to address a final point that will clarify my intentions when explaining the findings of this cross-cultural study. This point was introduced in a summary article written about a conference called “Anthropological Perspectives on Holistic Healing” held in 1989. The authors ask:

Does medical anthropology look at systems of medicine and relate them to the societies in which they are practiced, or does medical anthropology look at the clinical efficacy and moral superiority of different medical systems and advocate one approach over another?\(^{14}\)

Each medical system must be evaluated on the basis of the culture from which it has sprung, so I would answer “yes” to the first part of the question posed by Goldberg and Hodes. However, I believe it is also possible to take positive guiding principles from any system and apply it to others.
for the benefit of all. While I refrain from making a judgment as to which health system is “morally superior,” the holistic approach of traditional medicine and the practice of medical pluralism are two such guiding principles that would help combat the spread of medicalization of social problems if adopted by health professionals in the western world.

Methods

I conducted my research for a period of ten weeks from May until mid-July in 2004 in Mampong, Ghana. Mampong is the capital of the Sekyere West District, one of eighteen districts in the Ashanti region in central Ghana. Its name literally means “a great town” (oman = town, pong = great). With a population of about 68,114, Mampong is home to 49.5 percent of the inhabitants of the district and it is a main center for trade and commerce. The native people of the region are the Ashanti. The Ashanti are a division of the larger Akan tribe, which makes up 44 percent of the total population. The Ashanti kingdom features prominently in Ghanaian culture, and the Asantehene (chief of the Ashanti) is still a powerful and influential figure in Ghanaian society.

The Asantehene’s palace in Kumasi, the largest city in the Ashanti region, is located thirty-seven miles southwest from Mampong. The second most prominent position in Ashanti society is held by the Mampongghene (chief of Mampong), so Mampong is also an important town in this region.

Mampong is also home to one of the Ghana’s district hospitals, which has a separate maternity wing and a midwifery training school, making it an ideal location to study medical pluralism in Ghana, because both health systems are serving the same population. The two Christian healers lived within the boundaries of Mampong itself, while Gyasi, the diviner or fetish priest, lived in Penteng, a nearby village with about five hundred inhabitants.

The population of the Ashanti region is mostly Christian, but there are also Muslims and those who believe in traditional religions, namely animism. The northern regions of Ghana have a higher frequency of Muslims, so the farther north one travels in the Ashanti region, the more Muslims there are. English is the official language of Ghana, and most of those who have gone to school can speak and understand basic English. Twi is the native language of this area, and I conducted interviews with the two Christian healers through an interpreter who speaks Twi. Gyasi speaks English very well, and I communicated with him without an interpreter. As well as interviewing the three healers about their healing methods, I also observed their healing ceremonies and interviewed those who had come for treatment.

Nana Gyasi: Mouthpiece of the Abosom

People are reluctant to talk about personal experiences with an okomfo. As I tried to interview people about the times they consulted an okomfo, I found that many denied they ever visited or consulted an okomfo. Most Ghanaians are Christian, and they are aware that the Western perspective of traditional culture and religion is often negative. An interesting side note, however, is that no one denied the existence of witchcraft despite negative stereotypes associated with traditional beliefs. The difference was that Christians believed it was their faith in God that protected them from the evil actions of others, while those who believe in traditional religion turned to the okomfo for protection.
This illustrates a fundamental concept of Akan ideology. The Akan people believe in the existence of a spiritual realm, and they believe events that take place in that realm can affect their physical health, as well as other parts of their lives (business, relationships, etc.). Gabriel Bannerman-Richter sums it up well when he states, “In the Akan world view, there is no clear distinction between physical and spiritual existences, for the two complement and merge in each other.”

It is this cosmological framework that leads traditional healers to practice holistic healing.

Nana Gyasi was the first traditional healer I met in Ghana. “Nana” is a term meaning “elder,” and it is reserved for those who are well respected in the society. He is a young man, twenty-eight years old, and very tall with long muscular limbs. His hair is rolled into long dreadlocks that hang loose past his shoulders. This type of hairstyle, which Ghanaians call “rasta,” is indicative of his role as diviner. Gyasi’s eyes are very expressive, and he opens them wide when he speaks about his life as one who has been selected by the gods to be the diviner at the shrine in Penteng.

He took this position after his uncle, the previous okomfo, passed away on 20 August 1995. Gyasi was in school studying to be an accountant. Even though he learned that many considered him to be the choice for the next okomfo, at first he refused to come and “do this work.” His father was a teacher, who often moved the family to different parts of the country to look for work, so Gyasi was used to traveling and hadn’t lived in Penteng for some time. He felt like a stranger in Penteng, and he really didn’t want to come back. The pressure for Gyasi to return to Penteng was hard on his family as well, because Gyasi was the educated son and the family didn’t want him to return to village life. What ultimately led Gyasi to this path was his concern for his father. His father had problems with his eyes, and Gyasi felt distinctly that if he did not come and perform this work for the people of Penteng, then his father would go blind. In order for his father to be “set free,” Gyasi came to Penteng and, with the support of the community, became the next okomfo of the shrine. His father’s eyes were healed, and Gyasi has been living in Penteng ever since.

The shrine area where Gyasi communicates with the spirits and holds consultations is set back behind the village houses, and it is very peaceful and serene. It is made up of a large open area, with chalk circles drawn on the ground. There is a small hut in the middle of the opening, with clothes hanging from the thatch on the roof on all sides. Gyasi told our group, consisting of BYU students and our professor, that these are clothes that he has taken from the witches he has caught. We were also told the hut contains witch-finding materials, but we were not allowed to enter. Near the hut, there is a table with a small statue of the shrine’s god. Another table is set farther back, and on it the elders have put offerings for the mmotiea (small, fairy-like spirits who live in the nearby forest). Gyasi’s chair is under a canopy made with bamboo poles and covered with palm fronds. While visiting the shrine, the other students and I walked around the compound gingerly and made sure not to photograph anything without asking his permission first. During our time there, most of us talked a little quieter, and the questions asked loudly seemed jarring and unnatural.

Gyasi holds consultations with those seeking his help every day of the week except Tuesdays. On Mondays, Wednesdays, and Fridays, the healing ceremonies are a bit more elaborate than on the other days, because the people of Penteng drum and sing as part of
Inquiry

the ceremony. In order to counsel patients, Gyasi must go into “spirit possession.” In his consultation sessions, he acts as the mouthpiece of the gods. When the consultations are finished, he actually has no memory of anything that went on while he was in possession. This is not to say that Gyasi himself is ignorant of healing methods, however. He has extensive knowledge of herbal treatments for a variety of conditions. He told us that he was trained in the skills of herbal medicine by the mmotiea, who are responsible for teaching a new okomfo all he needs to know to be successful. The mmotiea are also the ones who taught him how to do his hair in the “rasta” style. It is only possible to see these creatures if “you have eyes to see them,” Gyasi said. On more than one occasion, Gyasi told us that he has eyes to see things that we cannot.

Though various spirits possess Gyasi during the ceremony on different days, there is only one who possesses him during consultations. While in possession, Gyasi also seems to feel no pain. For example, while possessed with one spirit, he repeatedly poured sand in his eyes without flinching. Tolerance to pain is only one outward sign that indicates Gyasi is in spirit possession. It gives his patients assurance that he is acting as a mouthpiece of the abosom and transmitting messages from the spirit world. The manifestation of his pain tolerance on Quasi Day, however, was perhaps the most startling example of all.

Quasi Day is a holiday in Ghana when all of the traditional healers “perform.” This means they all enter spirit possession through drumming and dancing and hold consultations. We arrived in Penteng to observe Gyasi’s Quasi Day performance, when the drumming had already begun. Gyasi was up off of his wooden chair, decorated with shells and metal, and was bouncing up and down with small, jerky movements in time with the beat of the drums. The volume of the small band of drummers and singers had reached its peak, and we could tell he was already under spirit possession.

We waited to see which spirit would be speaking through Gyasi this time. The different abosom distinguish themselves by the different robes Gyasi puts on. He began to dance with his back held straight and tilted forward, moving his heels forward and back. It was the first time I’d seen Gyasi dance while going into spirit possession. I also noticed he was chewing a kola nut (a mild, caffeine-containing stimulant that is important in many West African cultures), something he didn’t usually do. Then the elders who worked at the shrine took off the white sheet Gyasi was wearing, leaving him only in shorts, and they began to vigorously rub poisonous plants all over his body. Gyasi had a look of amused detachment on his face—he was apparently feeling no pain or discomfort at all as they rubbed the plants very roughly over his chest, arms, and legs. He went into the small hut and put on a red ankle-length robe. This is the one he usually wore for consulting, so we recognized this spirit. He continued making his way around the shrine, throwing eggs and talcum powder and gathering different information from how they landed. He also shot a rifle in the air a few times—not part of his normal routine either—an act that made the obruni (white) spectators a little nervous.

After he poured libation on the grave of his uncle, he made his way to the consultation hut, and one by one the people who had come to see him were called into the hut. They had to remove their shoes and wristwatches (if they had one) before they entered. There were little wooden numbered tiles the people would take to indicate the order in which they would see him. I wondered if this was a modern touch, because it reminded me of western, monochronic
societies that place greater value on schedules, order, and efficient use of time. It didn’t seem to fit the laid-back, unhurried approach to time I had observed from many Ghanaians. Through the door, we could see him tossing cowry shells on the ground and answering questions. At times he was not even speaking Twi and the elders had to translate his responses. After consultations were over, Gyasi came out of spirit possession. He couldn’t remember anything about what had happened the entire time, and he had no marks on his body from the plants.

**Discussion: Consultations, Sacrifices, and Personal Responsibility**

From our visits at Gyasi’s shrine in Penteng, we learned that much of the ceremony is simply the spirit announcing its presence (though each action also has symbolic importance). It is only during the consultations that Gyasi takes on his role of healer. During consultations he asks the person seeking help a series of questions concerning his or her problem. He also throws cowry shells and reads the way they land to determine how to treat the patient. As this is going on, Gyasi’s father, an old man with very few teeth and short grey-white hair, sits on a chair in front of the hut and performs animal sacrifices (mostly chickens.) He cuts off their heads and drips the blood over what looks like an overturned bowl. He also drips the blood on some wooden tools, or talismans, nearby. The bowl and tools are stained black with dried blood and are swarming with flies. Gyasi’s father smears the blood on the bowl with his hand, chanting the entire time.

In treating patients, Gyasi employs some common methods, but he also shows a variety of responses depending on the specifics of the current case. Animal sacrifice is one of these common responses. Those who have come to Gyasi for help purchase the sacrificial animal in order to gain the favor of the gods, who will then act on their behalf in the spiritual realm. As well as animal sacrifices, Gyasi “prescribes” herbal medicines to deal with specific illnesses. He also counsels patients to change their behavior toward certain family members or other acquaintances as well. Gyasi’s treatments are at once spiritual, physical, and social in nature.

Many who come to Gyasi have illnesses that the doctors in the hospital could not cure, and so they determined (or were told) that they had a “spiritual sickness.” Though Gyasi doesn’t remember what goes on during his consultation sessions, he had clear opinions of his own when we asked him about the social problems he deals with, and how he treats them. He told us that one of the biggest social problems he encounters that manifests itself in illness is dishonesty, and the infidelity between marriage partners that goes along with it. Even when the people come to him for help, they often still refuse to tell the truth. He said that the gods want married people to be faithful to their partners, and even if people suffering from “spiritual sicknesses” still deny they have been unfaithful, it doesn’t matter because “the gods will know.” During consultations, the gods will discover the truth, and the patient will have to purchase an animal to sacrifice in order to be “set free.”

We also asked Gyasi to go into more detail about what he meant by “spiritual sicknesses” or *sunsum yare*. He answered that if doctors cannot cure your illness, and you’ve gone to the pastor to pray, and he also can’t heal you, you must find a “good person” to heal you. Gyasi made it clear that there are okomfo who are not “good people.” He knows of okomfo who tell people with malaria that they have sunsum yare, and tell them they must pay or they will die. They frighten them into paying when there is no cause. Gyasi’s background and the history of
how he became an okomfo illustrates that his motives for doing his work at Penteng are more pure. He is an okomfo because he answered a call from the spirit world, and so he has a good deal of influence and a respected position in the community because of his desires to serve the village and the gods. The strength of his personality and the fact that he holds the title of okomfo alone can facilitate healing for the patient. In his book, Patrick Twumasi stated:

Diagnosis of illness is deeply embedded in the whole magico-religious system. The medicine man performs acts which give the sick inspiration and restoration of confidence. He works with the strength of his own personality and with that of the magico-religious ritual which is a part of the common faith of the society of which he is a part. In other words, the whole weight of the community, its religion, myths, history, and spirit enters into therapy.17

Gyasi’s personality and position in the community has made him one of the most powerful people in the village, and he continually expressed his desire to use this opportunity to help the people of Penteng.

As a result of the position he holds, Gyasi also feels it is his duty to be an example of good moral values and encourage his patients to do the same. As mentioned before, he strongly detests dishonesty and infidelity. What sets Gyasi apart from the other healers is that he pays attention to personal responsibility. The spirits that possess Gyasi have no qualms about telling those seeking help what they need to change in their lives. The sacrifice that the patients purchase is a symbol of “owning” the problem, or making retribution for wrong acts that the patient has committed against the gods.

Gyasi’s healing practices yield insight into how the psycho-social and political-economic causes of medicalization function in Ghana. With his emphasis on personal responsibility, Gyasi did not attempt to absolve his patients of responsibility from their actions by assigning a label to their problem or separating them from their behavior. In addition, as a healer outside the realm of biomedicine, Gyasi had greater freedom to claim that non-physical factors (such as social or spiritual factors) may contribute to illness and to reflect this in his healing methods.

Hannah Dwomah: Spiritual Leader and Caretaker of the Mentally Ill

Hannah Dwomah, the Prophetess of the Ebenezer Church of Ghana, is both the spiritual leader of her church and a healer. Dwomah’s compound is on the outskirts of Mampong, and it only took Jones (my interpreter) and me about fifteen minutes to walk there from the center of town. In her compound, she has created a little community of patients, who reside in the houses along the periphery of the rectangular compound. A large cement building with a tin roof stands in the center of the compound, and this is where she holds church services.

Dwomah, an active and alert woman in her sixties, is a strong leader for her congregation. On our first meeting, she took time out to sit with me on the steps of the church house and answer my questions. She also introduced me to the patients who were staying with her and told me their stories. My first question for her was how she came to be the Prophetess. Like other Ghanaian healers,18 she believed her abilities were natural gifts, and like Gyasi, she felt it was her calling to be a religious leader and a healer. Her first experience of prophesying occurred when she was five years old. Her father was married to two women, her mother and
a woman whom Jones called “her mother’s rival.” Her mother’s rival was childless, but one day she showed kindness to Dwomah by giving her an egg, and Dwomah prophesied that the women would conceive and “bring forth a child.” This was the case, and from that moment on, she has “heard voices telling her what will happen.” These voices are what direct her as to what she should do for her patients.

She uses a mix of biomedical treatments (drugs from the pharmacy) and traditional medicine (herbs), but her main form of treatment is to pray for people and give them “blessed water.” The blessed water is regular water she prays over and to which she adds cologne called Florida Water bought in Kumasi.

One of the most interesting components of her healing is her work with people who have “madness.” Her treatments for patients with madness have a spiritual, physical, and social dimension. As I interviewed her, she gestured to a school-age boy lying on the step nearby. His eyes were bloodshot, and he appeared to be very lethargic. She told me this boy was suffering from “madness.” I asked her what symptoms denoted “madness,” and she told me bad behavior such as “keeping knives” was one sign of “madness,” but there are many signs. This boy had just arrived that day, but she pointed to another one nearby who had been there for six months. He had “madness” because he drank too much wine.

We met another young man who had also come to the compound with “madness.” He reported that he heard voices telling him to get up and run or people would come and kill him. It is clear that Dwomah did not try to differentiate between social causes of “madness” and other types of “madness,” distinctions that would definitely be made if he were a patient in a western biomedical system.

She held healing ceremonies that were a part of the worship ceremonies of her church, held in the large rectangular room in the center of the compound. I, another female student, and our other translator, Paul, had to remove our shoes upon entering. The other student and I had to cover our heads with scarves when we entered as well. Dwomah was wearing a long white dress with blue embroidery around the neck, and a white head scarf. First there was a worship ceremony, with singing, praying, and preaching from the Bible. Following this, the healing service began. Those to be healed got off of the long wooden benches they were sitting on and danced around a free-standing crucifix in the center of the room. There were different groups of people that got up to be healed, such as a group of pregnant women and people with “madness.” There was also a group for men, who consisted of three men and seven women, who were standing in for their male relatives (most of whom were working abroad). After the members in each healing group danced around the crucifix, they kneeled around it in a semi-circle while Dwomah or one of her assistants prayed for them. Then they got up, went outside, and drank the blessed water that another assistant poured into their hands.

Discussion: Separation of the Individual and Socially Unacceptable Behavior

Though people come to Dwomah to be cured from what they call “diseases,” her compound functions more as a place to rehabilitate those who have social problems, as well as what we would classify as mental illness in the U.S. Alcoholism is a social problem that she faces on a regular basis, and she sees it as a symptom of “madness.” At one point during the healing ceremony, she chastised a woman in the congregation for not coming up to be healed. She
declared that the woman was a drunkard, and she didn’t want to come up because she didn’t want to stop drinking. Alcoholism is not the only physical/social illness that she grouped under the heading of “madness.” As mentioned previously, other deviant behavior such as “keeping knives” could be classified as “madness.”

At the time I visited, there were more than ten people staying in her compound. Some had been there for long periods of time (months to even years), and it was clear that she had taken responsibility for caring for them. Others were there on a more short-term basis. One twenty-two year old woman refused to eat and bathe; her family brought her to Dwomah from Kumasi. She had been there for two weeks, fed and clothed by Dwomah, and she would now eat and bathe herself. Whether long-term or short-term residents, she cared for their physical needs as well as prayed that they would be “set free” from their “madness.” In this way, Dwomah absolved her patients from personal responsibility for the madness that was plaguing them and allowed them an opportunity for recovery and successful re-integration into society. This reflects the approach that can often lead to medicalization in the presence of a hegemonic biomedical system. The difference is that while western health professionals see a person as basically under the control of their physiological processes, and therefore not responsible for actions, she sees a person with madness as under the control of the devil and therefore not responsible for their actions. This is not to say she doesn’t expect the patient to take an active role in their healing process. The example of her chastising a woman in her congregation for not coming up to be healed of her drinking problem illustrates this point. The patient must be willing to change, but ultimately, only forces beyond the individual’s control can heal them.

Her congregation is an offshoot from a Methodist church that existed in the area. Her main preaching assistant, however, is a converted Muslim. His path to the Ebenezer Church of Ghana began when he fell sick and was counseled to visit a Muslim Maalam (the equivalent of Christian prophet-healers in Islam). He was reluctant to do this because he suspected that the Maalam would say that the sickness was caused by his father, mother, or some other family member and thus cause a conflict. This mode of ascribing causation to another person is not uncommon, as the next case study illustrates. He chose to visit a doctor instead, but he was still not cured. Finally he came to Dwomah’s compound, and he recovered from his illness. He has been with her ever since and preaches in her worship ceremonies.

Though she acknowledges the existence of witchcraft, and the possibility of one person cursing another, she does not single out specific people and attempt to destroy witches or punish witchcraft. In this way, her healing does not promote contention and feed rivalries and distrust, but rather it “serves as a form of social concept which helps to reinforce the mental and physical well-being of the social group.” Regardless of what evil forces may be causing her patients to be ill, Dwomah’s healing is based on the belief that there is an all-powerful God who can choose to heal the patient if it is His will.

Observing her healing methods offered another perspective on how the psycho-social and political-economic causes of medicalization in the U.S. are also at play in Ghana. She, like an increasing number of medical professionals in the west, assigned labels to illnesses that fell in the uncertain area between physical and social illnesses in order to distance her patients from their actions. This offered them an opportunity to re-enter society when they were cured. Though there are similarities in the psycho-social functions of her methods and western medical professionals,
there is still no medicalization of social problems in this situation because Dwomah does not emphasize biomedical explanations of the social problems she encounters. This is because her role as a healer is not tied to the biomedical system, and she, like Gyasi, has more freedom to attend to the non-physical components of illness.

**Blind Pastor Peter Oppong: Can Consideration of Social Factors go too Far?**

*Using Healing as Social Control to Gain Power and Status*

Pastor Peter Oppong is also a Christian prophet-healer, like Dwomah, but his style of healing and the methods he uses are very different from hers. One occasion during Oppong’s day-long healing ceremony illustrated his healing style and methods very clearly. As I was sitting on the wooden bench in the meeting hall, the drumming and clapping of his congregation had risen to a frenzied pace, and the crescendo of sound seemed to make the tension and suspense hanging in the room almost palpable. The most energetic was the little man himself, the blind pastor of the Glory Be to God Church.

He was wearing a purple robe that reached his bare feet. His eyes were open as he whirled around in a circle, hopping on one foot. I could see the pale blue, opaque disks that covered his irises and pupils glazed with a fine brown fibrous film. He was approximately five feet tall, had a stubbly beard, and he never seemed to tire during the all-day worship service. As the bongo player and the young boy at the base drum picked up speed, I could tell it was time for another of what Oppong called his “wonders and miracles.” He is famous in the community for these feats of healing. Jones told me that the council of spiritual pastors in the district wanted to make him an elder and “raise him up to be a great man.”

It was Friday, the day he holds his church services, and a group of nearly thirty people had gathered in the rectangle meeting house. The building has a tin roof, and the walls are made from dried palm fronds. The floor is dirt and there are benches along the walls and in rows on one side of the room.

One of his patients was a young woman, who was very pregnant and looked very distressed. Her brightly patterned shirt was lifted up to expose her rounded belly. She looked young, but I’ve learned that Ghanaians always turn out to be older than my original assumption. The blind preacher had woven a small whip-like tassel out of four leaves from a palm frond, which were only loosely bound together. As he waved it around the young woman, he seemed to be wiping her down with the leaves, especially across her belly. Jones translated their exchange for me. This woman had already given birth to two sons who had died. During this third pregnancy, she had started having some bleeding. Oppong’s diagnosis was that the devil had planned bad things against this child—and, in fact, her baby had already been boiled inside her womb. He told her when she gives birth, the baby will already be dead. The woman didn’t say anything in response, but her eyes began to cloud up. He went on to prophesy that her marriage was unstable, and if the woman didn’t pray hard, her husband would go and marry another woman. He said her husband was currently flirting with another lady elsewhere, and if this third child died, he would surely divorce her. Then Oppong proceeded to rub her belly with the strong-smelling holy oil poured from a small glass bottle.

I was beginning to wonder if he was going to dismiss her, when he began to counsel her to be respectful to her family members. He placed his leaf-tassel in a cup of holy water, taken from
a large basin under the table with the microphone equipment on it, and gave the woman some
to drink. Then he began running the tassel over her body and the music (which had died down
during their exchange) started up again. He told the woman that if she caught one or two of
the long, thin leaves (they look like very large blades of grass, about ten inches long), then her
baby would be delivered alive and healthy. He whirled around, stomping and shouting “Ai!,”
and the young mother kept her eyes locked on the hand clutching the leaf tassel. Suddenly he
stopped and released the bundle into the air, the leaves separating as they floated down. The
woman grabbed at them—but they all slipped through her fingers and landed on the ground.
The entire room groaned; the woman across from me covered her eyes with balled fists for a
moment. The young mother looked visibly shaken, but maintained a stoic look—almost as if
she were holding her breath.

Oppong became agitated that she didn’t catch any, and stomped back and forth with more
fervor than before. The four palm leaves lay scattered on the ground around the mother’s feet,
and it struck me how helpless she seemed there with her huge, bare stomaching bulging out and
her arms hanging limply at her sides. He declared he would do it again, but he would need
seven thousand cedis more (the original price was ten thousand cedis—about one U.S. dollar).
The woman’s family members returned with the money, and he made a new leaf-tassel, taking
four more leaves from his assistant holding a palm frond. The music reached its peak once
again, and everyone in the rectangular meeting hut was on their feet. Oppong danced and
spun, as the woman stared at him with her hand slightly raised and a tear streak shining on
her cheek. He stopped and held the fronds still for a moment in front of her and then released
them. The woman grabbed at the air and was left clutching two leaves against her chest. The
room exploded in relieved excitement, and I couldn’t help but cheer and clap as well as the
woman wept softly with joy.

Discussion: Blame and manipulation

This example, while only one of many in the five-hour healing ceremony, shows Oppong’s
healing methods—a mix of entertainment and Christian spiritualism. In this case, he declared
the cause of the young woman’s pregnancy troubles was that “the devil had planned bad
things” against the child. He counseled her to be respectful to her family members, implying
that her misbehavior toward them was the reason for her being susceptible to the devil’s
designs on her child. This is only one example of his turning to social causes to explain
disease; and out of all of the cases from that days’ healing session, this was the one instance
in which he hinted that the woman herself may need to change her behavior. In the other
cases, he attributed disease to the actions of other people. For example, during this ceremony,
eleven women were told that their disease or infertility was the result of a family member
or someone in their community cursing them. In fact, this was the most common diagnosis
of all illnesses. I choose this example to illustrate another point, however, which was the
vulnerability of his population, and the opportunity he has for exploitation of those who have
come to trust him.

Oppong turned to witchcraft to explain disease more often than the other two healers,
though at the onset of this study, I expected to see more of this from Gyasi, simply because
he is an okomfo and Oppong is a Christian. There are many different actions that he said
witches take to harm people, but there is a general theme of witches “eating one’s flesh” in the spirit world. As Bannerman-Richter explains in his book, Ghanaians believe that witches are people who can exit their body and wreak havoc on others in the spiritual realm. Witches meet as groups and must take turns bringing human flesh for all. Witches can only steal this flesh from those related to them; this is why Oppong points to family members as the cause of illnesses. Stolen flesh in the spirit world translates into physical illness in the real world. The link between physical and social is very strong in this sense, because one’s relationship with the witch often determines whether they will be the one the witch hurts. However, innocent people can also be hurt by witches. Witches need to supply flesh for the group when they are called upon and may be forced to injure an innocent person to do so. Thus, one cannot make a simple connection between behavior witches don’t approve of and ill health.

In the same ceremony, another woman had come to Oppong with all kinds of health problems. She told him that she dreamt she was being given bad food. He confirmed her belief that someone was trying to poison her and declared that she would die, but because of his prayers, she is alive now. This same woman also had a dream that someone was using a syringe to extract blood from her daughter. He translated this dream to mean that her enemies are stealing blood from her daughter to drink. The enemies are people in her house, because this is where she had these visions.

Oppong’s tendency to attribute illness to witchcraft yields an important insight into how the psycho-social factor in healing that can lead to medicalization in the West functions in his situation. Unlike Gyasi and Dwomah, he does not stress taking personal responsibility for actions or give a catch-all label to the problem in order to assign responsibility to unknown causes. Rather, Oppong places responsibility for illness on the shoulders of the family members or neighbors of the suffering person.

Another example of attributing illness to witchcraft occurred in the case of a woman whose granddaughter had a cut head. The woman reported her granddaughter was also very prone to illness. He told her that she had enemies who were witches, and these witches had cut off the child’s head (in the spirit world) and used it to play football (soccer). This is why the child has a “sickness in her head” all the time. He treated her by putting talcum powder on her head and then poured blessed water on her (he also has a bottle of strong-smelling blessed water, as did Dwomah). The purpose of this was to change appearance of the child’s head so that when the enemies come they will not recognize the head as their football. The woman was then given a special salt to put in the bath water of the child and counseled to buy millet, sugar, and red rice to feed the child.

Besides examples of “diagnosing” the witchcraft, I witnessed a witch being “cured.” Sandra was a twelve-year-old girl, and curing her of witchcraft was a large part of the healing ceremony. Oppong confronted her with being a witch, and she tearfully confessed to it. He declared that they had procured her witch animals (the embodiment of her witchcraft), which were a caterpillar and a frog. They had the frog there, and in order to release her from her witchcraft they burned the frog outside with kerosene (after a few attempts—it kept escaping from the plastic bag and his assistants had to chase it). He said she had become a witch by spending too much time at the “family house,” which is the home of her grandparents. He counseled her mother to not let her go there as often.
His methods in treating physical and social illnesses rely heavily on attributing all illness to social causes. Most often, he points to inter-relationship issues as the key, but his methods put more emphasis on assigning blame to “enemies” rather than encouraging healthy healing of damaged family ties, etc. Reading of Twumasi’s work suggests that traditional healers can play a role in promoting social well being for the community. He stated that in Ghana, healing is “much more than just the art of curing ills; it performed an integrative function as well . . . the traditional practitioners performed social analysis in order to restore harmony to the group.” However, accusatory healing methods such as Oppong’s do not promote social harmony, rather they propagate a cycle of distrust, jealousy, revenge, and contention among families.

The main value of the psycho-social component of healing is to assign something or someone responsibility for the illness in order to know how to combat the problem. Each of the healers dealt with this problem in a different way, and their responses fall on a continuum when compared with each other. Gyasi advocates taking personal responsibility for actions, Dwomah assigns the illness to unknown causes, and Oppong blames others (see Fig. 1).

Oppong’s healing methods do fulfill the necessary function of identifying the source of the illness, however, his case also serves as a cautionary example of the danger of overemphasizing social factors. Just as the overemphasis of physical factors can lead to medicalization, the overemphasis of social factors can lead to distrust, jealousy, and contention in a community. He used these methods not only to help heal his patients, but also to create a position of authority for himself. He encouraged people to think of their families and neighbors as enemies so that they would come to rely on him as their protector. When examining the psycho-social function of healing, it is important to remember there must be a balance between stressing physical and social factors. Otherwise, negative consequences such as medicalization on the one hand and manipulation of vulnerable people on the other can result.

Results and Literature Review

The three case studies presented here have illustrated a continuum of responses from traditional healers who deal with health problems that have social roots. Though the treatment styles are different, each healer has found a way to deal with these illnesses without focusing solely on the physiological side of the disease. In other words, they have not medicalized the problem. Despite the fact that the psycho-social component of medicalization exists in Ghana, especially as manifest in Dwomah’s practice, there is no medicalization per se, because there is no over-arching biomedical framework (political-economic cause of medicalization), and because the healers use holistic methods.

The political-economic causes of medicalization are best explained using the theoretical framework of critical medical anthropology. This theory emerged in the 1970s and came into its own in the 1980s. Anthropologists such as Arthur Kleinman, Merrill Singer, and Hans Baer were instrumental in espousing this new framework. In essence, critical medical anthropology seeks to interpret health and systems of healing based on the political and economic constructs of each culture. Baer, in particular, emphasizes the importance of studying the “political economy of health,” which he defines as “a critical endeavor which attempts to understand health-related issues within the context of class and imperialist relations inherent in the
capitalist world system.” These underlying political issues play a major role in shaping medical systems, especially biomedicine.

There are also two sub-areas of this political framework: the political economy of illness and the political economy of healthcare. The political economy of illness addresses the many preventable health problems that, according to Baer, can be traced to the inequalities inherent in capitalism. In relation to medicalization, however, the political economy of healthcare is the relevant issue. The political economy of healthcare is how class and power relationships affect the delivery of health services. Kelman’s in-depth analysis of the evolution of American medicine shows how it grew over time from a “cottage industry” to its present status as “a corporate and state enterprise involving not only the medical profession, hospitals, universities, and research institutes, but also pharmaceutical, insurance, and medical equipment companies.” These outside interests encourage the growth of medicine as an industry and push biomedicine to expand its boundaries into other areas of health.

Though Baer claims the imbalance in power relations between the classes is responsible for the problems in the current biomedical system, a distinction must be drawn between the medical professionals, who prescribe the drugs for social problems, and the political and economic forces at work that influence their behavior. Physicians in the western world are an elite group, generally made up of people from the upper class. However, the imbalance of power doesn’t lie here, at the individual level, because the physicians rarely, at least consciously, attempt to control their patients’ social behavior by prescribing them certain medications. In fact, “physicians themselves are undergoing a process of ‘depolarization’... in which their work is more and more being dictated by massive medical bureaucracies.” This is part of the trend of medicine turning into “big business.” Physicians are no longer as free as they used to be, and they now find themselves acting as an instrument of larger market forces.

**Medicalization: The Result of Doctor/Patient Power Relationships or Hegemonic Forces?**

Though Baer would disagree, some would argue that it is not hegemonic forces, but rather the power relationships between physicians and patients that is the key in understanding the inequality of the biomedical system. James Trostle, for example, studied the concept of “compliance” and dissected the reasons for why physicians were so concerned with ensuring their patients were in compliance with the doctor’s orders. He saw this as a clear manifestation of the ideology prevalent in biomedicine that the doctor and his prescriptions were the ultimate authority in healing. Just as compliance is about power and control, medicalization could also be seen as a physician’s attempt to maintain his control over any situation. Many feel they must “do something,” even when confronted with illnesses that are really social in nature, partly because of training and partly because of the faith patients put in their physicians. As specialists in the physical causes of disease, they naturally look to find a physical solution to the problem with which they are presented.

Trostle holds the opinion that doctors’ self-aggrandizing motives lead to coercive and manipulative efforts to increase patient compliance. He argues that they are guided more by their ideological views about what is best for the patient, rather than allowing the patient greater autonomy and self-care options. In an extension of this view of doctors’ motives, one who
Inquiry

ascrives to this description would say that doctors are purposefully and consciously trying to force their expertise into other facets of their patients’ lives. I argue that despite Trostle’s opinions on the importance of doctors’ motives, the case studies presented in this article (which put forth examples of healers with very different motives) show that without the framework of the market forces behind it, these factors will not lead to medicalization regardless of doctors’ motives and attitudes. The three healers had very different attitudes toward the amount of control they wished to exert over patients, yet all three of them were disconnected from any sort of network of outside forces that was encouraging them to view the patients in a less holistic way. Therefore, holism is downplayed and medicalization increases when there is consolidation of the medical system, and the political and economic forces behind the system have greater importance in determining this than doctor’s motives and doctor/patient relationships.

In Ghana, a country with a high degree of medical pluralism, there has yet to be the same amount of consolidation of the healing systems that there has been in western nations. Biomedicine is growing in Ghana, and most people who visit traditional healers also go to hospitals or health posts to seek treatment. Often patients will turn to an alternative health system (whether it is biomedicine or traditional healing) if the other system has failed them. Even though patients interact with both kinds of health systems, the traditional healers do not rely on the biomedical system for legitimacy, but exist outside of this system. They are more autonomous and are free to treat the whole person rather than act in the specific bounds delineated by the norms of the profession.

Holistic Care and Ambiguous Boundaries in Health

Turning to the final portion of my argument, it is the holistic methods of traditional healers that make medicalization of social problems less prevalent in non-western societies. Traditional healers do not focus solely on physical or physiological processes; rather they use holistic methods that emphasized spiritual healing and the importance of righting social wrongs. By Sharon Kaufman’s definition, the “holistic approach posits that the patient’s psychological, behavioral, and sociocultural characteristics (as well as physiological and biochemical characteristics) influence the course of illness and recovery and are therefore directly relevant to medical care.” In the grand tradition of anthropology (which has been built upon the principle of holism), I argue that a holistic approach to health is one remedy to stem the tide of medicalization of social problems.

Holism is well suited to dealing with physical/social problems in particular. This treatment style emphasizes healing the entire person and gives equal weight to both physical and non-physical components of health. In this way, holism counteracts the tendency of healthcare professionals to create artificial boundaries in health. Constructing an artificial boundary between physical and social health, for example, allows for the possibility of one exerting undue influence over the other (such as in the case of medicalization of social problems), and this leads to the negative effects of neglecting other areas of health.

Kaufman discusses the problem of health professionals’ perceptions of ambiguous boundaries in health in her work on stroke victims. She argues that this ambiguity is precisely what makes holistic care the desired method of treatment. In her opinion, the “expanding medical gaze” of biomedicine and health professionals is beginning to intrude into people’s
“life worlds.” It is clear that she feels this is a problem, especially for victims of chronic illness who are already so vulnerable. Kaufman presents holism and medicalization as two opposing forces in the conceptual framework of health. In building on her work, I agree that the lack of actual boundaries in health is what makes holistic treatment possible and necessary, and this is one method to counteract the medicalization of social problems.

In Western society, however, artificial boundaries in health are already firmly entrenched in healthcare systems. The concept of breaking down these artificial boundaries is the theme of many researchers who are interested in holistic healthcare. Daniel Moerman, for example, in his study of symbolic healing stated that there are “no fundamental boundaries between the mental and the physical.” As a result, he believes that the construction of healing symbols is just as integral to the healing process as the physical processes of healing. Traditional healers in Ghana often facilitate healing by symbolic means. The act of sacrificing a chicken, for example, is a symbol of asking for forgiveness from the gods. This sort of healing method is holistic in nature, and it is very important in dealing with illnesses that stem from social problems because it incorporates more forms than physical healing. As a result of the connection between mind and body, Moerman concludes that “ultimately healing is an aspect of social meaning,” and it is important not to try and separate the physical part of healing from its social counterpart.

James Fernandez takes this claim one step further in his statement concerning how the “illnesses men and women suffer are a symptom of the ‘sickness’ of their society. The microcosm reflects the macrocosm.” In his view, social issues and health are inseparably connected, and one cannot heal the body without also addressing the underlying social factors. In his study of prophet-healers in Africa, Fernandez also made a strong case that because of this connection, healers are treating the social problems of the community as well as caring for individuals’ physical health needs. In quoting another anthropologist, John Janzen, Fernandez said:

Janzen identifies a wisdom in these healing groups which contrasts with the Western sense of medicine and healing. That is the wisdom of taking illness and disease and turning it into social order. It is the same wisdom to be noted in the prophet’s own career: the transformation of the sufferer into the healer, of encountering the solution in the problem, of making community out of suffering isolation.

In Fernandez’ view, a person’s physical disease represents the “sickness” of their society, and the holistic methods of the traditional healers work to “turn the illness of the body into that healthy social order it can itself reflect.” The three healers in this study each work in their own way to maintain a healthy social order through healing practices.

The healers also held core beliefs as to the interconnectedness of the physical and social health. In each case, the healers advocated treatments that would heal which ever of these were not in order, often prescribing the same treatments for either problem. This shows that these issues were not separate to them. These holistic treatment methods are well suited in treating illnesses that stem from social problems because of the “boundary-less” nature of health. Because the population as a whole recognizes, in essence, the interconnectedness of social and physical health, the healer is free to counsel in each of these areas. They are also not restricted...
by exterior forces, because their profession is not consolidated like that of biomedicine, and capitalist forces have less influence on their healing methods.

**Applications**

This research offers a jumping-off point for further study concerning the causes of the medicalization of social problems and the role holistic healing practices and medical pluralism can play in curtailing this trend. There exists further opportunities for cross-cultural analysis of medicalization, as well as synthesis and interpretation of the growing body of literature on this topic.

Much of the research cited in this paper is from the 1970s through the early 1990s, when medical anthropology and critical medical anthropology were developing into the subdisciplines they are today. When medical anthropology was just emerging, many advocated what they called “therapeutic” or “clinical” anthropology, where the anthropologists would take on the role of healer in many cases, in light of their understanding of the holistic nature of health.

History has shown that this proposal never became a reality, but the emerging field of applied medical anthropology has done much about the health issues being studied. One vocal critic of “clinical” anthropology in the early 1980s was Howard Stein, who said that this new movement stemmed partly because many in medical anthropology have “long demonized the orthodox biomedical model, and idealized the putative holism of groups fortunate enough to resist the Western medical imperium.”

One reason that applied anthropology is a successful subdiscipline where clinical anthropology failed is that today anthropologists are more willing to acknowledge positive traits that promote health wherever they be found—whether in biomedicine or in traditional healing systems. This approach is beneficial, because it is not productive to “demonize” biomedicine, or even the hegemonic forces of capitalism. It is important, however, that people be aware of these forces in action in their lives. Just as the healers could benefit from learning from biomedicine, biomedical professionals could benefit from learning about the holistic methods of the healers. Specifically, one opportunity for applied anthropologists today is to examine how holism and medical pluralism could be applied to the problem of medicalization in Western medicine, in order to promote treatment for those with illnesses stemming from social problems.

**Conclusion**

In summary, this study breaks down the problem of the medicalization of social problems into its two components: the psycho-social function and political-economic framework. Ethnographic case studies of three different healers show that the psycho-social function is present in some of the healers’ practices because they too offer a label for the social problem at times, and turn a complex health issue into a disease that can be easily “cured.” Thereby, health is linked with maintaining social order in Ghana as well as in the United States. However, medicalization does not exist in Ghana because the political-economic framework in this nation is fundamentally different than that of a society with a firmly established biomedical system, such as the United States.

Instead of a single, dominant health system there is a high degree of medical pluralism. In addition, the holistic practices of the healers counteract medicalization, because they resist separating health into various compartments (and consequently avoid emphasizing one part
of health over another). Encouraging western medical professionals to adopt the guiding principles of holism and medical pluralism in healthcare is an important step to curtailing the trend of medicalization. Medicalization may provide respite from individual responsibility for the sake of maintaining social order, but, in the end, this confining approach to health can only offer society a temporary solution to complex social problems. Recognizing the value of the social as well as physical factors in health will result in a more comprehensive approach to health, and this will, in turn, be an important step in building a healthcare system focused on complete and total well being.

NOTES


6. Ibid.


9. Dr. David Larson at the Spirituality and Healing in Medicine symposium, sponsored by Harvard Medical School’s Department of Continuing Education. Quoted in Reuters 3/30/98.


13. Ibid.


18. Ibid.

19. Ibid.


23. Ibid.

REFERENCES
Maize agriculture in Mesoamerica dates back to almost 5000 B.C., at a time when grinding tools also began to emerge as important instruments for food preparation. In archaeological excavations spanning the Mesoamerican landscape, *metates* have been ubiquitous in houses of the Olmec, Maya, Aztecs, Zapotecs, and many other cultural groups. Their principle function has been to grind maize into *masa* (dough) in order to prepare traditional foods such as tortillas, tamales, and atoles. They are also used for grinding other foods and materials such as chile, cacao, seeds, coffee, salt, ceramic temper, and paint pigments.

Maize grinding is considered one of the most important and time-consuming female activities in the Mayan household. The women that continue to use *manos* and metates today rise early in the morning to grind corn and prepare tortillas for the day’s meals. The work is arduous and long. Some older women suffer from rheumatic shoulder pains, which are most likely attributed to the physical demands of grinding.

Metal hand grinders (Figure 1) may have appeared around the beginning decades of the twentieth century and could be used for a very rough grind. A few decades later, gas propelled motors, which drove large industrial grinders, were introduced that could grind maize in seconds, a process that would normally take a woman most of the morning. But before the introduction of motorized or electric grinding mills and hand grinders into much of Mexico and Guatemala, maize was being processed solely on metates.

John Clark said that in ancient times “manos and metates were probably the most essential implements in any household.” By understanding the importance of maize consumption and preparation in Mesoamerican culture, it becomes evident that the task of grinding corn for meals was (and still is in many cases) an indispensable and labor-intensive routine.

The purpose of this paper is to analyze the existing ethnographic accounts of the time it took women to prepare maize on metates. Considering the differing times presented by these accounts, a conclusion will be made on their validity. In addition, I will compare these results to four others recorded in my 2004 field season among the K’ekchi’ and Quiché of Guatemala. Looking through a broader lens, this study will aid in reconstructing a small portion of the lives of people who lived in the houses that are excavated in Mesoamerican archaeology.
Factors Determining Grinding Time

First, before looking at the specific ethnographical studies of maize grinding, there are some issues I would like to bring to the table. Determining the amount of time that women spent grinding corn each day may be affected by a number of factors. These include, but are not limited to, stone composition, metate style, and the individual operating the metate. Because there is no indication of composition or style in some of the available ethnographic records, it is hard to determine what type of stone the metates were made of or what style they represented. This section will highlight what the preferred styles and types of metates used by women in Mesoamerica may have been.

Type of Stone

Metates are made of several types of stone that all have specific characteristics. Basalt, especially vesicular basalt, is among the most common (Figure 2). Other types include granite, rhyolite, andesite, quartzite, sandstone (which is common in the American Southwest), and even limestone. Naturally, softer stones such as limestone and sandstone would not be the most desirable on which to grind because stone particles would contaminate the food being milled.

According to Clark, metate stone is acquired either by being quarried or collected from surface boulders. Surface boulders are often river cobbles of andesite, granite, or quartzite. The most common and desirable quarried stone for the purpose of making metates is vesicular basalt. Michael Smith wrote that basalt metates were made in and distributed from the Otumba city-state region among the Aztecs in the Valley of Mexico. Also, analysis of vesicular basalt provides evidence that it produces metates with the longest life use.

I recently visited two quarries in Guatemala. One is located in Nahaulá in the department of Sololá and the other in San Luis Jilotepeque in the department of Jalapa. Both exploit vesicular basalt for the production of modern metates. The metateros (stoneworkers) determine quality of the stone by examining the density of vesicles on the rock. When the rock exhibits fewer and smaller vesicles, the basalt is considered to be too hard and difficult to work with. If the vesicles are too large then the stone might be too soft and particles of stone will contaminate food. A perfect medium determines the finest quality of vesicular basalt.

Mary Spinks researched metates located in prehistoric houses of Copan, Honduras. Rhyolite represented the majority of stone metates in the houses excavated. She found that 68.2 percent of all footed metates found were made of basalt. Her ethnographic investigations showed that “rouglier stone is good for breaking maize kernels. A vesicular rock would be constantly rough. New pores would be opened as old ones were worn away.”

Jenny Adams conducted experimental work upon metate types similar to those found in the archaeology of the American Southwest. Although not directly associated with Mesoamerica, this information is an invaluable analog for understanding the essential efficacy and function of metates worldwide. Adams found that vesicular material provided a better surface on which
to grind seeds and dried kernels because it did not add particles of rock to the flour. Although metates of other types of material and surface texture exist and are produced, it seems that ones of vesicular basalt are preferred and make up a large portion of those produced and used in Mesoamerica today.

**Style of Metate**

Another aspect of Adams’ experimental work looked at the efficiency of different types of metates. Again, she used styles that correlated to the American Southwest, which include basin (Figure 3), flat/concave, and trough metates. These types closely relate to those found in Mesoamerica, although the terminology and taxonomic method to describe them might be a bit different.

Adams showed that trough metates (Figure 4), those with “intentionally manufactured rectangular basins or troughs,” could grind more grain per unit of time than the basin type of metate. (“Trough” metates as described by Adams are technically the same style as Clark’s “restricted” metate). She also demonstrated that the flat/concave and trough metates were “equally efficient” when tested in processing soaked kernels, which is the most common type of maize grinding performed among Mesoamericans.

Looking at a number of cross-cultural studies on the relationship of increased agricultural dependence and mano size, Michael W. Diehl found that manos with a larger surface area could process more grain than smaller manos. He concluded that “larger manos are more efficient than small manos, and flat-bottomed (trough and slab type) metates are more efficient than basin-bottomed metates for grinding large amounts of corn.”

**Individual Grinding**

During ethnographic work on grinding among the Hopi, Adams was informed, “A novice grinder may grind differently than an experienced one.” She explained that this variable was not considered in her experimental work on metates, but that it is an important one to consider. Essentially, someone with more experience will grind more efficiently than one who is just beginning to learn how to grind on a metate.

For example, Adams said, “Hopi women who have ground food all their lives emphasize using rhythmic strokes and using the whole body, not just the arms.”

Barry L. Isaac pointed out that because grinding maize requires a great amount of arm strength, preadolescent girls would not contribute significantly to the daily grinding process.
One would assume that they would have to endure a long period of constant, rigorous motion in order to efficiently prepare maize for those within the household.

The Codex Mendoza, a post-conquest Aztec manuscript, records information dealing with the instruction mothers would give to their daughters on how to grind with a metate. Figure 5 shows a mother with a speech scroll coming from her mouth, indicating that she is talking to or educating her daughter about grinding maize and preparing tortillas.

![Figure 5. An Aztec daughter being taught by her mother to grind maize and make tortillas. (Smith 2003:62 [Codex Mendoza])](image)

The accompanying text indicates that the girl is thirteen years old. Considering that this girl is essentially “in training,” she would still be learning to grind maize as instructed by her mother. This strengthens Isaac’s claim that preadolescent girls may not have had the experience or strength to perform this laborious task efficiently.

**Summary**

With these conditions defined, it seems that an optimal situation could be constructed. Essentially, a vesicular basalt, trough style (or restricted) metate combined with an experienced woman operating it would provide the most efficient grinding circumstances. Unfortunately, these variables are not available in the ethnographic data available on grinding times.

Later in this paper, I will show the results of four Mesoamerican women who ground a specific amount of corn from *nixtamal* to masa. I recorded the time it took from start to finish. But first, I will present the estimated grinding times found in ethnographies from around Mesoamerica and try to determine some middle ground.

**Ethnographic Data**

In searching for data on grinding times in Mesoamerica, I have encountered five different sources for the amount of time women dedicate to grinding maize daily. I will present these
along with some of my own ethnographic work among the K’ekchi’ and Quiché of the Highlands in Guatemala.

First, Beverly Chiñas studied the roles of women in a Zapotec community in the Isthmus of Tehuantepec, Oaxaca, Mexico. Speaking of some of their household duties, she said:

Tasks other than child care also demand attention from women of the household, cutting into the time which can be used to increase household income. But household tasks require rather less time in the Isthmus than might be expected, because of . . . a few simple but significant technological advances such as the mechanical nixtamal mill which saves six or eight woman-hours daily formerly devoted to grinding by hand.  

It is important to note that the estimate of six to eight hours by Chiñas is in terms of “woman hours.” It indicates that the grinding may not be the sole responsibility of one woman. According to Isaac, this may be a plausible case due to the larger household size in this community in comparison to the other ethnographic accounts. Also, families in Guatemala usually divide the work of grinding among the mother, daughters-in-law and daughters who learned to grind in their younger teenage years.

Beginning in 1957, Evon Vogt spent a significant amount of time with the Tzotzil-speaking people of Zinacantan, Chiapas, Mexico. His research touched on the preparation time of maize for tortillas. A significant aspect of this account is that all the grinding was done solely on the metate.

After being washed, the kernels are placed on a metate to be ground, ordinarily two or three times. The metates in use in Zinacantan are three-legged types made of basalt by the neighboring Chamulas and sold in the market in Chamula or San Cristóbal. They are placed on a board which raises them about twelve inches off the floor and makes it easier for women to grind in a kneeling position.

The grinding process is long and arduous. Women start in the morning between five and six and it is often eight am before they have produced enough tortillas for the day’s meals. As soon as a woman has enough dough ground, she begins to pat out tortillas and to cook them . . . .

Once cooking begins, a remarkably efficient set of operations is in process—for a woman may simultaneously be grinding additional corn, stopping to pat out tortillas when more are needed, and cooking tortillas on the comal. All the materials and instruments are within her reach from her kneeling position at the metate.

Although Vogt is vague on his estimated grinding time, we can roughly determine that it took the women of Zinacantan three to four hours to complete grinding and cooking all the tortillas in the morning. I will return to discuss how simultaneously grinding masa and cooking tortillas plays into this and other estimated times.

Although Vogt is vague on his estimated grinding time, we can roughly determine that it took the women of Zinacantan three to four hours to complete grinding and cooking all the tortillas in the morning. I will return to discuss how simultaneously grinding masa and cooking tortillas plays into this and other estimated times.

In an introductory reader to Aztec archaeology and ethnohistory, Smith referred to “modern Mesoamerican peasant women” and compares them to ancient Aztec women. Although there are no ethnographic works cited for this comparison on grinding times, it represents yet another interpretation of how much time women dedicated to grinding maize daily.

Commoner women spent much of their work time cooking and preparing food. Grinding corn for tortillas and tamales was the single biggest task. Before the advent of mechanical
mills, modern Mesoamerican peasant women would spend five or six hours each day grinding corn for the family’s meals. Aztec women must have spent a similar amount of time at the metate (grinding stone).

George Foster conducted fieldwork among villagers in Tzintzuntzan, Michoacán, Mexico, intermittently in 1944, 1946, and 1958. At the time of conquest, Tzintzuntzan was a great city and the capital of the Tarascan Empire.

Foster’s work focused on the modern mestizo village of twenty-two hundred inhabitants in the middle of the twentieth century, and he considered some of the changes facing this rural community similar to others in the world’s developing countries.

As with previously described ethnographies, a portion of Foster’s research focused on the peasant society and their daily routine. He explained the woman’s duty of grinding maize and cooking tortillas for her family:

After grinding, nixtamal becomes a dough, masa. The careful cook regrinds this little by little on her metate, stopping to scoop up the resulting varves from each stroke of the mano, the cylindrical grinding stone which she holds in both hands. Small daubs of dough are patted into tortillas, an operation that takes about fifteen seconds for each. . . . A good worker who is not interrupted can make and cook four liters of tortillas—sixty-five or seventy—in about an hour; this meets the needs of an average family.

In contrast, thirty years ago before mechanical mills were introduced, hand grinding of the nixtamal alone required an additional two hours of backbreaking work, time which was found by arising two hours earlier than at present.

This account estimates grinding, without the aid of a “mechanical mill,” to be approximately three hours. Foster also included in the hour of the final grind of nixtamal the step of patting small daubs of dough into tortillas. In my 2003–04 fieldwork, I, too, had observed this among the K’ekchi of Alta Verapaz. A woman, during the final grind, will grind out enough dough for one tortilla (Figures 6 and 7). She will pat out that tortilla (Figure 8) and after laying it on the comal to cook, will return to grind enough dough for the next one.
Briefly, the K’ekchi’ continue to use metates for a final processing of corn and other foods. Most use them daily, and some women still use them to grind corn for every meal. Rosa Ca’al, the woman in the photographs above, had ground the amount of corn needed for one meal with a metal hand grinder. She then proceeded to do the final grind on the metate and cooked the individual tortillas intermittently. It took approximately twenty to thirty minutes to complete the small amount of corn used only for this meal.

This process of grinding for the last time and cooking the tortillas simultaneously is similar to Vogt’s description of the Zinacantecos and Foster’s account of women in Tzintzuntzan. The concluding “fine grind” while also individually cooking the tortillas appears to be common practice among at least three (including the K’ekchi’) of the six examples presented, and that may be due to the fact that they are the only ones that report such behavior.

The last reference to daily grinding time is Oscar Lewis’s observation in Tepoztlán, Morelos, in the 1940s. He briefly mentions that the introduction of a mechanical mill to this area freed women from four to six hours a day.

### Daily Grinding Time Estimate

The paucity of data on grinding times makes estimating an accurate mean time a difficult task. Isaac also briefly analyzed the estimates of grind times of Lewis, Foster, Vogt, and Chiñas. He explained that a pre-industrial Mesoamerican peasant woman, in addition to the preparation of food, would be responsible for “all of the household’s marketing (which may require quite a bit of foot travel), some or all of its pot-making and weaving, and all of its childcare and its laundry (the latter, but hopefully not the former, on a rock at the spring or well); in addition, she cares for a small flock of turkeys . . . and tends a kitchen garden that provides essential greens.”

Isaac posed an evident question. How would a woman have time for these other activities in the day if a third of her waking hours were spent grinding? This question makes me especially skeptical of the claims by Chiñas that maize processing on a metate occupied six to eight hours of a woman’s daily work time. It seems that the energy expended during grinding would not be worth the end result or the effort.

For estimation purposes, a simple average of the median times given by these five ethnographic descriptions can be made (Table 1). Although the situations and circumstances were probably different in every case, this helps narrow down the amount of time it took to grind corn to a time of 4.8 hours a day.

This number still seems high to me, and I am more inclined to feel that on average, women were grinding in the range of three to four hours a day; two to three hours being dedicated to grinding out a rough grind and one hour or so performing a fine grind and also cooking the tortillas.

### Table 1

<table>
<thead>
<tr>
<th>Estimator</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiñas (1973)</td>
<td>6</td>
<td>8</td>
<td>7.0</td>
</tr>
<tr>
<td>Vogt (1970)</td>
<td>3</td>
<td>4</td>
<td>3.5</td>
</tr>
<tr>
<td>Foster (1979)</td>
<td>3</td>
<td>3</td>
<td>3.0</td>
</tr>
<tr>
<td>Lewis (1949)</td>
<td>4</td>
<td>6</td>
<td>5.0</td>
</tr>
<tr>
<td>Smith (2003)</td>
<td>5</td>
<td>6</td>
<td>5.5</td>
</tr>
</tbody>
</table>

Average 4.8
Grinding Times Recorded in Guatemala, 2004

In May and July 2004, I conducted a number of surveys among the K’ekchi’ and Quiché of the Guatemala Highlands. Part of this research included recording the time it takes to grind and cook tortillas. I included some controls such as only grinding boiled maize, specifically twelve ounces of nixtamal, and the tortillas were cooked immediately after or during the process. Initially, six women agreed to and participated in the experiment, but only four of them completed the task according to the controls set, so only the data recorded from these four women were included in the analysis.

I divided the process into stages: first grind, second grind, third or fine grind, making and cooking the tortillas. Sometimes, as stated above, the third grind and the patting out and cooking of tortillas is combined. I included the time it took to do the fine grind (Table 2) for each as well as the patting out of tortillas (Table 3). This is because these two processes were consistent between the K’ekchi’ and Quiché participants. In addition, the total grinding time (Table 4, next page) for twelve ounces of nixtamal, from the first grind until they were removed from the comal, are listed below.

<table>
<thead>
<tr>
<th>Person</th>
<th>Tortilla Number (Amount of time/seconds)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Amalia Tiul Chub Che (K’ekchi’)</td>
<td>—</td>
</tr>
<tr>
<td>Sebastiana Chol Che (K’ekchi’)</td>
<td>—</td>
</tr>
<tr>
<td>Manuela Tziquin Tambriz (Quiche)</td>
<td>—</td>
</tr>
<tr>
<td>Pascuala Choc de Diego (Quiche)</td>
<td>33</td>
</tr>
<tr>
<td><strong>Average</strong></td>
<td>24 sec.</td>
</tr>
</tbody>
</table>

Table 2. Third Grinding time for four women on each tortilla made.

<table>
<thead>
<tr>
<th>Person</th>
<th>Tortilla Number (Amount of time/seconds)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Amalia Tiul Chub Che (K’ekchi’)</td>
<td>—</td>
</tr>
<tr>
<td>Sebastiana Chol Che (K’ekchi’)</td>
<td>38</td>
</tr>
<tr>
<td>Manuela Tziquin Tambriz (Quiche)</td>
<td>30</td>
</tr>
<tr>
<td>Pascuala Choc de Diego (Quiche)</td>
<td>27</td>
</tr>
<tr>
<td><strong>Average</strong></td>
<td>34 sec.</td>
</tr>
</tbody>
</table>

Table 3. Time for four women to pat out each tortilla.
Table 4. Full grinding time for four women.

<table>
<thead>
<tr>
<th>Person</th>
<th>Time (min</th>
<th># of Tortillas</th>
<th>Amount of Nixtamal</th>
<th>Metate Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amalia Tiul Chub Che (K’ekchi’)</td>
<td>20</td>
<td>6</td>
<td>12 oz</td>
<td>trough (restricted)</td>
</tr>
<tr>
<td>Sebastiana Chol Che (K’ekchi’)</td>
<td>17</td>
<td>6</td>
<td>12 oz</td>
<td>trough (restricted)</td>
</tr>
<tr>
<td>Manuela Tziquin Tambriz (Quiche)</td>
<td>21</td>
<td>7</td>
<td>12 oz</td>
<td>basin (unrestricted)</td>
</tr>
<tr>
<td>Pascuala Choc de Diego (Quiche)</td>
<td>16</td>
<td>7</td>
<td>12 oz</td>
<td>basin (unrestricted)</td>
</tr>
<tr>
<td><strong>Average</strong></td>
<td><strong>18.5</strong></td>
<td><strong>6.5</strong></td>
<td><strong>12 oz</strong></td>
<td></td>
</tr>
</tbody>
</table>

Total Time (6-7 tortillas)

To summarize the tables above, on average, the women took twenty-four seconds to grind out each tortilla on the final grind. They averaged thirty-four seconds on each tortilla when it came to forming or patting them out. Last, for six to seven tortillas, the women averaged eighteen and a half minutes. If we break this down, it takes approximately two minutes and fifty seconds of grinding, forming, and cooking to produce one tortilla.

How does this translate into the total daily time a woman in Mesoamerica dedicated to grinding and making tortillas? I surveyed a few people about the number of tortillas a person might eat at one meal. Among the K’ekchi’, one person might eat three to five tortillas each meal. The Quiché said that eight to ten was the norm. I realized that these averages were about the same amount of corn consumption because the K’ekchi’ tortillas are bigger in diameter than those of the Quiché. So on average, a person might eat six and a half tortillas at each meal, meaning that close to twenty tortillas are consumed by one person per day.

To make tortillas for one person for one day would translate to approximately fifty-six minutes of grinding and cooking time. For a household of five people, this could take close to four and a half to five hours. None of the ethnographic accounts say how many people were being fed by the tortillas ground in each specific time, so it is not possible to compare daily times among them. But, according to the estimated times it took the four women in my study, the mean time of 4.8 hours is close to how long it would take to prepare tortillas for a family of five people.

Many other factors also affect how long it would take to grind each day. In many cases, women have help from other female family members. Also, the age of the person determines how many tortillas he/she will eat. A child will not eat as much as an adult. But the time it takes to grind out one tortilla from nixtamal and cook it, which is about three minutes per tortilla, is the result of this study. Of the four women, they were able to make either six (K’ekchi’) or seven (Quiché) tortillas within about the same time, give or take three to four minutes. Altogether, this research provided further evidence that grinding maize was a major part of the day in the life of Mesoamerican women and now there is a way to approximately calculate how long a woman spent grinding, depending on family size.

Conclusion

Taking a final look at the data presented in this paper shows that women of Mesoamerica, past and present, have dedicated many hours a day to grinding maize on metates. The different
ethnographic accounts show that an average of four and a half hours a day may have been dedicated to this task. But again, these times are subjected to many other factors such as the size of the family, whether or not a woman was required to make food for tribute, etc. With so much time being allotted to one specific chore, the controlled experiment is especially beneficial in narrowing down the estimates presented in this paper by the various ethnographers and in offering a more defined representation of at least one aspect of the daily life and responsibilities of prehistoric Mesoamerican women.

NOTES
5. Ibid., p. 84.
8. Antonio Sohm Tzep, personal communication.
9. Spinks, Mary Louise. Metates as Socioeconomic Indicators during the Classic Period at Copan, Honduras, PhD dissertation, Department of Anthropology, Pennslyvania State University, University Microfilms International, 1984.
13. Clark, p. 95.
17. Ibid., p. 68.
20. Isaac, p. 16.
22. Smith, p. 131.
23. Ibid., p. 131.
25. Ibid., p. 52.
26. Isaac, p. 15.

REFERENCES
Among Xhosas (Ko-saws) in South Africa, storytelling is a magnificent art. Their stories are more than mere entertainment. Xhosa scholar Harold Scheub says storytelling for the Xhosa people is “not only a primary means of entertainment and artistic expression in the society, it is also the major educational device.” Yet beyond education, the most important role of the stories is to allow expression. Especially now, with the recent demise of apartheid and some of its effects lingering on, the need for expression about past sorrows through stories is greater than ever before. Upon investigation, these stories yield profound insights into the Xhosa’s racial identity and perception of self. For both the individual and the culture, these stories and their heroes demonstrate their own significant roles in providing reconciliation and healing for the youth of South Africa.

Individual
Stories provide a common cultural heritage that has long been one important element of the unifying force for Xhosas that resisted the divisive powers of apartheid; but, more importantly, they provide a wealth of role models and friends that see troubled individuals through difficult and otherwise lonely lives, showing them the way to ultimate healing. The challenges for poor black children in South Africa today are many. Those I taught at Daily Bread Children’s Home were AIDS orphans, abuse victims, street kids, or kids from financially destitute homes.

Some were traumatized from witnessing violent beatings and murders, others were trying to come to terms at the beginning of their lives with the disease that would soon end them, while a few felt humiliated for their young pregnancies. All of the children suffered from being marginalized in society and restricted to the small, impoverished farm. Still they consistently demonstrated amazing resilience. They all cared for each other in the enormous family of seventy or so that they had become. They knew each other intimately and accepted each other completely.

Where did this come from, this courage and hope? When I investigated where that support and inner strength came from, I found, as I had expected, that their heroes and role models taught them in a variety of ways to hold their chin up, as it were. Also, I was surprised to find that the telling of those stories was just as important, if not more so, than the heroes themselves.

In an early discussion about heroes, I asked the students to write down who their hero was and why. I was touched to read a ninth-graders’ response: “My hero is Haggan. Why is because he knows my story and I know his.” When I asked him who Haggan was, he told me it was his grandfather’s grandfather. The stories of this great-great-grandfather’s life struggles had survived to support and sustain his great-great-grandson, whom he had not known, but who felt deeply that he knew his great-great-grandfather.
Realizing how important heroes were to the children, I prepared more lessons and games that focused on them and facilitated discussion of their problems and fears and how their heroes could help them. They told me stories of their past ancestors, while I taught them about the heroes in the struggle against apartheid. Little time had passed before I realized the authentically profound power the children found in linking their hardships to those of their ancestors. But the fact that they expressed themselves through the stories strengthened them perhaps even more. This fact was explained clearly in the following statement:

Narrative understanding is our most primitive form of explanation. We make sense of things by fitting them into stories. When events fall into a pattern we can describe in a way that is satisfying as narrative, then we think that we have some grasp of why they occurred.¹

When stories are told that give voice to the repressed and ignored, it is powerful. In her book *Country of My Skull*, Antjie Krog, a journalist, expressed what I noticed as a teacher: the need to relate narratives of suffering is contagious. She said all the people who hear those narratives must “tell stories not to die of life.”² And it wasn’t long before I caught the need myself. I found myself writing in my journal for hours each night after I returned from the school. I could not handle the culminating weight of the painful narratives I would hear about the students, whether from them or the teachers, without moving it on to the page. From my first exposure to the specifics of each of the children’s own record of their respective brutal histories, I found myself impatient to write at length about the things I experienced, not being able to really relax or rest until I did so.

I soon noticed that telling these stories restored a sense of dignity to the children. By telling their own accounts of how they felt victimized, they purged themselves of their respective pasts. The simple act of speaking about those events has cultural relevance to the prominence of storytelling among the Xhosas. As previously mentioned, great value continues to be linked with oral tradition and remember that “what is important is not so much what is told . . . but rather that telling occurs.”³

Thus, the historical truth of the stories and their prominence within the culture generally become irrelevant next to the promise of speaking unchecked and undoubted. Hearing those testimonies, even if only in the privacy of a schoolroom on a secluded farm, is still “the validation of the individual subjective experiences of people who had previously been silenced or voiceless.”⁴ Though he or she never forgets the trauma experienced, the empowered victim sees him or herself as having absolute control and decision in their well being. A man who was dismembered by a bomb sent to him in the mail exemplifies this movingly:

I do not see myself as a victim, but as a survivor of apartheid. . . . I am not captured by hatred, because then they would not only have destroyed my body, but also my soul. . . . Ironically, even without hands and an eye, I am much more free than the person who did this to me. . . . I say to everyone who supported apartheid, “Your freedom is waiting for you . . . but you will have to go through the whole process.”⁵

My dear friend Lindile also exemplifies this. When he was twelve, he was assaulted by hired mercenaries for speaking out against the corruption at Daily Bread. Twenty men came to the farm in uniforms with night-sticks in their hands. They assaulted over fifteen defenseless children and left them bleeding and crying on the ground. But Lindile smiles
about it now, saying, “I’ve told that story so much, and now I know that on that day those who were the most wounded were those mercenaries.” They had surrendered their humanity, and in so doing were the worst off. Beyond the therapeutic purging achieved through actually telling the stories, there is moral strength gained from the heroes of past myths.

Underneath the act of telling itself, the hero is the central interest of all Xhosa tales as he or she consistently embodies the benefits of overcoming suffering. Scheub said, “The hero is . . . a man who distinguishes himself by deeds of daring and bravery” as well as “destroys evil by means of his valor and wit, affirming the natural order by accepting [it] as valid.” In the stories, the natural order seems to be one of serious trials and greater rewards, and by accepting that order, the hero helps people understand how to enjoy life despite its terrors. His or her goal is “to enlarge the pupil of the eye, so that the body with its attendant personality will no longer obstruct the view.” In other words, the hero teaches the purposes and promises of suffering. The rewards can be greater than the pains.

“Suffering takes a man from known places to unknown places. Without suffering you are not a man. You will never suffer for the second time because you have learned to suffer,” author Joel Matlou writes. The first threshold on the hero’s path is suffering. All the insights and remedies that he gains come because he has crossed the threshold of pain. The greatness he achieves for himself and for his people dwarfs whatever troubles he has had to endure, for “the powers that watch at the boundary are dangerous; to deal with them is risky; yet for anyone with competence and courage the danger fades.” The trials of life can be regarded as the price to pay for wisdom and happiness.

Suffering also teaches empathy. The old saying “No man is an island” is relevant because shared life experiences forge them into communities that are sensitive to the bad and good that befalls its members. Writer Mtutuzeli Matshoba said, “What is suffered by another man in view of my eyes is suffered also by me. The grief he knows is a grief I know. Out of the same bitter cup do we drink. To the same chain-gang do we belong.”

Andisiwe, an eighth-grade girl, spoke often about the lessons she learned from the past, or as she called them, “The things our ancestors have for us.” She explained that her predecessors held valuable lessons for her on how to endure hardship well:

There was not much food before because the whites had pushed all of us onto small little lands that was dry and not good for growing food that they needed; and then they were separated and alone. So they said, “Either we can stay hungry or we can get together and share what we have and see if it is not much for us.” So they all moved close to each other and made farms and shared their food and houses with each other. Things weren’t so bad after all; they just had to be close. And it was a happy time.

By viewing how suffering can bring people together, when they respond appropriately (at the same time qualifying as heroes), it is appropriate now to consider the importance of storytelling more generally, and the role heroes have in reconciling an entire culture.

**Culture**

In a myth called “Keepers of the Flame” that is prevalent across the entire continent of Africa, Africans are identified as the ones who maintain that flame of humanity and common charity as a natural result of the creation. The gods call the monkey, bird, and the black and
white man together to give them the four gifts of the creation. The gifts are food, water, books, and fire. The monkey and the bird make off with the food and the water. The gods give the black man the flame and charge him with the responsibility to be its keeper. The white man is pleased to have the books, but when the lights go out, and he is alone, the black man draws near him to help him see. It is significant to remember that this myth was transmitted through all the generations under the apartheid regime to survive today, encouraging at least symbolically the reunion of black and white. Yet in a more detailed description and analysis of another myth, we see one instance of how black South Africans were taught to react when confronted by hatred, oppression, and objectification.

In a tale that originated in southern Africa called “The Maidens of Bhakubha,” a terrible monster comes to haunt the small village of Bhakubha, where things have long been peaceful. The calm setting is soon disrupted by the presence of this barbaric monster. Unaware of him, the princess and her attending friends and maidens disregard cultural rules and go down to the forbidden waters. There they undress, leaving their clothes on the shores of the lake. They swim and play naked in the water, laughing and enjoying each other’s company. As the day closes they sense their absence in the village will be noticed, and they decide it would be best to head home. The princess, however, will not be entreated. She wants to enjoy her time with her friends and persuades them to stay a little longer. They remain until it gets so late that all finally agree they should leave. As they climb out of the lake onto the shore, they are terrified to see a huge slimy monster lying across their clothes.

The foremost girl sings to the monster to give her back her clothes. The monster looks up and down with an evil smile at her naked body during the song, and after she finishes, he hands over her clothes. All of the maidens decide to do the same, entreating the monster with their lovely singing voices and exposing their naked bodies to his gruesome eyes. But when it was the princess’ turn, she stood back stubborn and proud, refusing to be eyed by the monster.

“Come forward and sing, Nomtha-we-Langa,” called the other girls. The princess yelled back, “What! Beg for my clothes from this ugly monster? How dare he lay his loathsome belly on the clothes of the maidens of Bhakubha?” She then marches in front of the monster making an ugly face and singing deliberately in a husky voice, showing “her defiance and contempt by rejecting the words of persuasion sung by the other girls.” The monster quickly lunges forward and bites her on the thigh, which causes her head to transform into the same head as the monster. Her maidens flee in terror and the princess, ashamed to return to her village, must live in the woods with the monster.

A long time passes before anyone hears from the princess again. Then one day, her brother hears her singing in the trees and decides to confront the monster and defeat him so that his sister can return to her old form and be allowed to go home. He goes swimming in the lake, hoping to find the monster lying across his clothes when he came back to shore but is disappointed when the monster fails to appear. Despite the pleadings of his parents, he continues to seek the opportunity to confront the monster, which he finally does. Helped by his closest friends, he slays the monster and finds the princess hiding in the back of his chamber. They all return home to the cheers and applause of the king and his court. The prince receives special congratulations from the chief councilor:
All of your fathers, grandfathers, and great grandfathers at this meeting envy you this great deed. Even if they don’t say it to you, in their hearts they are asking themselves at this very moment if, given such an opportunity, in their youth, any of their age-groups would have been able to display their manhood in such a worthy manner.\textsuperscript{18}

The princess, now transformed back to her original appearance, is reunited with her dear friends after many years of shame. They rejoice to be with each other again. Soon they are all married to the noble warriors who slew the monster and saved the princess. The princess and her husband open the ford that leads to the forbidden waters, and the great river that results sweeps away all the old water. All the maidens and their husbands cross the river one after another into immortality.

This tale is a powerful lesson on handling antagonism from violent intruders—confrontation is the key to success. Though the first to resist was sure to endure violence, pain, and maybe death, the resistance lives on symbolically in her friends and family. The determination to rid the village of the monster spreads to everyone, even those who were at first determined to appease it and ignore its degrading and advantageous behavior. To overcome the monster it was necessary for the princess to take on some of his terrible attributes, but the ends justified the means as it rid the village of the monster. Whether the myth originated as a means to deal specifically with white aggression doesn’t matter, as the conditions under apartheid would inevitably lead most people to interpret the monster that invades a village, claims the village’s property as its own, and objectifies its women, as representative of whites.

In discussing these myths, it is crucial to remember that an exaggerated reliance on the past’s ability to provide answers for the present often ignores the fact that new troubles call for new actions. In that way, the princess of Bhakubha embodies when and how to break from the past. When what has been done is not enough to combat new dangers and threats, new ways and measures must be made. The question becomes how to connect with the past without being limited by it. As Frantz Fanon, scholar of black identity, has said, “I am not a prisoner of history. I should not seek there for the meaning of my destiny. . . . In the world through which I travel, I am endlessly creating myself.”\textsuperscript{19}

As I witnessed the way my lessons tended to overemphasize the importance of looking to the past, I felt the need to help them see that the past does not resolve itself and that it depends on the vision and drive of real heroes who step up to solve the problems. So I began teaching them about the heroes of their present. I say “present” because their actions have so directly influenced how things were for the children in South Africa. I prepared a series of lessons about politicians and activists that fought against apartheid, many of whom were killed in that struggle. We spent several days discussing Steve Biko, because he embodies a special connection with the past while stressing the importance of breaking with yesterday.

Biko, the founder of the Black Consciousness movement in South Africa, fought to improve the self-image of blacks, which was too often detrimentally linked to the colonial ideologies that equate black with evil, inferiority, and laziness. He called on the great heroes of the past to disprove that belief. But he was always quick to point to the inadequacies of the past where, for example, “The white missionary described black people as thieves, lazy, sex-hungry, etc., and because he equated all that was valuable with whiteness.”\textsuperscript{20} My goal was to get the students to recognize this aspect of Biko’s message: “There is always an interplay
between the history of a people, *i.e.*, the past, and their faith in themselves, and hopes for their future. Realizing this interplay, I believe, prepared the children to become agents of change, to become heroes themselves.

A letter from Andisiwe represents the desired equilibrium between respect for the past and responsibility for the future. She wrote to Steve Biko’s wife:

> Your husband has show a lot abut life and he has open our eye to see the light. Mister Biko is a roll model to us becouses to day we are free and it is all because of him. Miss Biko I am telling you Mister Biko does mean a lot in our past as blacks but know I now that we no longer say black or white because now we are united.

She told me she would have to be like Biko if the bad things at Daily Bread were to be changed. She recognized Biko’s role as a hero not only in gratitude but in emulation as well.

**Change**

These stories provide the necessary link between the past and the present. They continue to transmit the responsibilities of successful adults in the culture and to render children proud of their heritage. We have discussed how they teach how to handle conflicts, but more important and relevant to today’s South Africa, they teach how races can come together and even seem to hint that they were always meant to. The heroes of these tales cross thresholds of racism to pave and point the way to a unified society, which is largely responsible for the powerful unifying rhetoric that is healing South Africa today.

Pierre Hugo, apartheid scholar, said that during apartheid, white South Africans were terrified of the independent figures of the past, those heroes who stood up in defense of their people and demanded fair treatment, so they tried to erase them. The mission of recovering real and mythical heroes along with their histories becomes all the more urgent. Hugo quoted scholar G.M.E. Leistner who told of the irrational fear whites had (and certainly many still have) of being “drowned in a sea of blacks . . . swayed by latter-day versions of Shaka, such as Nguema and Bokassa.”

At its root, this fear of black African heroes is a fear of self-awareness, of a life-giving connection between past and present that enables and empowers the masses of black people to be self-governing and demand the rights and opportunities that have been taken from them. A simple quote from a prominent newspaper illustrates the point: “[This continent, Africa], in fact is still possessed of an inherent savagery . . . the brutality of a dark continent surfaces shamefully and shockingly.” The white fear of losing power and control was willing to go to any extremes necessary to contort and confuse blacks’ history, saying they were lost without the West’s white heroes. Biko campaigned vehemently against this, and said, “Colonialism is never satisfied with having the native in its grip, but, by some strange logic, it must turn to his past and disfigure and distort it.”

The situation demanded a new solution and Biko led the new movement in exorcising the demon of self-hate among blacks, for “black consciousness makes the black man see himself as a being complete in himself.” Biko’s purpose was to show how the black culture could be sufficient in and of itself and that it was inasmuch as it accessed its true roots and genuine history. Once rooted in its place, black consciousness grew independent of anything else. And it continues by adding to the wonderful array of colors and races in South Africa.
There are still lingering signs and manifestations of the old system of racial division: townships, squatter camps, etc. But hope is rekindled whenever a child hears a story about his or her ancestors and their moral courage and determination. After its first ten years of democracy, South Africa considered itself “The Rainbow Nation of God.” As each color is allowed to tell its own stories, it makes national identity wonderfully dependent on a wide spectrum of skin colors and shades.

Conclusion

In conclusion, I realized how the telling of these stories has the power to bring together people that would otherwise remain separated, as it did for the commissioners assigned to investigate the atrocities of the apartheid regime. When Krog asked Archbishop Desmond Tutu why he thought so many working for the commission jelled, he answered, “In part, I would say it is the experiences we have gone through together, even if they were awful.”

By this same process, I was reconciled to the children I taught; the gap between our distinct experiences was filled by the knowledge I shared with them. The kids learned they could trust in friends, and the way I viewed people was completely transformed, having forged a hope of human resiliency: “by a thousand stories I was scorched / a new skin.”

Realizing the reconciliatory power of sharing stories, Krog wrote at the close of the Truth and Reconciliation commission, “Because of you / this country no longer lies / between us but within / it breathes becalmed / after being wounded / in its wondrous throat.” It seems that the country’s future is all the more secure now that it has recovered its collective voice, which is made possible as each person tells the story of how they became who they are.

My experience as a teacher in South Africa taught me that what once seemed impossible to overcome falls down at our feet once we talk about it. We can come together despite the dividing differences: “Human relationships can be forged under the most deprived circumstances. People can cherish one another, survive, and foster the kind of humanity that overcomes divisions.” South Africa taught me that we are all healers. Whatever the forces that afflict and torture us, there is a simple beauty in sharing our load with others. Though our tears are of sweat and blood, we can find profound solace if our mouths meet the ears of a friend. And whatever the space that divides and keeps apart, they can be overcome by the fusing potential of sharing experiences by telling stories.

NOTES
3. Ibid., p. 64.
5. Ibid., p. 20.
11. Campbell, p. 82.

REFERENCES


Cough it Up: Anthropological Perspectives on Respiratory Infections in Antigua Santa Catarina Ixtahuacán

Justin C. Wheeler

Background

Acute infections of the respiratory tract are a leading cause of death in the world’s developing nations world. In fact, advanced acute respiratory infections account for four million deaths among children worldwide each year. The problem is just as severe in the remote and rural areas of Guatemala, where there is limited access to modern medical care. In addition to the lack of medical services, the complexity of successfully treating and preventing acute respiratory infections is compounded by the cultural practices and beliefs of the native population about illness. Due to the impact of differences in native medical attitudes and practices and the current model of western medicine on medical care, public health professionals must consider cultural beliefs and behaviors when introducing and implementing preventative medical programs. In addition to examining environmental factors and economic limitations, local perceptions of illness causation and prevention must be considered in order to effectively and efficiently reduce incidences of severe respiratory infections in rural Guatemala.

This study analyzes the environmental, economic, and social factors that contribute to the high incidence of respiratory infections. The attitudes and beliefs about the cause and prevention of respiratory infections among the Maya Kiché people living in the rural Guatemalan mountain community of Santa Catarina Ixtahuacan are also examined.

Methods

Data gathering methods include participant-observation, informal and semiformal interviews, and free listing activities with informants to gain insight into their medical understanding. Through free listing activities, informants identified the Kiché nomenclature of many illnesses, including respiratory infections. With the help of Kiché translators, I asked questions concerning the perceived causes, cures, and prevention of the respiratory infections identified during the course of the study. At the end of the study, I designed and administered a formal survey in fifty-nine households, in which I sought information from a primary adult parent of either sex, but I accepted information from consenting adults ages eighteen or older if a primary parent was not available. The data was gathered using a convenience sample to ascertain frequency of infection, attitudes towards infection, and general knowledge of respiratory infections. All names have been omitted to protect the privacy of the informants.

Respiratory Infections in Guatemala

Deaths caused by respiratory infections are prevalent throughout Guatemala, especially among infants, young children, and the elderly. In 2002, the World Health Organization cited Guatemala as the country with the fourth highest infant mortality rate in the Western Hemisphere. The Pan American Health Organization identified acute respiratory infections as
the leading cause of morbidity and mortality in Guatemala in 1999, with 1,019,247 reported cases.³ Pneumonia accounted for 228,762 of the infections and 11,082 deaths. Sixty-three percent of the cases and 50 percent of the deaths were among children under five. Another study reported that in 1995, acute respiratory infections were the leading cause of death among children ages one to four, accounting for 26 percent of all deaths. The small village of Antigua Santa Catarina Ixtahuacan and other mountain communities of Solola have a similarly high incidence level of respiratory infection. A health professional working for the Centro de Salud in Nahuala (a government-subsidized regional health center) identified young children as being most susceptible to respiratory infections and cited pneumonia as the most common cause of death among infants. Health officials from the Centro de Salud in Nahuala reported that 205 cases of pneumonia and 717 cases of acute respiratory infections had been reported in the health district of approximately 20,000 during the first six months of 2004.⁴

Based on personal observations and interviews with medical workers, the extent of infections from pneumonia and other respiratory infections is even more serious than the numbers suggest. Many ill members of the community were observed that never went to the Centro de Salud for treatment. One healthcare worker from the Centro de Salud estimated that less than 50 percent of acute respiratory infections are reported and treated at the clinic. This translates into as many as twenty-eight hundred cases of acute respiratory infections and some eight hundred cases of pneumonia a year in the health district, or over 10 percent of the population being infected. A practicing doctor in Nahuala’s Health Center identified respiratory infections such as pneumonia as being extremely common, to the point of being endemic in the region.

Local health authorities understand the need to develop programs that will reduce the number of incidences of respiratory infections, and the impact they have on communities. All of the healthcare workers at the Centro de Salud were aware of the high levels of infection and mortality rates. However, an extremely limited budget, an undersized staff, the urgency of other medical needs of the community, and a complicated and changing national healthcare plan limit the ability to develop and implement preventative programs by the Centro de Salud.

By examining the wide scope of factors that contribute to the high levels of acute respiratory infections, the vectors of infection and transmission can be identified and a plan of action formed to create change. Analyzing local cultural practices, medical terminologies, and beliefs will also ensure that preventative programs are developed in the most effective cultural context possible.

Physical Factors Contributing to Respiratory Infections

A variety of factors can increase a population’s susceptibility to respiratory infections. In Ixtahuacan, a number of these factors exist that cause increased levels of infection of the respiratory system and facilitate the spread to others. These include environmental stresses, high levels of wood smoke inhalation, poor nutrition, and minimal formal education.

The Environment

At an altitude of seventy-six hundred feet and nestled several miles inland from the fertile Pacific coastal plains, the mountain valley geography of Santa Catarina Ixtahuacan makes the
area subject to low temperatures and large amounts of rainfall during the rainy season. Nearly every afternoon from May through September, Ixtahuacan’s climate is characterized by cool temperatures and rain. This is the same time of year when the children of the community are in school. Though the people of Ixtahuacan don’t let the rain interrupt the tasks of daily living, such as working in the corn fields, gathering firewood, washing laundry, or playing pick-up games of soccer, the cooler temperatures and rain cause residents to spend extra time indoors, both during school as well as in the afternoons and evenings.

The cold temperatures also promote the common practice of family members sharing beds. Because of economic constraints and to facilitate heating and lighting, most of the adobe or wooden homes in Ixtahuacan are quite small. Bedrooms and beds are shared by several family members, both for economic as well as thermodynamic benefits. For example, I shared a small adobe hut with three boys ages eight to fourteen. I had my own bed, but the three brothers shared a bed to help keep each other warm against the cold night air. An illness contracted at school was sure to be passed onto siblings or family members living and sleeping in such close vicinity. School classrooms, small homes, and tight sleeping quarters yield an increased chance of being exposed to family members or schoolmates who have been infected by a highly contagious respiratory infection. Respiratory infections, common during the wet months of the year, are easily passed from one person to another. The small houses in Ixtahuacan pose an additional threat to respiratory health because of the danger of smoke inhalation.

**Smoke Inhalation**

Another factor contributing to the high levels of respiratory infections is wood smoke inhalation. The Washington State Department of Ecology, in conjunction with the Department of Health, released an informative booklet outlining the extensive health risks associated with extended exposure to wood smoke. The booklet explains that when the small particles found in smoke from wood burning fires are inhaled, the nose and respiratory system can’t filter them out. These tiny particles lodge in the lungs, exponentially facilitating lung infections such as pneumonia and chronic bronchitis. The elderly and the very young are the groups most at risk from exposure to wood smoke inhalation.

Due to both tradition and economic necessity, the entire population of Ixtahuacan cooks over wood burning fires. There are two cooking methods used by residents: cooking over an enclosed fire on a metal plancha or griddle connected to a rudimentary smokestack to provide ventilation, or using a *xk’ub*, a ring of three cement blocks or stones around an open fire inside the home. The smoke escapes through a hole in the roof or through open eaves on the side of the roof. The air in a house where the *xk’ub* is used will still be very smoky. Additional exposure to wood smoke occurs when beds are in the same rooms as the cooking fire, which is common among economically disadvantaged who can’t afford to construct a separate building to use as a kitchen.

Gas stoves are not used in Ixtahuacan because of the high cost of purchasing and refilling gasoline cylinders, and the difficulty of transporting cylinders from neighboring Nahuala. Residents also held the common belief that the gas from the stoves *hace daño* (does damage) to the eyes. When surveyed, 83 percent of families used planchas, while the remaining 17 percent principally use the *xk’ub* for cooking. The majority of families that use the plancha
Inquiry

Young families, usually with many children under the age of five, may do so because of economic necessity, not having the five to eight hundred Quetzales required to build a plancha (This price was quoted by two hardware store owners in Nahuala but could be slightly inflated. One dollar in the U.S. = about eight Quetzales at the time of the study). The elderly also continue to cook over open fires both because of economic necessity and adherence to cultural tradition.

Poor Nutrition

Another factor that plays a key role in susceptibility to respiratory infections is nutrition. Malnutrition weakens the body’s resistance to infectious attack. This is especially true with the very young and the elderly, who have underdeveloped or weak immune systems. Poor nutrition is common in the area, which topic is addressed further in the study by Lee and Sinclair. One of the best ways to prevent respiratory infections is through the promotion of proper nutrition, which occurs primarily through education.

Education

Educating residents about the causes of respiratory infections and how to prevent them is one of the most crucial tools health professionals have in the fight against infection. Unfortunately, most adult members of the community have little or no formal education. Some men and a large portion of adult women speak very little Spanish. This limits effective communication with predominantly Spanish-speaking health professionals trying to teach preventative measures. Traditional beliefs on cause and prevention are more widely known and therefore are more culturally acceptable than many concepts from the field of Western medicine. The vast majority of the adult population simply has not been exposed to current information on how to cure and prevent the illnesses they are faced with in everyday life.

In the past, the Guatemalan government has established programs meant to educate rural citizens on how to treat and prevent common illnesses. Two residents interviewed were ex-health promoters involved in such a program. They had been part of a government-sponsored program established for the purpose of teaching increased illness awareness to the entire community through local residents. The two had taken several months of government-sponsored classes on the basics of western medicine a number of years ago with the purpose of passing on the knowledge to members of the community. Unfortunately, the program is no longer in place and it appears the information has not been effectively taught to residents. In fact, when the ex-health promoters themselves were asked to identify the cause of respiratory infections, both gave traditional explanations of blaming the cold air or dust for the illnesses. These answers matched the majority of the population’s response to the same question on the survey. Only upon further questioning did they cite other infected people as a vector for causing respiratory infections. More effective forms of education are needed in order for a change to occur.

A push for education over the last ten years by both national as well as local leaders has produced a rising generation, ages twenty-five and under, fluent in Spanish and familiar with both modern and traditional concepts of illness. Older members of this age group associate the causes of illnesses with infections from bacteria with a much higher frequency than their
parent’s generation. However, traditional cultural beliefs still play a large role in the outlook all Ixtahuacanios have on respiratory infections.

**Cultural Perceptions and Behaviors Concerning Illnesses**

Every culture has certain beliefs and behaviors related to illness. This includes unique understandings of what constitutes an illness, unique names of sicknesses, ideas on what causes an illness, and methods and resources for curing sicknesses. Understanding these facts facilitates effective and culturally sensitive preventative measures, and I was able to observe examples of each of these topics while in living in Guatemala.

Soon after arriving in Ixtahuacan, I experienced firsthand the unique medical beliefs of the local population. Nearly all of the children of the family I lived with appeared to have chronic runny noses. Though runny noses are common among children everywhere, the number of sniffling children seemed significantly higher than anything I had seen before. Nobody seemed to be overly concerned by the mucous running down their faces accompanied by occasional sneezes, and the only acknowledgement of this phenomena was when a parent or sibling would mutter to the youngster the Kíché phrase “Kó pátzam” (There is [stuff] in your nose). This was only used when a particularly long, dangling strand of mucous was threatening to fall onto or into someone’s food. Then the youngster would either sniff the mucous back in or use the back of their hand as a wiping mechanism.

When I questioned the father of the family I was living with if his children were sick with a gripe, or a cold, he told me no, that the runny nose is normal, and they were all healthy. On another occasion, he explained that he was happy because none of his children were sick, even though to me almost all of his children seemed to have chronic colds. What to me constituted a sick child was to him perfectly normal. This contrasted sharply with the Western world of medicine, where a child who has a runny nose accompanied with a lot of sneezing is almost always identified as being ill. The conditions the local population categorize as an illness, the local terms the people use for these illnesses, and what the population does to prevent and cure them are important to understand.

**Kíché Nomenclature**

Although the majority of the population understands at least a little Spanish, Kíché is the dominant language, and most residents are not familiar with Spanish medical terminologies. Therefore, having an understanding of Kíché medical terminology is important to ensure that informants clearly understand survey questions asked concerning a specific illness. The free listing process identified the health conditions the people view as important and legitimate illnesses, and what they do to cure and prevent infection. A basic knowledge of Kíché terminologies of illnesses can also shed light on beliefs and practices directly related to maintaining good health.

When asked to give a list of illnesses, informants almost always produced a list of words that would be defined by Western medicine as *symptoms*. The lists consisted mostly of terms that describe the physical manifestation of common ailments, such as fever, cough, cramps, and other physical manifestations of illness. For example, the Kíché word for fever is *q’aq’,* which means “fire” or “hot.” Kíché names for Western illnesses that are a combination of a
variety of symptoms are also usually words or phrases that describe the physical symptoms. Informants would usually name only the more complex illnesses after persistent, direct inquiry. Concurrence in nomenclature among informants is anything but universal. An example is the illness bronchitis. The K’iche’ equivalent most often associated with bronchitis is chakij qulaj, or dry cough, but jeqnak qulaj (loud or whooping cough), qulaj (just a cough), and kaxom jolomaj (headache) were also used.

The Maya K’iche’ of Ixtahuacan are not familiar with the Spanish nomenclature of many diseases, at most having only heard mention of many illnesses. There are exceptions to this, and at times Spanish names of Western diseases are assigned to medical conditions that differ from the Western medical definition. For example, on several occasions informants described a persistent cough as tos ferina, which is the Spanish medical term for whooping cough. In reality, whooping cough has been successfully contained and nearly eliminated in Guatemala for a number of years. Centro de Salud in Nahuala reported that there have been only three or four “unconfirmed cases” in the last fifteen years. However, to the people of Ixtahuacan, tos ferina is a very real respiratory infection. According to several informants, tos ferina is characterized by a lingering cough that sometimes is so severe that a person with the illness may experience coughing fits that last for extended periods of time and often make breathing nearly impossible.

The importance of understanding local medical terminology became apparent while studying pneumonia. In Spanish there are two words for the illness, neumonía and pulmonía, both of which refer to an inflammation and infection of the lungs. When asking informants for the K’iche’ term for pneumonia, a definitive native word for the illness was not given, and it seemed for the most part people used the Spanish names. The health professionals in Nahuala informed me that neumonia is the term used locally by the medical profession, possibly because of local associations with the word pulmonía.

When surveyed, only 12 percent of the population sampled had heard of neumonía. However, 76 percent of informants had heard of pulmonía. Of those who had heard of pulmonía, 71 percent described it as a pain one feels in the upper back caused by repetitive and strenuous work like weaving or hauling wood, or excessive sun exposure. Upon inquiry, informants showed “where it hurts” when someone has pulmonía, and they would point to the upper back around the shoulder blades and say “in the lungs.” Only 29 percent equated pulmonía with a respiratory infection.

Interestingly, the people pointed to the same location on their back when asked where the lungs are located on the body. It appears that the word pulmonía has been associated with all pains in the upper back, regardless of whether a respiratory infection is present or not. This could cause serious confusion to a patient or parent if a doctor gave a diagnosis or preventative instructions for an illness that they understood to be a backache, when they obviously have a cough. Medical personnel in the area need to be aware of the K’iche’ nomenclature for illnesses, including any ambiguities, in order for effective communication with K’iche’-speaking patients to occur.

Causes

Understanding the cultural beliefs behind what causes an illness is important to understand in order to determine what types of education are needed in a community to improve
understanding of prevention as well as overall respiratory health. In Ixtahuacan, informants commonly attribute the cause of respiratory infections, such as colds, to a variety of things, especially excesses or imbalances in life. In July, I took the concept of participant observation to heart and developed a cold myself. Taking advantage of the situation, I asked informants why they thought I was sick. One woman, a forty-year-old shopkeeper and grandmother, summed up the causes of the common cold: "Es por el frio o es por demasiado aire. Es por el polvo. Tambien es por andar sin zapatos o ropa o no toparse" ([Colds are caused] because of the cold or because there is too much air. It is because of the dust. Also, it is because of walking without shoes or clothes or not covering your head.). Another common response was that residents simply did not know what caused others to become ill with a respiratory infection. Interestingly, no informants attributed the source of my illness to another sick individual. In the survey, respondents who had a formal education agreed that it is possible to contract colds from other people, but this was never identified as a primary cause of why I was sick.

The idea of germs spreading illness from one person to another is not a prevalent explanation for respiratory infections. Even the citizens of the village with the most formal schooling first attributed sicknesses they or others had as coming from the environment but never as coming from another person. There is very little understanding of germs among the village parents and grandparents, who have little or no formal education. This is important, because if a sick person is not readily recognized as a source of illness, no preventative actions will be taken when around ill people.

Cultural Behaviors

There are several cultural behaviors that are possible vectors for the spread of respiratory infections. Physical contact, such as hand holding among youth of all ages is a social norm, facilitating the spread of respiratory infections. Covering one’s mouth when coughing and hand washing immediately afterwards are uncommon practices among children and adults. The soap that most families have available is primarily made for washing laundry and is not antibacterial. As mentioned earlier, family members, healthy and ill alike, share beds as well as bedrooms both because of economic necessity and to help keep warm in the cold environment. This includes young children with school-aged siblings, who may contract respiratory infections at school and pass them on to susceptible family members.

Curing

"Nosotros curamos aquí" (You cured here.). This statement made by a local weaver describes the general attitude of the population toward curing in Ixtahuacan. In town, there are several medical resources that the population turns to for healing. Unfortunately, consulting a professional medical doctor is not one of them. The nearest public Health Center is a forty-minute, nine-kilometer ride in the back of a small pick-up truck on a dirt road followed by another three-kilometer ride down the Pan-American Highway. The cost of the trip, five Quetzales each way ($0.60, or an eighth of a day’s wage), makes a special trip to the doctor economically, as well as physically taxing. Medical choice is made based on economic resources, ease of accessibility, and severity of the illness. This means professional medical services are usually not the first choice made by Ixtahuacanios, when seeking medical care.
Because the majority of the population does not resort to professional medical care, there are few opportunities for medical workers to educate the population on preventative measures. At the request of one of the health professionals in the Health Center, who hoped to change this fact, informants were asked why they do not go to the free health clinic in Nahuala. Informants shared several reasons for not going to Centro de Salud. These reasons include having heard that they do not give out medicine there, doctors only give out aspirin instead of the medicine you need, the clinic is too far away, Guatemalan doctors are not as good as foreign doctors available at clinics in other areas, they rely on God for healing instead, they only use natural medicines, there is too long of a line, they end up having to go to the pharmacy for medicine, so they just go the pharmacist instead, and the doctors simply do not cure there. Some informants claimed they only go to the health center for serious problems they have little experience with, such as dog bites, but cure everything else in town.

Natural Cures

Because of the rural location and limited economic resources, Ixtahuacanios employ a wide variety of curing methods. One of the most popular and common recourses for illness is to use home remedies, or medicinas naturales (natural medicines). When asked why natural cures are so popular, natives cited both economic necessity and the fact that natural practices are tried and tested traditions. One informant told me that he used natural medicines, because they were healthier and had been used by his ancestors.

Most natural cures involve the use of plant-based medicinal treatments or practices that have been passed down or learned from other members in the community. Several natural cures were described (and recommended) to me during my study. Dried herbs used to make teas were common remedies for coughs and sore throats, especially manzanilla, or chamomile. A couple of traditional or alternate healing methods were quite unique. One traditional healing practice to fight a sore throat and cough is to place a slab of meat that has been heated in the fire on your neck. This draws out the pain and cures the malady. Another unique healing process requires that a local healer, or curandero, massage a mixture of chewed-up tobacco, candle wax, and homemade soap onto your neck and chest to treat a severe cough. This is usually coupled with prayers to God or saints, particularly the city’s patron saint, Santa Catarina.

Medical Care Options

The most popular and most common method of curing is to purchase relatively cheap and common medicines like aspirin, decongestants, or antacids from one of the ten or so tiendas in town. Often these medicines play a supplemental role in a mostly natural treatment regime, where an ill person will take pharmaceuticals in addition to a natural treatment. For more serious or persistent illnesses, buying more advanced (and more expensive) drugs from a pharmacy in a neighboring city is an option. On several occasions the owners of pharmacies were noted as viable sources of medical advice, even though they have no formal medical training.

Ixtahuacanios can also go to a local curandero for medical advice, natural or chemical medicines, or injections with various drugs, ranging from B vitamin supplements to antibiotics. Finally, the wealthiest members of society and those faced with especially serious illnesses may
WHEELER

choose to go to a professional medical doctor. This could be a public or private doctor in a number of locations, including the neighboring major cities of Totonicapán, Quetzaltenango, Nahualá, or Sololá. The majority of people do not seek professional medical advice (doctors with a medical degree), unless the situation is considered to be muy grave, or very serious. This could be a dog bite, persistent and long-lasting illness, or when a young child gets very sick. Professional medical workers need to be aware of what resources patients have and what treatment options a parent or patient may consider instead of going to a public clinic.

The problem with using only natural or local medical resources is that parents are not exposed to information on how to identify, treat, and prevent severe childhood illnesses, such as pneumonia. When not treated with antibiotics, pneumonia can be fatal, and is not easily distinguishable from less severe upper respiratory infections. If residents are not aware of how to prevent and treat severe respiratory infections, fatality levels will continue to be very high.

Prevention

Preventing illnesses is the subject of most interest to the public health sector, and the main goal of this project focuses on finding what concepts the people have of prevention and identifying effective ways to prevent incidences of severe respiratory infections in the community. Based on the high number of respiratory infections, any preventative strategies currently in place are not very effective. Upon investigation of what concepts already exist for preventing illnesses in Ixtahuacán, it was found that the concept of prevention was not well understood. For example, one survey question asked “How do you prevent getting pulmonia, bronchitis, or neumonia?” The majority of respondents replied by listing curative measures, such as taking a pill. Confused by the response, I asked my eighteen-year-old translator if there was a distinction in K’iche’ between the words “cure” and “prevent.” He replied that yes, there were unique words for both, but that “La gente solo piensan en como curar la enfermedad cuando ya están enfermos. No piensan en como prevenir si no están enfermos. No es importante para ellos.” (“The people only think about curing the illness when they are already sick. They do not think about how to prevent the illness if they are not sick. It just is not important to them.”) In other words, thinking about being sick when you are perfectly healthy is not a common practice. Whenever sicknesses are brought up, recommending methods for curing are the natural and immediate response.

In order to get a response to my original question, my interpreter asked the question a second time, clarifying that we wanted to know what the informant did when they were not sick to keep healthy. Many informants were still confused by the question and usually responded by saying that they did not know. Several informants expressed the belief that it is important to maintain balance in the body, such as “a person should stay warm when it is cold.” This response could be directly related to the traditional belief of needing to have a constant balance between hot and cold in order to maintain good health. Based on the majority of the population’s response to the question, it seems that the concept of preventing illness is not prevalent in Ixtahuacán.

So why are modern medical treatments for the most part so readily embraced by the people, while Western preventative methods are nearly non-existent? Western treatments, such as pills and injections, are accepted by the people of Ixtahuacán as reliable sources of relief from
illness, and distrust of Western medical practices does not seem to be a contributing factor for the lack of preventative knowledge and practice in Ixtahuacan.

George M. Foster, a medical anthropologist who has studied rural health care, found similar results when analyzing a study by Erasmus on the effectiveness of preventative medicine in rural Ecuador. Foster stated, “As far as individual decision making is concerned, curative medical services are embraced much more readily than preventive services. The reason is obvious: the results of scientific curative medicine are much more easily demonstrated than the results of preventive medicine.” In other words, western cures are embraced because the results are empirically obvious, but preventative practices are less readily implemented because the positive effects are difficult to demonstrate and see immediately.

Medical professionals in Nahuala do have a plan for decreasing incidences of severe respiratory infections through preventative measures. The World Health Organization introduced an all-inclusive methodical check-up for infant and young child examinations in 2000, and the program is used by Centro de Salud in Nahuala. One of the doctors explained that regardless of the reason a parent brings their child to the health center, they will take advantage of the opportunity to teach them about the most prevalent and dangerous childhood illnesses, such as pneumonia, and how to prevent them. They also check for additional signs of illness, such as respiratory infections (usually by counting breaths), poor nutrition, and stunted growth. This way they can identify any health concerns early and possibly correct and prevent more serious infections in the future. Unfortunately, as mentioned previously, there are very few people from Ixtahuacan that make the trip to Centro de Salud for treatment, and, therefore, they do not benefit from the program.

Despite the lack of preventative programs in place in Ixtahuacan, concepts about how to prevent illness do exist in the community. One popular method, mantenerse fuerte (keep yourself strong), as one informant put it, was to get an injection from a curandero who has experience giving injections. In reality, it seemed that anyone with a syringe was qualified. One of these people gave occasional shots of B vitamins to those willing to pay. However, it wasn’t for the benefits of the vitamins. Instead, it seemed it was the concept of the injection itself that attracted customers. Several informants cited injections as great ways to fight illness. Shots were not identified as a direct way of preventing illness, but informants did say it made you strong and able to work.

Another cultural belief on preventing illness relates to where a child is born. The tuj, or small sweat lodge used as a bath house, traditionally doubles as a delivery room for women. One father, when discussing illness, stated that his children were all healthy and all had been born in the tuj. I asked what would happen if a child is born outside of the tuj. He replied that the child would be out in the cold and could catch illnesses that would afflict them for their entire life.

Some members of the population have more general concepts of prevention as well. Two informants identified several ways that a person can keep from spreading illnesses like colds. They both said that washing your hands often and not being around others keeps someone from spreading illness. Both had received lessons eight years earlier on varied health topics as part of a now-moot government program. At the time, their job was to share the things they learned in the classes with the rest of the community, but the program
was abandoned, and the information has not been successfully shared and reinforced with community members.

Overall, it appears that prevention is not a well understood concept in Ixtahuacan. The people place little or no emphasis on preventing illnesses, including respiratory infections. Therefore, solutions are needed to improve the levels of prevention of severe respiratory infections.

**Possible Solutions**

The key to preventing respiratory infections is to promote education and programs that will result in changes in behavior. This includes information on how to treat and prevent these illnesses. The majority of the population seldom visit the health center, and in order to effectively communicate educational messages to the population, it is important for medical personnel to use the institutions that are all ready in place in town. This includes churches, schools, a minimally organized local government, or else the use of public areas, such as tiendas or the market area. Using the radio to broadcast messages would also be effective, as many families listen to the radio throughout the day. Possible solutions I would suggest include the following:

- Promote proper nutrition in schools, with a special emphasis on the importance of eating a balanced diet in order to boost the immune system. Also, identify and encourage the consumption of foods that are good sources of vitamin C.

- Encourage and promote the construction of *planchas*, especially for young families who would like one but do not have the economic resources to do so. This would greatly reduce exposure of young at risk populations (children ages zero-five) to high particle wood smoke during developmental stages in life and improve general health as well as reduce incidences of severe respiratory infections.

- Teach and reinforce preventative practices in schools, such as covering when sneezing and hand washing, as well as the cause and cures of upper respiratory infections.

- Hang informative posters on prevention, symptoms, and causation of respiratory infections, similar to those found currently in the Health Center, in local stores or in other public arenas such as churches or schools. Include pictures depicting symptoms and K’iche’ terminologies for the community members with little or no formal education.

**Conclusion**

In conclusion, it is imperative that health professionals examine cultural as well as physical factors present in Ixtahuacan in order to create and improve effective prevention techniques. By gaining an understanding of the local cultural perceptions of respiratory infections, as well as considering the many other factors that contribute to respiratory infections, medical professionals can more effectively implement programs that will reduce mortality and morbidity rates by preventing respiratory infections among the Maya K’iche’.

**NOTES**

7. Lee under review; Sinclair under review.
8. Leyn under review.

REFERENCES
A joint venture between Brigham Young University’s David M. Kennedy Center for International Studies and Department of Anthropology to highlight outstanding student field research with elements of primary and original research.

PUBLISHERS
Jeffrey F. Ringer, director
David M. Kennedy Center for International Studies, Brigham Young University

David P. Crandall, chair
Department of Anthropology, Brigham Young University

MANAGING EDITORS
Ashley Tolman
Evie Forsyth

EDITORIAL BOARD
Lynn Elliott, director
International Study Programs

David A. Shuler, field studies coordinator
International Study Programs

We wish to thank the communications team at the David M. Kennedy Center for International Studies for their editorial and graphic assistance.

CONTACT INFORMATION
Inquiry Journal
204D HRCB
Brigham Young University
Provo, Utah 84602
Tel/Fax: (801) 422-1541/0381
E-mail: inquiryconference@yahoo.com

ISBN 0-8425-2643-9