“I Want to Go Gently”: How AIDS Patients in Ghana Envisage Their Deaths

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Abstract
This article examines the views of persons living with AIDS about how they want to die and how they are planning for their deaths. Participants for the study were purposefully drawn from an HIV clinic in an urban town in Ghana. In-depth interviews were conducted with 25 persons living with AIDS. Three preferences of death were identified by the participants. These include the desire for a quick death, death at home, and death without emaciating. Planning for death involved attending church and taking care of children. Inherent in the responses of the participants is the concern for cost of care, dwindling network of family carers, and stigmatization and shame. The article concludes that the government needs to provide support for home-based care, establish a pension for AIDS patients, support families to pay for the funeral expenses of their relatives, and scale up effort to reduce HIV/AIDS-related stigma.

Keywords
good death, weakening of the extended family system, preparation toward death, HIV/AIDS, Ghana

Introduction
In advanced countries, death has been largely gerontologized and medicalized. Advances in technology and science together with Western medicine have changed the way diseases are managed and death conceptualized (Hughes, 2017).
Medical advances have made it possible for death to be postponed. Consequently, death is increasingly regarded as the problem of the aged (because they are the ones most close to it) and also a function of the failure of medical science. Thus, many people shy away from talking about their own death. To reduce the fear associated with death, the term good death was introduced (Bloch & Parry, 1982; Hughes et al., 2008). This term was originally used by Bloch and Parry (1982) to describe the situation where there is a mastery over a fearful biological occurrence. Later the concept was used to describe euthanasia (Hughes et al., 2008). Advocates of euthanasia argued for a death free of pain. Also, the hospice movement advocated for good death to signify a death with dignity. They further advocated that patients are made very comfortable while they await their deaths.

There are variations across cultures in peoples’ explanations for why death occurs, and in perceptions of what it is to die well or badly (Seale & Van der Geest, 2004). The literature on good death have expanded from cultural definitions (Counts & Counts, 2004; Van der Geest, 2004) to include individuals’ conception of what it means to die a good death (Kikule, 2003; Pierson, Curtis, & Patrick, 2002). In many cultures, including those in Africa, a good death is the one that occurs at old age, at home surrounded by family and where the individual has had time to sever his relationships with family and friends (Counts & Counts, 2004; Nzioka, 2000; Van der Geest, 2004). At the individual level, a good death includes dying at home and surrounded by family, a death free from pain, at peace, and being independent (Hughes et al., 2008; Kikule, 2003; Pierson et al., 2002). Many of the studies on good death are about older people and people suffering from terminal diseases such as cancer and Alzheimer’s disease (Akechi et al., 2012; Van der Geest, 2004). Very few studies have focused on AIDS patients’ conceptualization of a good death (Kikule, 2003; Pierson et al., 2002), and what it means for them to die a good death. Such studies in Ghana are also very few. In a study on how AIDS patients perceive a good death, Pierson et al. (2002) identified 12 domains of good death. This included symptoms control, quality of life, people present, the dying process, location, sense of resolution, patient control of treatment, issues of spirituality, death scene, physician-assisted suicide, aspects of medical health, and acceptance of death. In conceptualizing their death as either good or bad, AIDS patients are envisaging how they want their deaths to be.

Many AIDS patients are young, with many dead or have watched friends and family die of the disease (Shilts, 1987). Additionally, advances in medicine have meant that AIDS has been transformed from a terminal disease to a chronic one (Pierson et al., 2002; Siegel & Lekas, 2002). Chronic diseases are normally incurable; thus, cure is not the goal of treatment but containment and slowing down the progress of the disease (Siegel & Lekas, 2002). There is still no cure for HIV and AIDS. Available drugs allow patients to live meaningful lives. This has
made caring for AIDS patients a little bit difficult (Selwyn & Arnold, 1998). As is the case with chronic diseases, AIDS patients are expected to follow a treatment regimen and require a lot of self-care in terms of taking one’s drugs and engaging in physical exercises. Additionally, they may have to contend with periods of remission, recurrence, or stable periods interrupted with periodic symptoms (Siegel & Lekas, 2002). Furthermore, AIDS patients experience uncertainties even in the era of highly active antiretroviral therapy. Although AIDS patients are no longer faced with imminent death, they still recognize that they could face set backs and fall seriously ill. Again they understand that not everybody can tolerate the side effects of the highly active antiretroviral therapy, still others think of developing resistance to the therapy (Siegel & Lekas, 2002). Envisioning how they want to die may help AIDS patients to cope well with the disease and eventual death. As Glaser and Strauss (1965) suggest, an awareness of one’s death allows the individual to accept death and even to plan toward it.

This study, therefore, explores how AIDS patients in an urban town in Ghana envisage their deaths and even plan toward it. Studies on how AIDS patients in Ghana envisage their death are very few. An understanding of how AIDS patients envisage and plan toward their deaths will help policy makers to make policies that will improve on the end-of-life care for the seriously sick, particularly, patients with advanced AIDS.

**Methods**

This article is part of a wider research that explored how AIDS death is constructed in the New Juaben Traditional Area in Ghana. Data for this article are based on in-depth interviews with 25 persons living with AIDS. Participants were recruited from the HIV clinic at the Koforidua Regional Hospital, in the Eastern Region of Ghana. They were recruited with the help of health-care workers at the HIV clinic, who informed people living with HIV/AIDS (PLWHAs) who had come for their monthly appointments at the clinic about the study. Participants were interviewed on clinic days which are Tuesdays and Wednesdays. The interviews took place over 1 month. This ensured that all patients had the chance to be interviewed within the 1 month cycle. An average of four participants was interviewed on each clinic day. Since this was a hard-to-get group, there was no criterion for participation. The only criteria were that participants are AIDS patient and must be willing to take part in the research. Twenty-four of the interviews with the participants took place in one of the rooms at the clinic. Participants preferred to be interviewed at the clinic to their residences and other venues as they felt their privacy would be better protected there. One participant, however, was interviewed at her home. She was not recruited at the hospital. She was recruited with the help of an informant who worked at the hospital.
The interviews with the participants were conducted using a semistructured and open-ended interview guide. This allowed for follow-up questions and elaboration of issues. The interviews were conducted in the local language (Twi) which was spoken by all the participants. The interview guide for the participants was divided into four sections: demographic characteristics of participants, their experiences of living with HIV and AIDS, treatment, and care, how they envisage their deaths to be, and how participants made sense of death from AIDS. This study is based on how they wanted the dying process to be.

The interviews lasted for between 45 minutes and 1 hour. With the permission of the participants, all interviews were tape-recorded, transcribed, and translated into English. In translating and transcribing, care was taken to retain the original meaning in the Twi language. Where appropriate certain Twi words were left as they were and as stated by the participants and a translation provided in a footnote. The data were then coded and common themes identified for analysis.

**Findings**

In all, 25 AIDS patients participated in the study. As indicated in Table 1, 19 of the participants (representing 76%) were women while 6 (representing 24%) were men. Two of the participants had secondary education, 14 had primary/middle school education, and 9 had no education at all. None of the participants had a tertiary education. The period since the diagnosis of the participants ranged from 4 months to 10 years with the average being four and a half years.

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<th>Table 1. Demographic Characteristics of Participants (Mean age = 36).</th>
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Quick Death

Without exception, almost all the participants expressed the desire for a quick death. This they described as dying gently and peacefully. The participants were concerned with prolonged periods of sickness. This is what some of the participants had to say:

I want God to take me away quickly without making me sick for a long time; maybe I should die when I complain of headache. (33-year-old woman)

I want to die just three days after I fall sick: I don’t want to be sick for a long time. (41-year-old woman)

Getting sick and lying down for your family to be lifting you and turning, that one is not good. Two, three days, I go [die] that is how I want to go. (36-year-old man)

For some of the participants, a quick death is death after 3 days of being sick. Three days has cultural significance in Akan. Among the Akan, 3 days (nansa) is considered neither too short nor too long a period. It is seen as just the perfect period for an event. Dying before 3 days may be considered too sudden. Such deaths could take on spiritual meanings. When deaths take on spiritual meanings, they may be seen as punishment from the gods or ancestors, witchcraft, sorcery, or as a result of a curse (duabo). Such deaths may be categorized as bad—deaths which are sudden and violent and do not attract an elaborate funeral rites.

Inherent in the desire for a quick death was the concern of care. Getting someone to care for them was a major concern shared by several of the participants, especially in the event that they become ill for prolonged periods of time. Below is what some of the participants said:

If I get sick for a long time, the family members may not want to come near me. (45-year-old widow)

I want to go gently (bɔkɔɔ) because I don’t have any helper. If God should call me, He should call me peacefully; He shouldn’t let me be sick for a long time. (40-year-old woman)

I don’t want to be sick for a long time before I die so that I do not become a burden on my children. (40-year-old man)

As indicated from the statements above, some of them pointed out that they do not have anybody to care for them in case they become ill; this they indicated as not having helpers. In Ghana, the care of the seriously sick is the burden of
relatives (Antwi & Atobrah, 2009). Thus, the seriously sick, including AIDS patients rely on the benevolence of their families for their health-care needs. In recent times, the care of the sick in Ghana is facing serious challenges due to the weakening of the extended family unit (Nukunya, 2003). In the past, the extended family was the basic social support unit. They took care of orphans, the sick, and the elderly. In recent times, however, the extended family is contracting. This means that people would disregard their traditional rights and obligations to those outside the nuclear family in favour of the immediate ones (Nukunya, 2003). Thus, the network of carers for the sick becomes limited.

Also, the narratives reveal that economic issues were a source of worry to the participants. Although antiretroviral therapy (ART) is highly subsidized in Ghana, many patients are unable to afford it. A month’s supply of ARTs cost five Ghana cedis (about $3 USD in 2013). In the study, some of the participants indicated that they could not afford the cost of ARTs. In addition, the patients complain of the cost of transportation and food. This makes it difficult for AIDS patients to adhere to their treatment regimen. Available data indicate that 32.8% of all HIV positive persons (that is, 75,762 out of 231,205) were on ARTs in Ghana (“Ghana AIDS Commission,” 2014). Those not on it are held back by access and affordability. As the demographic characteristics of the participants show, almost all of the participants are of low economic status. They were seamstresses, barbers, and petty traders. Some indicated that they were not gainfully employed and so have to rely on relatives for their upkeep.

In view of the cost involved in taking care of the seriously sick, some families are unwilling to spend money on a sick person who they think will die anyway (Van der Geest, 2002a). As a result, some families may abandon their sick relatives, but rush to perform a lavish funeral when they die (Van der Geest, 2000). This sentiment was echoed by some participants who feared being abandoned by their relatives. Thus, some families may abandon AIDS patients due to financial reasons. Stigmatization, on the other hand, also contributes to families abandoning relatives who are HIV/AIDS positive. Some of the participants gave instances of some AIDS patients who had been abandoned or were not given proper care by their families. Being witnesses to and having heard about some of these incidents, participants did not desire to be invalids or bedridden for a long time.

**Emaciation**

Also present in the accounts of the participants was that they were anxious about emaciation. Dying gently for the participants also meant that they should not emaciate before their deaths. To the participants, emaciating would expose their AIDS status. Many people in the community still expect
an HIV-infected person to be wasted, have gaunt look, and look very sickly. At the beginning of the epidemic, and when ARTs was not yet available, many AIDS patients emaciated before they died and many of them died painful deaths (Shilts, 1987). Furthermore, images used in HIV and AIDS campaigns showed the infected as emaciated, thus, associating emaciation with being HIV infected. Even with the availability of ARTs, many people still imagine AIDS patients to be emaciated and gaunt looking. This is what some participants had to say:

Someday, if God calls me and I die, He should let me die gently [bɔkɔsɔ]. He should not let me be emaciated by the disease [AIDS], so that it would not show that it is this disease [AIDS] that killed me. I want to go gently. I don’t want to be sick for a long time...defecating on myself. (41-year-old woman)

Dying is not my problem; I don’t want to be ugly [tantan tan]. (41-year-old woman)

Also, there were worries of loss of control and shame. Some participants feared they would vomit and defecate on themselves, and the family would have “to be lifting and turning” them. Not being able to control ones’ bowels during ill health may be a source of disgrace to the patient. Vomit and faeces are “dirty” and are abhorred by the Akan. The sick, especially when aged, may feel uneasy and embarrassed when they have to be helped in using the toilet (Van der Geest, 2002b).

The fact that participants perceive that emaciating would reveal their HIV status and therefore wished that their status remain a secret indicates that HIV and AIDS is still a highly stigmatized disease in Ghana. The stigmatization of HIV and AIDS in Ghana has been well documented in other studies (Asiedu, 2010; Mill, 2003). Furthermore, the participants concern with emaciation may be due to the practice of laying-in-state. In Ghana, corpses are normally laid-in-state for public viewing as part of funeral rites. This is an important part of the funeral rites among the Akan. This practice goes back to the precolonial era. In traditional times, after a death, the corpse is bathed and dressed in nice clothing and jewellery and laid-in-state. The family and mourners kept wake till the next morning when the body is buried. Although wake-keeping is largely not observed in Ghana recently, corpses are still laid-in-state as part of funeral rites. Families take great care in making the corpses of their relatives presentable. It is common for mourners to discuss how beautiful or otherwise a corpse looked. Thus, there may be speculations if the corpse looked significantly different from how they were when they were alive. As seen from the statements above, emaciating will make them “ugly” (tantan tan). Thus, emaciation will give rise to speculations and gossip, which is a very powerful social control tool. Emaciation, in their view could reveal their AIDS status.
Place of Death

The location of death was also important to the participants. Majority of the participants expressed the desire to die at home, not at the hospital. Dying at home was preferable as it would afford them the opportunity to conceal their HIV-positive status. The following statements indicate this preference:

Because in the house, nobody will know that I am there. However in the hospital people will come and look at me. (35-year-old man)

What I always think about is the fact that if I become very sick and I am admitted to the hospital, and maybe I am put in a room where if people come and visit me, they would know that this is the disease [AIDS] I am suffering from... I think a lot about that. (41-year-old woman)

I don’t want to fall sick for a long time. I don’t want people to visit me at the hospital except my church members or close family members. (58-year-old woman)

The participants were concerned that they may not be able to control the visitors who would come to see them if on hospital admission. The hospital system in Ghana is such that one does not have a ward to one’s self, and therefore, will not be able to control people coming into the wards. Patients, thus, have little or no privacy at hospital wards. At home, however, they contend, they would be able to regulate the visitors. In fact, in the home, it is possible for family members to conceal the ill health of a person (Van der Geest, 2002a). For some of them, however, it did not matter whether they died at the hospital or not. Like the 58-year-old woman above who said, if she is taken to the hospital, she would still determine who should visit or not.

Invariably, some of the participants did not know whether AIDS patients are admitted to a ward different from other patients. They are of the view that if AIDS patients are admitted to a different ward their status would be disclosed to others. This is because anybody who goes there would be tagged as an AIDS patient. Their views are not far from the truth because some of the doctors’ names at the Koforidua Regional Hospital have become synonymous with HIV and AIDS so that anybody who goes to their consulting room is suspected to be an AIDS patient. Similarly, the Korle Bu Teaching Hospital in Accra—the largest referral hospital in Ghana—has a Fever’s Unit. The Fever’s Unit takes care of all contagious diseases, including HIV and AIDS and other opportunistic infections. However, since HIV and AIDS were included on the list of contagious diseases, that unit has been tagged as the unit for HIV and AIDS patients. Subsequently, all who visit there are labelled as AIDS patients. The Koforidua Regional Hospital does not have a separate ward for HIV and AIDS patients. At the hospital, all patients are put in the same ward. Thus, only nurses and
physicians can identify AIDS patients. It is the view of the hospital that putting all patients in the same ward will reduce stigmatization.

Nevertheless, there are those who do not want to die at the hospital regardless of whether there is a separate ward for AIDS patients or not. The participants explained that sometimes hospital staff disclosed their status to others. One of our participants recounted an incident at the hospital where she and her aunt went to visit another aunt who was an AIDS patient. She said one of the nurses at the ward, pointing at her aunt, told others that she (the aunt) was an AIDS patient. She said she was saddened by the incident and pretended that she did not know the woman. She then asked herself whether if she was ever admitted at the hospital, she would be treated in a similar fashion.

Preparations Toward Death

Participants were also asked about the preparations they and their relatives made toward their deaths. Almost all the participants indicated that they did not have wills; nor were they planning to have one written. A keen observer in Ghana would soon discover that many Ghanaians die without having written a will. This may be due to the fact that there are traditional norms regulating inheritance and succession. Among the matrilineal Akan, traditional norms indicate that inheritance and succession passes from a man to his sister’s sons. Thus, many widows and children were left without any inheritance when their spouses and fathers died. This prompted the promulgation of the Intestate Succession Law in 1985 (the PNDC 111) (Nukunya, 2003), which made it possible for widows and their children to inherit the property of their spouses and fathers. Despite this, several of the participants disclosed that they did not have any significant property to warrant the writing of a will. Also, none of the participants have planned or were planning for their funerals, in terms of where they should be buried, leaving money for the funeral, or indicating whether religious services should be conducted. Below is what some of the participants said:

When I die, my children will perform my funeral. Also I go to church; I pay all my dues, I pay my tithes, so the District [church] will collaborate with my children to perform my funeral when I die. Because of the church’s welfare [scheme] when I die, there will be no problem [burden] on the family. I have made no plans. I have never worked before. My husband used to be a surveyor for the Highways so we used to travel a lot until we came home to settle. Currently, I am not working, so I cannot say that “my child, let us go and sign, so that when I die, this and this or that is for you.” (Widow, 58 years)

I have made no preparation for my death: I don’t care how my funeral is organised. I am only concerned about where my soul will go to. (Woman, 33 years)
I have made no preparations or plans towards my death. But I think it is imperative especially for the rich in society to make their wills that would state how properties should be shared amongst their children. (Woman, 41 years)

Furthermore, participants did not plan for their funerals because in Ghana the performance of funeral rites is the duty of the extended family. The family takes care of the laying in state, the burial, and the final funeral rites of their relatives. Thus participants indicated that they have made no plans toward their funeral rites.

The preparation made by some of the participants was religious in nature. Some of them indicated that they were planning their deaths by attending church services and being active in church. Being active in church included attending church regularly and paying dues and tithes as indicated by the 58-year-old woman above. Their objective in attending church was that should they die the church would perform their funeral rites. This was a sure way, they thought, of having an appropriate burial and funeral rites in the event that their families did not perform their funeral rites. Having a church burial in Ghana is desirable. It also legitimizes and normalizes a death which otherwise would be considered bad (Van der Geest, 2004). They were also mindful of the fact that the church does not discriminate when performing the funeral rites of its members. The church performs the funeral rites when the individual pays his/her tithes and dues and attends church regularly. Below are the responses from some of the participants:

As for death, the preparation I can do is that I will join a church. If you join a church and follow the instructions of the church, in the future when God calls you, the church can do something for you. (Woman, 33 years)

I don’t know how my funeral would be organised, but I have given myself to Christ so that if my family does not perform a befitting burial for me, the church would do it. (Woman, 41 years)

That is why I am now attending church. I want the word of God to dwell in me richly so that it shall be well with me. (Man, 36 years)

Other forms of planning included taking care of children. This reflects the fact that the majority of the participants were in their reproductive years and had children still living at home. The average age of the participants was 37.5 years. Thus, taking care of their children, which included giving them an education which would make them self-reliant in the future was the ultimate preparation the participants thought they could make. Children in Ghana are considered as insurance for one in his or her old age. It is expected that children will care for their aged parents when the parents are no longer able to care for themselves.
Parents who do not care for their children, however, should not expect them to take care of them (parents) in their old age (Aboderin, 2004) and may also not perform their funeral rites when they die. Below is how a mother of two and a father of four were planning for their deaths:

I would make preparation for my children. I do not have any property. But I hope that with the help of God I would be able to leave some property (agyapadea) for my children. (Woman, 40 years)

I don’t have a house; I have not yet built one. I am making preparations to build one for them [children]. Also, some of my children are in high school; I want to be able to take care of them so that they would get a good job. I am praying that by the time I am 90 years, I would have done all these things. (Man, 45 years)

A few though, opined that they have made no plans at all because it is not necessary. They are of the view that whether they plan or not death would come anyway. Still, others thought they would not die soon so there was no need to plan for their deaths.

Discussions

This article explored how AIDS patients in Ghana envisaged their deaths, and the preparation they were making toward it. Three major themes were identified. These are the wish for a quick death, concerns with emaciation, and the desire to die at home. These wishes together constitute dying gently (bokọ) by the participants. Inherent in their wishes surrounding death were the issues of care (that the cost of care, appropriate care, and dwindling network of carers), stigmatization, and shame.

The desire for a quick death (which featured prominently) was borne out of participants’ apprehension about appropriate care, with respect to the cost of health care. While the National Health Insurance Scheme (NHIS) makes it possible for patients to afford health-care services, some major surgeries and some diseases are not covered. As already explained above, many AIDS patients say they cannot afford the cost of the ARTs which is highly subsidized. In addition, some patients complain of the cost of food and transportation. And of course, the demands of long-term care can impose significant economic drain on the family. Indeed, looking at the fact that majority of the participants were of low-income status, with some depending on their families, they do not wish to be invalids for a long time. A similar sentiment was expressed in a study conducted by Kikule (2003). Kikule explored the health needs of the terminally sick in Uganda. The study involved patients with cancer and HIV and AIDS, the majority of them being AIDS patients. Majority of the participants had unmet needs; many of them needed money for medical expenses and other basic needs.
This may lead to isolation and abandonment of patients. Indeed, the abandon-
ment of some AIDS patients and the elderly is not uncommon in Ghana and 
elsewhere (Anarfi, 1995; Crenstil, 2007; Nyblade et al., 2003; Van der Geest, 
2000).

Furthermore, the wish for a quick death brings to the fore the weakening of 
the extended family system in Ghana. As explained above, the extended family is 
the main support system in Ghana and most of Africa. The implication of a 
weakened extended family is that the poor and the vulnerable, especially the 
seriously sick, the aged, and orphans are left without support. There is the need, 
therefore, for the state to increase health-care services for the seriously sick, 
especially AIDS patients, and to support families to increase home-based care. 
This will reduce the fear of many AIDS patients who dread being abandoned by 
their families.

The participants concerns about emaciation and the desire to die at home 
both show that HIV-/AIDS-related stigma is still problematic in Ghana. Stigma, according to Goffman (1963), is a deeply discrediting attribute, 
which reduces a person from a whole to a tainted, discredited one Stigma 
ocurs when society labels someone as tainted, less desirable, or handicapped. 
HIV-related stigma is widespread in Ghana (Asiedu, 2010; Ulasi et al., 2009). 
AIDS patients experience stigma from family, friends, and the community. 
Family members of AIDS patients may refuse to sleep in the same room 
with them, eat their food, and not use their items. Moreover, the stigmatized 
may endorse the negative labels imposed on them by others. In such an 
instance, they exercise power over themselves which acts against them. This 
is what Goffman referred to as internalized stigma. Internalized stigma in turn 
generates shame. Shame is a negative emotion elicited when a person experi-
ences failure in relation to personal or social standards, feels responsible for 
this failure, and believes that the failure reflects self-inadequacy rather than 
inappropriate behaviour. This is reflected in HIV-positive people’s views of 

The preparation participants were making toward their deaths was also 
explored. The findings highlight the cultural differences in the preparation 
toward death. In the West, the preparation is in the form of writing a will, 
giving instructions on the death process (e.g., not wanting to be on a life sup-
port) and giving instructions on funeral rites (Marshall, 1975). In Ghana, how-
ever, death preparations did not include those mentioned above. As mentioned 
elsewhere, the extended family is responsible for performing funeral rites of its 
members, and also it is perceived that only the rich should write a will. 
Participants in Ghana rather plan their deaths by attending church services 
regularly and working hard to educate their children. The church plays an 
important role in funeral celebrations in Ghana and would only participate 
when the individual has met all of his or her obligations such as paying tithes 
and offerings and by regular church attendance (Van der Geest, 2004).
Conclusion

The death wishes of participants in this study reveal that stigmatization and shame are still of great concern to HIV/AIDS patients in Ghana. Stigma and shame, it is observed, may act as barriers to care and treatment. In many countries hard hit by HIV, there are efforts to help people live positively, which includes being more open about their status and not being governed by the shame that keeps them silent. In view of this, the Ghana AIDS Commission (the body in charge of AIDS policy in Ghana) in collaboration with some nongovernmental organizations (NGOs) has designed programmes aimed at reducing stigmatization of AIDS patients. One of such programmes is to encourage AIDS patients to be open about their status and to educate the Ghanaian society about HIV and AIDS. The AIDS patients who come out are known as AIDS Ambassadors. A few AIDS patients have openly disclosed their status. Some of the programmes embarked upon include workshops and seminars for some organized groups such as students, religious groups, and traders. Despite this, there is still a lot of secrecy and silence surrounding HIV/AIDS in Ghana (Ohemeng, 2012). Most of those who disclosed their status are not well known in society. So far, no prominent person has openly disclosed his/her status, giving the impression that only those of low socioeconomic status are infected. Again, Ghanaian families do not disclose the cause of death of their relatives. This is in contrast to countries such as Uganda where there is a lot more openness about open about HIV/AIDS. AIDS patients in Ghana should be encouraged to openly disclose their status. Families, similarly, should be encouraged not to hide and abandon relatives infected with the virus. When the Ghanaian society opens up, and more and more people, especially prominent ones disclose their status, HIV/AIDS would move from the back burner to the fore, thus reducing stigmatization and shame.

This article furthermore indicates the importance of funeral rites among Ghanaians, particularly among Christians and Traditionalists. Hence, an understanding of how AIDS patients envisage their deaths and by extension their funeral rites is very important. Funerals are great social events in Ghana. As observed by Van der Geest (2004), funeral rites are an opportunity for the extended family to showcase its social and economic status in society. This, however, depends to a large extent on the manner of death—whether good or bad. Discrimination of AIDS patients even in death is prevalent in Ghana (Ohemeng, 2012). Some emaciated patients may not be laid-in-state, may be buried quickly and may not have elaborate final funeral rites, especially when they are poor. To help reduce the apprehension of AIDS patients about their funeral rites, the government or nongovernmental organizations should set up a fund to help perform a befitting funeral rite for patients whose families may not have the resources or even be unwilling to do so. Furthermore, AIDS patients can be encouraged to form funeral associations to help organize the funeral rites
of members, as is done in South Africa. In South Africa, funeral associations are common. Members of the associations contribute toward the funeral of a deceased member (Nicolai, 2007). Although funeral associations are not common in Ghana, there are welfare associations that contribute to help a member during funerals and births (Lyon, 2003). Associations of AIDS patients should be encouraged to contribute toward the funerals of each other. In this way, if a family refuses to perform the funeral rite of an AIDS patient, or does not have the resources to do that, the associations may step in.

To address the cost of care of AIDS patients and the dwindling network of family relations, the government should support home-based care in Ghana with counselling, professional help, and training for families to be better equipped to take care of its own. Moreover, patients with advanced AIDS could be supported with allowances so they can provide for themselves without depending on anyone.

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**Notes**

1. This is the case with HIV/AIDS since it is seen as a death sentence.
2. It is not always the case that corpses are laid in state in Ghana. When the death is a result of a motor accident or fire and the body may have been damaged extensively, the deceased is usually not laid in state before burial.
3. Wake-keeping was banned by some churches in a bid to cut down the cost of funeral rites which is thought to be too expensive, especially among the Akan. Currently, wake-keepings are not observed in most parts of the country, particularly, if the deceased was a Christian.
4. The wards are designated as female medical, male medical, female surgery, male surgery, maternity, and children’s ward. The medical wards take care of cases considered to be medical, not surgical cases.
5. This law has since been amended and replaced with the Intestate Succession Act, 2009. The new Act gives a larger proportion of the estate of the deceased to the surviving spouse and children than was the case under the old law. Among other things, it makes provision for spouses, who may be in a polygynous marriage, instances where the surviving spouse contributed to the acquisition of the estate and for dependent children.
6. This law does not treat the widow as the automatic next of kin. A will is still needed in order for property to go to a widow or widower and children. Many widows though, are not taking advantage of the law, basically because of high illiteracy among women. There are no data that suggest that many property owners are now writing wills.
References


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