

UNIVERSITY OF GHANA, LEGON

COLLEGE OF HUMANITIES

**SHRINES AND HEALING IN THE KETE-KRACHI AREA: THE
CASE OF DENTE**

BY

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DECLARATION

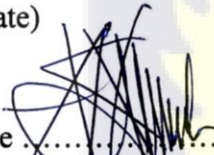
Except the quotes and paraphrases that have duly been acknowledged in this study, I declare that the thesis is a result of an independent study carried out at the Institute of African Studies, University of Ghana, Legon, under the supervision of Prof. Albert Kanlisi Awedoba, Prof. Samuel Aniegye Ntewusu, Prof. Abimbola Adesoji, and Prof. Deborah Atobrah. No part of this thesis or in full has been submitted elsewhere for award of any degree.

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DEDICATION

This thesis is dedicated to *Wuruboare* (the Supreme Being) and my father, the late Francis Kofi Awubomu, whose sudden death occurred on 15th October, 2018 at the Korle-Bu Teaching Hospital, Accra, barely two months after I had started my PhD studies at the Institute of African Studies, University of Ghana, Legon. May his soul rest peacefully in the bosom of his maker. Special dedication goes to my mother, Mary Anatorsu Ntewusu Awubomu for her love, care, and prayers.



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ABSTRACT

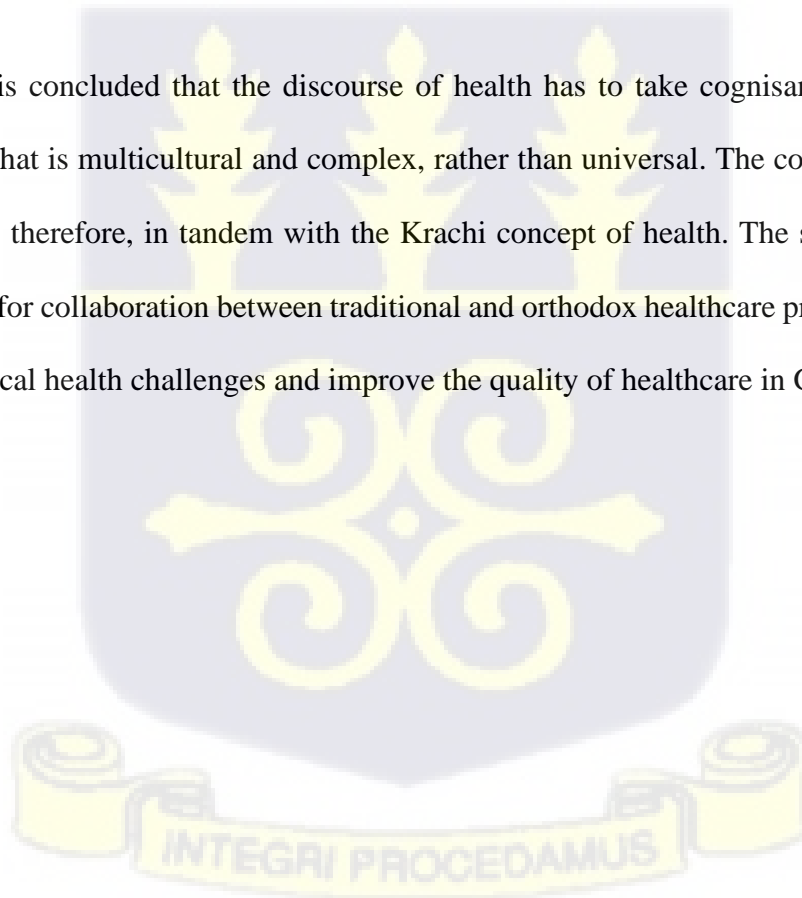
Healthcare systems in Ghana, including the public, private, and the informal healthcare sectors are convoluted. The informal healthcare sector is the subject of attention in this thesis. The study interrogated shrines and healing in the Kete-Krachi area using Dente as a case. Situated within the tradition of social determinants of health, the thesis argued that in the Kete-Krachi area health is socially constructed, requiring the use of various approaches to mitigate an anomaly. It argued further that the diverse health approaches in the Kete-Krachi area is a result of the varied conceptualisations about health. Besides, it argued that the social and religious interpretations pertaining to health are connected with worldview, which mirrors on and shapes the understanding of the Krachi people and their response to healthcare. It called for the need to interrogate shrines in the discourse of healthcare.

Premised on the interpretations pertaining to health and ill-health, the study leaned on the constructivist model that argues that people construct their world of realities. The study therefore engaged the qualitative approach, and the non-probability sampling technique was used in this study, as the researcher hails from one of the study areas. The purposive sampling technique was employed in this study; those who had in-depth knowledge about the subject under interrogation, were identified and included in the sample. Following the spread of the Dente shrine in the Oti and Northern Regions of Ghana, interviews were conducted in the Krachi West Municipality, and Krachi East and Kpandai Districts. The phenomenological approach adopted in this study ensured that the research was portrayed from the perspective of the research participants. Extensive interviews were conducted with eighty (80) participants from different social backgrounds. Out of this figure, fifty (50) of the respondents were males while thirty (30) were females. Research was conducted

in the Public Records and Archive Administration Department at the national and regional levels. Such archives encompassed the National, Volta Regional, and Northern Regional Archives.

The study discovered diverse explanations for which deities are consulted for healing. Economic constraints, social and religious interpretations to health, and long distances to healthcare facilities, among others, account for the reasons why Krachi shrines, particularly Obourfa-Dadiefafa and Kikpare, have transformed into traditional health centres. The study further found extensive use of herbal medicines to heal illnesses in the affiliate shrines of Dente.

The thesis concluded that the discourse of health has to take cognisance of health as a concept that is multicultural and complex, rather than universal. The complex view about health is, therefore, in tandem with the Krachi concept of health. The study underscored the need for collaboration between traditional and orthodox healthcare practitioners to deal with critical health challenges and improve the quality of healthcare in Ghana.



TERMINOLOGIES

Deity: A supernatural force believed to possess power and is worshipped by individuals or groups of people.

Dente: The Krachi state deity believed to be superior to all deities in the Kete-Krachi area. Dente is also the name of the shrine.

Healing: The processes of recovering or regaining sound health.

Health seeking behaviour/choice: The preferred health approach, or a combination of health approaches in a single health condition or episode. It also refers to the actions or inactions that individuals who perceive themselves to have a health challenge undertake in order to find a remedy to their condition.

Indigenised shrines: Shrines introduced by settlers and incorporated into the traditional practices of the Krachi people many years ago. They are believed not to have a link with the Krachi ancestors.

Indigenous shrines: These are shrines owned by the autochthonous people and are believed to have a link with the Krachi ancestors. These shrines have been passed on from one generation to another.

Informal healthcare: Healthcare provision or system which is not within the scope of formal institutions.

Kete-Krachi area: The Kete-Krachi area refers to the towns/settlements within the Krachi West Municipality that are (including other areas that were) headed by the Krachiwura (paramount chief).

Orthodox/allopathic healthcare: Healthcare practices which are traced to the Western world. These healthcare systems are dominated by health professionals such as nurses, pharmacists, and physicians who deliver healthcare using drugs, surgery, among others.

Private healthcare: The provision of healthcare services or products which are owned and controlled largely by individuals rather than government and are greatly urban based.

Public healthcare: Healthcare institutions largely controlled by government with a purpose to deliver healthcare services to the citizens. Public healthcare is often financed from the public account.

Settler shrines: These are shrines owned by settlers. They are often 'mobile' as the settlers migrate. Settler shrines in the Kete-Krachi area are sometimes referred to as 'anti-witchcraft' shrines.

Shrine: A shrine is an abode for a spiritual force. It may be an enclosure, or a room created to contain artifacts meant for religious activities. Shrines may be natural or man-made artifacts.

Traditional healer/medical practitioner: Traditional healers refer to healthcare providers who are recognised by communities to provide healthcare using local therapies.

Traditional Medicine: African based knowledge system used for diagnoses, prevention, and treatment of illnesses and other health conditions.

Herbal Medicine: This refers to substances derived from plants that are used as therapies in Africa or elsewhere other than Western or Eastern medicines.

Healthcare system: The organisation of people and institutions, including resources, in the provision of healthcare services to meet the health needs of a target population.



LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
BANGA	Building a New Generation of Academics
CDC	Centres for Disease Control
CEFIKS	Centre for Indigenous Knowledge Systems
CIKOD	Centre for Indigenous Knowledge and Organisational Development
CPMR	Centre for Plant Medicine Research
CSRPM	Centre for Scientific Research into Plant Medicine
FGD	Focus Group Discussion
GHPTHA	Ghana Psychic and Traditional Healers Association
GILLBT	Ghana Institute of Linguistics, Literacy and Bible Translation
GNATH	Ghana National Association of Traditional Healers
GPPA	Ghana Priests and Priestesses Association
GPTHA	Ghana Psychic and Traditional Healing Association
HAG	Herbalist Association of Ghana
HBM	Health Belief Model
HIV	Human Immunodeficiency Virus
IPCC	Intergovernmental Panel on Climate Change

ITAM	Institute of Traditional and Alternative Medicine
KNUST	Kwame Nkrumah University of Science and Technology
KVIP	Kumasi Ventilated-Improved Pit
LEAP	Livelihood Empowerment Against Poverty
MISR	Makarere Institute of Social Research
NHIS	National Health Insurance Scheme
ORGIIS	Organisation for Indigenous Initiatives and Sustainability
PHC	Population and Housing Census
PMTHA	Plant Medicine and Traditional Healers Association
PNDC	Provisional National Defence Council
PRAAD	Public Records and Archives Administration Department
SDOH	Social Determinants of Health
SMCD	Supreme Military Council Decree
TBAs	Traditional Birth Attendants
THs	Traditional Healers
TM	Traditional Medicine
UG	University of Ghana
UHAS	University of Health and Allied Sciences

UNDP United Nations Development Programme

WHO World Health Organisation



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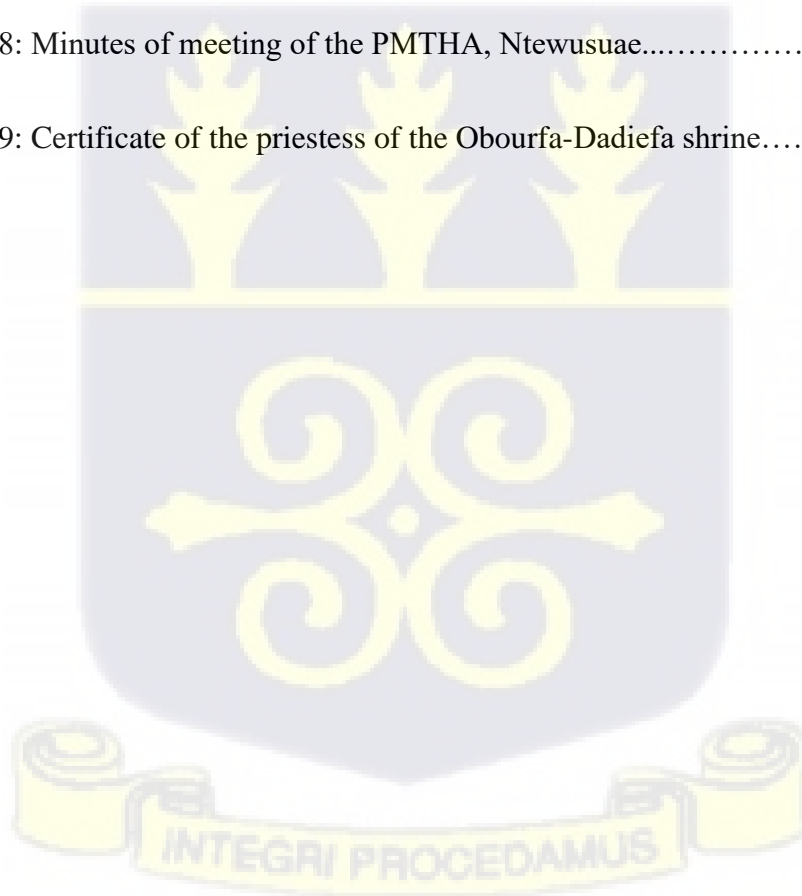
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CHAPTER ONE

BACKGROUND TO THE STUDY

1.1 Introduction

Ghana's health systems have variously been described as 'complex', 'pluralistic', and 'multifaceted' (Gaddah & Munro, 2011; Salisu & Prinz, 2009). The public health sector is largely controlled by the government through the Ministry of Health (MoH) (Nketiah-Amponsah & Hiemenz, 2009; Gaddah & Munro, 2011; Salisu & Prinz, 2009). On the other hand, the private healthcare sector is greatly marked by formal healthcare providers such as medical doctors, pharmacists, and nongovernmental organisations, whereas the informal healthcare providers comprise herbalists, traditional birth attendants (TBAs), traditional orthopedic specialists, priest-healers, to mention a few. A study on shrines and healing falls under the informal healthcare sector. The discourse on health should therefore consider shrines. The private sector is perceived to be efficient, and this bolsters the perception that they are connected with high levels of utility and quality, comparative to the public healthcare sector (Nketiah-Amponsah & Hiemenz, 2009; Turkson, 2009; de-Graft Aikins & Ahmed, 2014).

The corpus of literature that sought to compare the private and public healthcare systems describes the former as capable of addressing the needs of clients. Consequently, private healthcare facilities are preferred to public healthcare systems as a result of accessibility, shorter wait-times, privacy and confidentiality, coupled with the general responsiveness to the needs of patients (Adesanya, Gholahan, Ghannam, Miraldo, Patel, & Verma, 2012;

Montagu, Angelmyer, Tiwari, Dasser, Rutherford, & Horvath, 2011). In terms of cost, however, private healthcare facilities are comparatively expensive, a situation that makes it difficult for Ghanaians who lack financial resources to access their services (Tenkorang, 2016). The informal health sector, to which Traditional Healers (TH) belong, is prevalent in Africa. Though there is a glut of European medicines, interchangeably termed as “Allopathic”, “Orthodox”, “Scientific”, or “Western” on the African markets, they are less patronised as compared to traditional healthcare system in Africa.

This study is situated within the parameters of the tradition of social determinants of health (SDOH). Rudolf Virchow, a German physician known for his works in pathology, forensics and social medicine, wrote in the mid-19th century that if medicine was to make great strides, then it should be linked with the larger political and social life of people (Virchow, 1849). Virchow notes that all obstacles to health should be removed for it to become a common good. Although Virchow upheld the social determinants of diseases, he maintained that climate and biology contributed to outbreaks of epidemics (McNeely, 2014). The social, environmental and political determinants of health have since been embraced (Schechter, 2003). The SDOH is used in contemporary times to refer to the non-clinical factors that impact the health of people. These include worldviews, environment, and food, among other factors. From 1948, the WHO began to incorporate social indicators in the definition of health. The SDOH model was Africanised by Ichoku, Mooney, and Ataguba (2013). They argue that health should be viewed from social and cultural perspectives. This thesis leaned on the Africanised SDOH model by Ichoku, Mooney, and Ataguba. The thesis argued that the diverse health approaches in the Kete-Krachi area is a result of the different conceptualisations of diseases and ill-health. Furthermore, the thesis

argued that social and religious interpretations concerning health or ill-health are connected with a people's worldview, which mirrors on and shapes the understanding of the Krachi and their response to healthcare. It explored how belief systems impact health choices; and this is where the link between shrines and healing becomes eminent.

Related to the SDOH model, on which this thesis is premised, is the 'helplessness beliefs model'. The helplessness belief model emphasises the inability of people to deal with the perception that there is no relationship between their own behaviour and their outcomes (Seligman, 1975), thus some failures are believed to be insurmountable while others are uncontrollable. When failures are perceived as insurmountable, it leads to passivity, depression, the decline of performance and loss of motivation. Under such circumstances, causal interpretations of failed activities prove to be relevant (Abramson, Seligman, & Teasdale, 1978). Proponents of helplessness beliefs postulate that when individuals encounter failures or challenges in life, the question *why* is often posed, and explanations are classified according to underlying causal dimensions (Graham & Weiner, 1996, p. 75).

In the view of Seligman, human outcomes are usually not attributed to their own conduct. In Kete-Krachi, the use of the 'helplessness belief system' to explain social patterns of life including anomies is, however, prevalent. Among the Krachi (*Kaakye*), a breach in social relations may cause illnesses. Indeed, challenges in the human domain that are perceived to be insurmountable (which are sometimes caused by the actors themselves) are often sent to the supernatural for redress. Given the prevalence of the 'helplessness beliefs system' in Kete-Krachi, it is axiomatic that the belief system has created religious nomenclatures, authorities and institutions that render spiritual and quasi-spiritual services to people for health purposes.

Another model which fits into this study is one of the behavioural change theories, the 'health belief model (HBM)'. This model was developed by Irwin Rosenstock in 1966. Premised on the 'behavioural change theory' which explains why people do or do not adopt certain health behaviours, the health belief model establishes the logic for the behaviour of patients. It dissects, for example, the reasons and validity of people accepting or rejecting X-ray examinations (Raingruber, 2008). In the 1970s and 1980s, the model was further developed to include illness behaviours, prevention of illnesses and health screening (Becker & Maiman, 1975). The model is used to predict general and positive health behaviours.

As indicated, the HBM is based on the knowledge and beliefs of individuals pertaining to their own health. These subjective explanations given to health and illnesses can therefore be better understood through phenomenology, where detailed explanations about health-seeking behaviours are elicited. The HBM has six constructs: perceived severity, perceived susceptibility, perceived benefits, perceived barriers, cues to action, and self-efficacy. Perceived severity refers to individuals' belief about the gravity of a health problem. Perceived susceptibility refers to beliefs about the likelihood of being affected by the health problem. Perceived benefit refers to beliefs about the benefits in participating in health promotion behaviours while perceived barriers denote assessment of possible challenges to adopting health-promotion behaviours. For instance, barriers include the lack of health insurance or transportation to health facility, and longer wait times at a health facility which could influence health behaviours. Cues, on the other hand, refers to factors which may be internal, such as pain or external, such as incapacitation of a family member from the health problem. Self-efficacy refers to the belief in the capacity of individuals to execute the

suggested health behaviour. These factors act together in the determination of whether individuals will exhibit certain health behaviours. In the context of this current study, the researcher's interest was in perceived severity, perceived barriers and self-efficacy. The assumptions and constructs contained in the health belief model guided the study to elicit critical information on the reasons that account for the failure to utilise biomedical health services.

The HBM is not without criticisms. It is criticised for deifying rationalism as the ultimate basis for health-related behaviours. Notwithstanding this criticism, it is common knowledge that there is generally a preponderance of rationalism over spiritualism in the determination of the health-related choices that people make in everyday life. However, there are exceptional cases where this rule does not apply. Among the Krachi, individuals' choices of health may be grounded in spirituality, requiring different health approaches. Despite the apparent weakness of this model, particularly in its usage to explain health-related behaviours in Kete-Krachi, the model provides clues for this study to examine critical explanations to health choices.

The popular perception in Western cultures is that traditional healthcare is ancillary to orthodox medicine. This perception is erroneous. Evidence shows that traditional healthcare (medicine) overshadows the use of orthodox medicines in most developing countries.

The World Health Organisation (WHO, 2003) defines traditional medicine as

... health practices, approaches, knowledge and beliefs incorporating plant, animal and mineral based medicines, spiritual therapies, manual techniques and exercises, applied singularly or in combination to treat, diagnose and prevent illness or maintain well-being (WHO, 2003).

The WHO approximates eighty percent (80%) of Africans as consumers of traditional medicine for primary healthcare. The significant percentage of Africans, and ultimately Ghanaians, utilising traditional medicine is due to a number of reasons. In the first place, there are inherent lapses in orthodox medicine in Africa in general. Secondly, other social interventions such as the National Health Insurance Scheme (NHIS) in Ghana have paved the way for traditional medicine to remain relevant. Aryeetey, Nonvignon, & Aikins (2014) have argued that the NHIS was recommended and promoted by the WHO so that low- and middle-income countries would achieve universal access to healthcare. In Ghana, for example, the NHIS covers some categories of traditional medicine, thus contributing to widening its market horizon. Although the scheme has minimised financial barriers to healthcare, unfortunately, it is fraught with many challenges such as high drop out rates, lack of confidence in the scheme, and the high out-of-pocket payments being incurred by the insured. Since the introduction of the on-the-spot-payment for healthcare in Ghana two and half decades ago, more than half of Ghana's patients have resorted to traditional and self-medications (Lartey, 2012, p. 58). A greater percentage of the Ghanaian citizenry, particularly in the rural areas, also resort to the use of traditional medicine (WHO, 2007, p. 75). The challenges facing the NHIS impact healthseeking behaviour among the Krachi people.

The utilisation and consumption of traditional medicine in Africa is not only high, but it is also the first line of treatment for a majority of Africans. In Ghana, Mali, Nigeria and Zambia, the first line of treatment for sixty percent (60%) of children with high fever resulting from malaria is the use of herbal medicine at home (WHO, 2003). An estimated

eighty percent (80%) of the populace of Ghana relies on herbal preparations for primary healthcare (UNDP Report, 2007).

It is common knowledge that Africa is made up of diverse ethnic groups and cultures. Apart from the cultural and ethnic diversities, some scholars have described the healthcare systems in Africa as pluralistic. Assessing rural healthcare of Ethiopia, Slikkerveer (1982) underscored the value of an “integrated approach” and “pluralistic view” concerning traditional and modern healthcare systems. Slikkerveer identified a wide range of medical systems encompassing macro-religious practices and the application of medicinal plants, often mixed with home treatments that reflect both mystical and pragmatic belief systems (Slikkerveer, 1982, pp. 1862 & 1863). Similarly, de-Graft Aikins & Koram (2017, p. 371) argue that Ghana’s healthcare sector has always been pluralistic, and that the traditional sector preceded the establishment of biomedicine in the colonial era.

It is axiomatic that traditional medicine predated the introduction of Western medicine in Africa. In addition, since its encounters with Western medicine, traditional medicine has held sway and demonstrated its numerical strength for decades. It should be borne in mind that traditional medicine in Africa is diverse and multifaceted, encapsulating all aspects of the healing processes and application of medicine. This worldview and application of medicine in Africa is aptly opined by Owoahene-Acheampong (1998, p. 121) when he said: “[U]nlike the Western worldview, the worldview of the Akan in particular, and Africans in general, is holistic”. Health, healing, and illness are components of the broader and integrated worldview of the Akan.

Twumasi (1975) has categorised traditional healers in Africa into traditional birth attendants, faith healers, spiritualists (diviners) and herbalists; Faith-based healing as

provided by both traditional priests and Islamic diviners during the pre-colonial and colonial epochs constitutes the contemporary transnational system championed by the Charismatic and Pentecostal churches. The faith-based healers deal mainly with social, psychological, and psychosomatic problems. Other forms of medicines that have dominated the Ghanaian healthcare system include Eastern medicines such as Ayurvedic and Chiropractic, which have become acceptable in the Ghanaian medical landscape (Kretchy, Owusu-Daako & Danquah, 2014). Traditional healthcare providers have been recognised, for instance, by Dr. Kwame Nkrumah's government through the establishment of the Ghana Psychic and Traditional Healers Association (de-Graft Aikins & Koram, 2017, pp. 371 & 372). Equally, there is a repertoire of herbalists in Africa, who dominate the traditional healthcare system. It is crucial to indicate that the Dente shrine predated Western and Eastern healthcare systems in Ghana. The effects of these multiple healthcare systems on shrines shall be indicated in the fifth chapter.

African medicine and processes are firmly embedded in indigenous knowledge systems. The WHO Report (2000) describes indigenous knowledge as “any understanding rooted in local culture”. Many scholars have attempted a description of indigenous knowledge. Ohiokpehai (2003) defines it as “knowledge of the people living together in a certain area, generated by their own and their ancestors' experience, including knowledge originating from elsewhere which has to be internalised by the local people” (Ohiokpehai, 2003, p. 267). Ohiokpehai's definition is inclusive as it recognises the dynamic nature of indigenous knowledge through borrowing of ideas. Indeed, people adopt ideas borrowed through conquests, trade, wars, and intermarriages. These borrowed ideas, together with lived experiences, help to establish knowledge systems that are passed on, usually from an older

generation, through different oral mechanisms (Najjemba, 2021). Indigenous knowledge encompasses knowledge forms that are held collectively by a population that informs interpretations of things. This knowledge system varies from one culture to another. It is viewed as a dynamic mix of both past traditions and present innovations with a view for the future (Adu-Gyamfi, 2019, p. 71).

Cultural understandings about health are paramount in Africa. Like elsewhere, Africans seek sustainable healthcare. The people's beliefs thus mediate how good health is sustained. Africans understand the interaction between the physical dynamics of health on the one hand, but nevertheless consent to spiritual manifestations (Lloyd, Haussman & James, 2019). Hence, health is conceived as having both mundane and spiritual dimensions in Africa. The spiritual dimension of health in Africa is vividly articulated by Ventévoel (1996, p. 17) that, "diseases of supernatural origin can be caused by being cursed by a person, breaking an oath, offending a deity, or stealing". From the foregoing viewpoint, it is clear that the Western worldview of health is alien to Africans. Social crimes such as murder, rape, abortion, including laughing at those suffering from diseases, are abominable. Writing on African concepts of health, disease, and treatment, Omonzejele (2008) asserts that health within the African context is all-embracing and does not only look at the proper functioning of the body organs. It includes the spiritual, physical, and emotional stability of self, family and community. For Omonzejele (2008), the African notion about health is broad, involving the use of herbs, sacrifices and divinatory performances.

The concept of health itself has been given different meanings. Like religion, health is an ambiguous and dynamic concept (Lloyd et al., 2019, p. 15). The World Health

Organisation (WHO), in the Preamble to its founding constitution in 1948, for instance, defined “health” as a “complete state of physical, mental and social well-being, not just the absence of infirmity”. This definition, though greatly extolled, has been critiqued from various dimensions. Huber and Green (2011, p. 1) have noted that the definition as offered by the WHO requires “total health, all the time”. They point out that populations in the Global North and South suffer from chronic and long-term diseases. The definition is further faulted for referring to health as a complete state, as it is impossible for people to realise that state (Huber & Green, 2011). They therefore suggested the construction of health frames which will systemise various operational needs. Many scholars have argued that health cannot be measured in absolute terms, but it should rather be viewed as a representation of a continuum. In effect, health should be viewed as a process and product of life and living. Therefore, virtually all individuals will be faced with a health problem or another in their lifetime that requires some form of healthcare or intervention (Nuhu, 2018).

The need for a comprehensive definition of health which focuses on “well-being” was however highlighted by the United Nations Development Programme (UNDP) (1964) which acknowledged seven areas of well-being, namely, economic, health, food, environmental, personal, community and political. Health, in the context of Africa, is also often connected with security (Takemi, Jimba, Ishii, Katsuma, & Nakamura, 2008). Health restoration also requires a reconstruction of individual’s spiritual-moral integrity which is restored through confession and rituals. Good health is thus conceptualised as “well-being” which arises from personal and community integrity (Akoi, 1970, pp. 48 & 49). According to Akoi, illness is not only a threat to the individual in Africa, but also to the collectivity,

solidarity and security. Given the belief in the African traditional setting that diseases have both spiritual and physical dimensions, spiritual and material medicines are sometimes applied in tandem. Furthermore, the diagnoses of diseases have both physical and spiritual paradigms. Sometimes, community cleansing is conducted to avert an impending calamity (Dzobo, 1972). Dzobo's assertion is illustrated in Krachi rituals (*mbusi*) performed to combat impending calamities. Religious rituals are used as a means to cleanse, heal, and also reconcile the individual with the community (Hevi, 1989, p. 6).

As indicated in the preceding paragraphs, there is the general view that healthcare worldwide is complex. Given the complexities of healthcare, Lloyd et al. (2019, p. 17) recommend that healthcare should be studied in a way that emphasises its place within the totality of human existence. The study of Social Determinants of Health (SDOH) has had a proclivity towards the narrow viewpoint of proximate social determinants of health – especially in the Western culture. Culture is arguably epistemologically empiricist (Ichoku, 2011), but this viewpoint tends to ignore the non-empiricist and more hermeneutical approaches in the understandings of health and healthcare (Ichoku, Mooney, & Ataguba, 2013).

Although the literature on social determinants of health is relevant, there is paucity of it on non-Western cultures, particularly Africa. Social determinants of health must be viewed as inclusive (Ataguba & Alaba, 2011). In Africa, both the spiritual and physical worlds are intertwined and inseparable. This makes it suitable to consider broadly, as a theoretical point of departure, the Social Determinants of Health, within which to explore the nexus between shrines and healing. This theoretical foundation is considered comprehensive in Africa where religion matters for the production and utilisation of health (Lloyd et al.,

2019). The proponents of social determinants of health argue that Africans are rational actors, with goals being pursued from the perspective of health as a spiritual and physical entity. There is no gainsaying that Ghana's pluralistic healthcare consists of both traditional and allopathic medicine (Hill, Hess, Aborigo, Adongo, Hodgson, & Engmann, 2014, p. 37).

When seeking healthcare, Ghanaians use traditional medicine, allopathic medicine, or a combination of traditional and allopathic medicine (Hardy, 2008; Hill et al., 2014; & Warren, Bova, Tregoning, & Kliwer, 1982). The observation of Hardy et al. is not different from the Krachi who, after consultation with their deities, seek either traditional or orthodox healthcare, or both.

Since the earliest contacts with Europeans when Western medicine was introduced in Ghana, Ghanaians have made use of a combination of traditional and western medicine. In his account of the disease environment in Southern Ghana, Pieter de Marees provided an insight into the prevalent diseases, highlighting pox, the clap, gonorrhoea, worms, headache and hot fevers as the most common diseases in Southern Ghana in the 17th Century. According to de Marees, the people of Southern Ghana predominantly applied traditional modes of treatments, but occasionally, they made use of imported herbal medicine brought to them by the Dutch. Similarly, Dr. Tedlie provided accounts of the people of Asante making use of a combination of traditional and Western prophylactics in the treatment of diseases. His account provided insights into how his clinic established in Kumasi in 1817 complemented traditional healing methods in treating various diseases in Kumasi, notably dropsy, crawcraw, liver cancer, guinea worm, skin disease, fever, bowel complaints, syphilis, umbilical hernia, hydrocele, bronchiectasis, hepatitis, urethral

stricture, cataract and elephantiasis (Addae, 1996, p. 20). The combined uses of traditional and Western prophylactics, believed to facilitate recovery of patients, are common in contemporary times.

Over the years, there has been a paradigm shift from the traditional ‘health care economics’ that underscores the individual perspective within the healthcare to the ‘health economics’ that views health as a social good. Health care economics involves medical model that stresses the maximisation of individual outcomes but considers social organisation of the health system as merely instrumental. Ichoku, Mooney, and Ataguba (2013) therefore argue that health economics has to pay critical attention to the social determinants of health; but in doing so, it must interrogate the reasons for structural variations that give rise to health inequalities. In view of this, Edwards (2001), Navarro (2002), and Mooney (2009), to mention a few, have argued for a new model that explores health within the social context.

Some scholars have proffered that the activities of health prevention and cure must take into account community value systems (Ichoku et al., 2013). Indeed, the quest for a shift in the health paradigm has compelled governments to recognise the socioeconomic determinant of health and commitments at addressing the causes of ill-health. This paradigm shift, averred to in Ichoku et al. (2013, p. 746), has to take cognisance of health as a concept that is multicultural rather than universal. It is from this angle that a new model of health, independent of the Western model, need to consider social and cultural values. Social capital, therefore, serves as a major determinant of health approach. Social capital among the Krachi people shall be detailed later in chapter seven. Although people often seek diagnosis in allopathic healthcare facilities, they also seek treatment and spiritual

explanations and meanings from traditional medical practitioners. Different healthcare approaches are premised on different frameworks in their understanding of health and diseases. In the light of this perspective, scholars have argued that allopathic medicine lacks knowledge and understanding of the cultural beliefs and practices of their clientele (Hill et al., 2014. p. 42).

Apart from the connection between society and health, in-depth literature exists on the link between religion and health, through African Studies, Health Studies, and Religious Studies. Religious beliefs play salient roles in the lives of people around the world. This is especially the case in Africa, where religion provides meaning, relationships and a worldview (Lloyd et al., 2019). Religiosity “is one of the psychosocial determinants of health” (Kagimu, Guwatudde, Rwabukwali, Kaye, Walakira & Ainomugisha, 2013). In Africa, there is the link between spiritual and physical health. Glick (1973, p. 185), in confirming the spiritual solutions to human challenges, indicates that ordinary human powers are insufficient to permit the satisfaction of all needs. Thus, among others, fears of starvation, disease and disaster, account for the reasons people turn to magical rites and spells with the hope of securing that which can never be wholly secured.

The view of health as ‘holistic’ is common among African societies. African societies consider health as broader and holistic, than the physical process. Prior to the World Health Organisation’s conception of health as all-inclusive, Africans had grasped the holistic idea of health. It is this explanation which opens Africans to the influence of belief systems. Working with shrines therefore assists practitioners of traditional religion to fully understand spiritually based reasons for illness (Dove, 2010, p. 826). For some, the physical, emotional, and psychological aspects of the individual continue to be independent

of the spiritual. Even from a Christian point of view, orthodox Christians believe that the physical body may be freed or healed of ailments without assigning any spiritual explanations to their causes, while emerging churches see the physical, mental and emotional health as embedded in the broader spiritual domain (Lloyd et al., 2019, p. 109). The overarching view is that both the “spiritual and physical worlds are intertwined” (Lloyd et al., p. 25). Theories of ‘sickness’ and ‘disease’ are interlaced with constructs about the world and social and cultural life (Olupona, 2004).

Traditional healers have in-depth knowledge about the history and culture which jigsaws into patient’s beliefs and worldviews of the causes of illness (Hill et al., 2014). Often, Western prophylactics are used first and when the illness persists, the diviner is used as the credible option (Olupona, 2004, pp. 111 & 112). While the observation of Olupona may be justifiable, it should be pointed out, on the contrary, that the Krachi may seek healing in the shrines first, based on the directives of the diviner, before consulting the hospital when all attempts have failed. The holistic nature of African healthcare is embedded in observations about health seeking behaviour. Indigenous healing illustrates a process in which the healer, client, in addition to the social and cosmological order, interact to arrive at a meaningful, desired results of healing to either individuals, groups or community (Obinna, 2012, p. 135). The case of Ghana is not different.

Approaches to healthcare in the Ghanaian context are based on an understanding of human being, life and health. ‘Being’ – from which ‘human being’ is derived – represents a ‘force’. ‘Human being’ thus refers to the immediate manifestation of a spiritual force or power, with the Supreme Being and spirit forces serving as the ultimate sources of power. ‘Human being’, whether male or female thus represents the dimensions of the Supreme Being. The

concept is therefore conceived as the vehicle via which the divine manifests itself in the universe. Ghanaians consider life as total, integrated contemporaneous experience of their existentiality in all the dimensions of life, namely, spiritual, and physical, social and personal (Hevi, 1989, p. 5). Individuals are, in this light, connected with both the material world, and through the *ntoro* (gene), *mogya* (blood), and the union in a person's *okra* (soul or temperament).

Sanctions from the spiritual world pertaining to deviant behaviours may include ill-health (Twumasi, 1975, pp. 22 & 23) and other social and economic hardships. The physical state of individuals or society may thus be a reflection of the spiritual-moral state. It is with this thought that illness is seen as a 'bad' spiritual-moral state. Considered in this context, individuals' freedom from the illness requires confession, performance of reconciliatory rituals, and making amends. Failure to perform these rituals results in the progressive deterioration of the well-being of the individual and society resulting in disaster or death (Hevi, 1989, p. 5). Belief systems impact on health choices as people consult shrines in the Kete-Krachi area for healthcare.

In their study on health-seeking behaviour of people living with HIV/AIDS in Ghana, Awusabo-Asare & Anarfi (1997) have pointed out that historically, diseases whose aetiology is difficult to trace have been given spiritual explanations among some ethnic groups in Ghana. Divine attribution to events in the affairs of people are common when society is unable to deal with unusual, sometimes new, circumstances within the context of existing knowledge and practice (Kirby, 1994). In spite of the dramatic socio-cultural change brought by formal education, conversion to Christianity and Islam, coupled with the alterations in the patterns of socialisation witnessed in Africa, people continue to assign

supernatural explanations to events (Awusabo-Asare & Anarfi, 1997, p. 244). HIV infections whose aetiology remains inexplicable with an unknown cure have therefore been assigned preternatural explanations rooted in the defilement of either themselves or the ancestors, or a breach in the moral code of behaviour (Awusabo-Asare & Anarfi, 1997, p. 245). Such explanations pertaining to unknown diseases affect health-seeking attitudes. Those who root their explanations in ‘bewitchment’ resort to diverse health approaches – either serially or simultaneously, with the hope of providing a cure or relief, and also seek explanations for the sources of infection, regardless of any education campaigns which might suggest that the disease has no cure (Awusabo-Asare & Anarfi (1997, p. 243).

Diseases with unknown remedies or sources are often linked with an offense against the spirits, ancestors, or the deities, or sometimes with failure to carry out one’s responsibility. Further, diseases arise as a result of curses or as a result of someone who has been wronged (Twumasi, 1975; Appiah-Kubi, 1981). These explanations account for the reasons why diseases in Ghana such as tuberculosis, measles, and guinea worm were all attributed to supernatural causes (Dickson, 1969). For instance, tuberculosis in Ewe is known as *yomekpe* or *ngolekpe* (ghost cough). Such diseases therefore have spiritual implications. Under such circumstances, there is often the belief that Western remedies are incapable of offering explanations or remedies. Illness terminologies in *Kaakye* have been offered in chapter three. Patients suffering from diseases whose causes are attributed to the supernatural may, together with their families, consult the supernatural for further explanation and treatment at the shrines, or seek other spiritual support (Awusabo-Asare & Anarfi, 1997).

Health seeking behaviour is premised on an understanding and interpretations of the causes of the sicknesses. People who embrace the germ theory of causation of illnesses show a differing attitude to the search for the cure to a disease, different from those who attribute the disease to a supernatural cause. Though people generally accept the germ theory of disease causation, some basic questions may arise about the occurrence of a disease at a particular time, or even why a disease affects a particular individual and not comparable others. Finding answers to such questions raises the supernatural question pertaining to the causes of diseases (Awusabo-Asare & Anarfi, 1997, p. 252) and the need to consult shrines. Such supernatural explanations of ill-health render it possible to rationalise difficult situations, particularly when there is a failed attempt to treat the patient (Castle, 1994). Hill et al. (2014) have further pointed out that local conceptualisations pertaining to illnesses influences treatment practices in rural Northern Ghana. Culture and traditions therefore play essential roles in the management of health problems.

From the afore discussed, it is clear that health is a social determinant that requires different approaches encompassing the physical and/natural, spiritual, and social. Such a complex approach firmly takes up the African conceptualisation of health. Shrines as a traditional health approach can therefore not be ignored in the discussions of traditional healthcare systems in Ghana. This thesis therefore examines the connection between shrines and healing among the Krachi. Unfortunately, in-depth study on the subject has not been conducted among them.

1.2 Problematizing the literature

The dominant literature on Kete-Krachi is contained in the works of Donna Maier.¹ Maier (1979) discussed Kete-Krachi and its knowledge in traditional remedies of healthcare delivery. Situating the Krachi Dente within Asante medical practices, Maier painted a picture about the spiritual powers and medical efficacies of Krachi Dente. According to Maier, the medical efficacies of the powers of the Krachi Dente were so overwhelming that the shrine became the last resort to provide curative medicine to an illness that defied orthodox medicine and prophylactics from other sources of healthcare. Maier's account provides ephemeral insights into Kete-Krachi's health and religious practices. As will be evident in subsequent chapters, this study adds to Maier's work on Kete-Krachi since her discussion on health concentrated on Asante medical practices in the nineteenth century.

Similarly, Maier (1981) argues that the sanctions arising from religious oaths, and the wealth emanating from the practice of religion, when managed well could provide the basis for secular economic and political power. Although the work heavily leans on religion and politics in Kete-Krachi, Maier (1981) notes that the Dente priest – Kwasi Gyantrubi – capitalised on a form of indirect taxation by selling to members of the Bron confederation the oracular advice, charms and medicine that the shrine provided. It is this prestige, religious legitimacy, and vibrant economic foundation, provided by the Dente Bosomfo which expanded his political supremacy (Maier, 1981, p. 243). Maier points out further that the Asante and Ewe consulted the Dente in such matters as illnesses, financial success,

¹ Maier's monographs on Kete-Krachi include the following: *Nineteenth-Century Asante Medical Practices* (1979); *The Dente Oracle, Bron Confederation, and Asante: Religion and the Politics of Secession* (1981); and *Priests and Power: The case of the Dente Shrine in the Nineteenth-Century Ghana* (1983).

and political and military issues (Maier, 1981, p. 230). Her work provides a foundation upon which this study is based.

In *Priests and Power*, Maier (1983) asserts that Kete-Krachi was a town not only known for its renowned shrine but also a flourishing market, and the converging point of both long-distance caravans from the Sahelian region with traders of goods brought from the coast. The work focuses on the general overview of Kete-Krachi and its rise, including the power relations that existed in the area. The book focuses, predominantly, on the nineteenth and twentieth century histories of the Gold Coast. In a review of the book, McCaskie (1985) raises questions as to why the Dente deity wielded so much power from an ‘insignificant’ material foundation – and in the context of *communitas* – what really bonded the Dente adherents together – whether it was a matter of faith, ethnicity or expediency? (McCaskie, 1985, p. 115). Explanations to McCaskie’s questions can be understood by examining Dente within the traditional healthcare system and the political organisation of the Krachi people.

Another important work that discusses the Dente oracle is Tonkin (2004). The author compares Ibinukpabi oracle at Arochukwu, Nigeria, and Dente and oracles located in Liberia’s Eastern Region. Tonkin notes that the link that Krachi had with Asante were much convoluted, with a location strategically powerful than any of the Malagueta Coast oracles in Liberia. She further points out that the Ibinukpabi oracle eventually became the organisational agent of the Aro state, which was widely consulted as a result of its efficiency (Tonkin, 1990, p. 43). She notes that in the 19th century, the Dente priests were very powerful and therefore led the Brong (Bron) Federation.

Venkatachalam (2012) avers that the growth of the Dente shrine in the Gold Coast under British authority was due to its role in society, particularly as an anti-witchcraft remedy. Following its relevance therefore, Dente was reinstated in the early 1920s, after it had been banned by the Germans, resulting in its proliferation in the central and coastal Ewe towns. Venkatachalam points out further that in Kete-Krachi, the home of the Dente shrine, the deity served as a cult where leaders of the Krachi state and other individuals consulted the *Bosomfo* (priest of Dente) in moments of crises (Venkatachalam, 2012). As noted earlier, priests in the Gold Coast under British authority were initially banned from all practices relating to witchcraft. This work opens the discussion on the social and spiritual elements of ill-health and the need to resort to spiritual approaches, rather than allopathic healthcare. However, references to witchcraft are not critically discussed in the context of traditional health in Kete-Krachi, creating a gap in the literature which this study fills.

Williams (1976/1977) portrays the medicinal knowledge of the Krachi people. He argues that the terms *odunsini* (herbalist, physician, and creator of objects) and *kisimen* (the powerful man-made or man-owned objects) possess enormous meanings. For him, *odunsini*, as creator or owner of *kisimen*, deals with three elements – an object, some herbs, and the blood of a sheep or goat. Symbolically, these items represent the ‘power’ of ‘force’ of a component of the natural or human world from which they are believed to have come. Similarly, the study details the medicinal values of plants and how they are used in shrines for healing.

Williams further points out that some reasons for which Dente *bosomfo* or *okisipo* (Twi and Krachi, respectively, that is priest of Dente shrine) may be disqualified from priesthood include the following: polydactyly (individuals with more than five fingers), leprosy,

insanity, circumcision, and imprisonment. Reasons of imprisonment as a means to exclude individuals from the Dente priesthood follow the construction of the prison ward by the Germans in Kete-Krachi in 1911. This illustrates the extent to which Kete-Krachi has undergone cultural change. Williams further argues that the Dente *obosomfo* (priests) do not conduct physical healing of any kind. While acknowledging this, the author notes that the *okomfo ojya*, an assistant to the head of a local divinity, has his status defined through possession. He offers prescriptions for all manner of ills, through the revelations and directives of the *okisi* (a divinity) while in a trance (Williams, 1976/1977, p. 26). Though Williams' work has highlighted some health nomenclatures and their functions such as *odunsini* and *kisimen* in the context of shrines, the author's narrative on the healing powers of the *Dente* priest were sketchy. Nonetheless, Williams' work provides a basis for this study to further interrogate the physiological interpretations of illnesses, and health in general, in Dente shrines.

From the above discussion, it is clear that very little work has been conducted on Dente. Even so, those works have focused on the political, economic, and religious roles, rather than healing. Thus, although a few studies have been conducted on Kete-Krachi, these works have not critically discussed Krachi shrines and healing practices in depth. Furthermore, the Dente shrine has received disproportionate research attention to the neglect of its affiliate shrines such as Obourfa-Dadiefia, Fofie, Kikpare and Akomagyo-Lente. Besides, the link between Dente and shrines such as Mprah, Tano, Akoadehye and Bruku in the Kete-Krachi area has also not been paid much attention in the literature. What is also clear is that some studies on traditional healing in Kete-Krachi tend to emphasise the spiritual component of healing. This current study fills this lacuna by exploring shrines

and healing in the Kete-Krachi area. It argues that there are dissimilar views relating to the concept of health.

Apart from a plethora of roles such as healing, protection from malevolent forces and enemies, provision of fertility, and economic protection, the thesis notes that the establishment and proliferation of shrines in Kete-Krachi and other towns in Northern, Volta, and Oti Regions owe largely to their roles in the traditional healthcare system. The thesis, therefore, argues that Kete-Krachi emerged as a powerful state as a result of its role in traditional healthcare, among other reasons. Second, the thesis indicates that the establishment and proliferation of shrines and their concomitant healing practices – though largely a relief to some members of the town – also affected access to allopathic healthcare in the Kete-Krachi area. The continuity of, and preference for, shrines may be found in the lapses in Ghana’s healthcare system too. There is a gap in scholarship as existing literatures do not thoroughly interrogate and delineate the nexus between orthodox medical systems and shrines and healing practices in Ghana. Therefore, this current study seeks to fill the gaps.

1.3 Objectives of the study

This study is driven by attainable objectives. Generally, the thesis sets out to study shrines and healing in the Kete-Krachi area. Specific objectives of this study are to:

- examine the conceptualisation of health, illness and health seeking behaviours among the Krachi people.

- interrogate the factors that account for the continual use of shrines in healing among the Krachi.
- delineate the peculiar health systems in the Kete-Krachi area to establish the nexus between traditional healing and allopathic healthcare systems.
- examine herbal medicine use in shrines and associational life among healers, and its impact on healing activities.
- elucidate indigenous healing systems to determine the extent to which this knowledge has altered over time.

1.4 Research questions

This study is not anchored to a hypothesis; it is driven by rational research questions. It seeks answers to a number of questions. Key among them are the following:

- How is health conceptualised among the Krachi people?
- In which way does conceptualisation of illness among the Krachi people inform health-seeking behaviour?
- How relevant are Dente and its affiliate shrines in the healing practices in Kete-Krachi?
- What links exist between the political/religious institutions in Kete-Krachi and traditional healing?
- What factors account for utilisation of shrines in healing?

- What roles do herbal plants (medicines) play in the practice of healing in the shrines?
- How does associational life promote healing practices in the Kete-Krachi area?
- Lastly, how has traditional healthcare changed over time?

These research questions elicited the data needed on shrines and traditional healing in the Kete-Krachi area.

1.5 Significance of the study

The study expands the field of Health Anthropology as an area of enquiry. The study also serves as a documentation and preservation of indigenous knowledge systems, which contributes to the global theoretical discussions on the concept of health. The study adds to the broader debates on integration of traditional and orthodox medicines or practitioners. It again adds to and expands the conceptual framework pertaining to the forms of knowledge production. In the field of (social) history, the study opens a discussion on the less-discussed factors through which Kete-Krachi emerged as a powerful state. It complements the plethora of literature on the Krachi by focusing on the changes and continuity, with much emphasis on shrines and healing. Importantly, it bridges the gap between Humanistic Studies, Pharmacy/Pharmacognosy, and the Biomedical Sciences as plants used in healing were interrogated. Lastly, the study has implication on policy, as recommendations were made concerning the nexus between allopathic and traditional healthcare.

1.6 Research Methodology

Various procedures have been duly followed to obtain data for this study in a bid to align with essential ethical standards of research. This subtheme therefore provides insights into the methods used for this study.

1.6.1 Research Design

Premised on the interpretations pertaining to health and ill-health, this work heavily leans on the constructivist model that argues that people construct their world of realities. They, therefore, assign different interpretations to their conditions based on their own worldviews. The study thus engaged the qualitative approach. This approach enabled the researcher to not only analyse and interpret findings from the insider perspective, but from the outsider's as well. This ensured a balanced analysis and reliable conclusion of research findings.

As a result of the qualitative nature of the study, sampling of shrines was done to ensure that the districts in Oti and Northern Regions of Ghana where Dente shrines are found are represented in the study. Although the focus of this research is Kete-Krachi, its (Dente) shrines are spread across, including parts of Northern Ghana and Oti Region. The non-probability sampling technique is relevant in this work, as the researcher knew the study area and was/is an insider. Dente shrines are common among the Nawuri, the ethnic group to which the researcher belongs. As a member of the Nawuri among whom data was gleaned for this study, the researcher was able to claim, with ease, some privileged

information about the Dente shrine and also had easy access to the Nawuri communities in the study area. This did not, however, obstruct the data collection process and research reliability as the researcher engaged empathic neutrality, an ethical principle, in the data collection process. The purposive sampling technique, a type of the non-probability sampling, fits this study. Adhering to the objects of the study, respondents who had in-depth knowledge about the subject under interrogation, were included in the sample. The selection of respondents to participate in this study was done with the assistance of the sub-chiefs of the Krachi people, opinion leaders, and the leadership of the *Lentekuo* (association of priests and priestesses of affiliate shrines of Dente), with whom the researcher established initial contacts. They directed the researcher to individuals and groups known to have adequate knowledge about the subject under interrogation.

1.6.2 Techniques of Data collection

Ethnographic research method which emphasises the study of phenomena within the context of culture is critical in a study on shrines. Here, the researcher is expected to be deeply immersed in the social culture of a people over an extended period. According to Bhattacharjee (2012), between eight months and two years of field study is suitable for ethnographic research. Using the ethnographical approach, I frequently visited and lived among the Krachi people between December 2020 and December 2021 to experience the cultures and practices associated with healing. I engaged in primary data collection (observation) and made sense of those aspects of the daily lives of the Krachi people that revolve around their shrines. The researcher took extensive field notes and narrated his

experiences in descriptive style to make readers experience the culture of the Krachi like the researcher.

According to Twumasi (2001), commonly used primary methods applied by social scientists to elicit data from the field include interviews, direct observation, participant observation, case studies, life history, diaries, the use of documentary evidence, letters, personal memoranda, panel discussion, group discussions and public records. Argues Blumer (1970, p. 20), there are no protocols to be followed in the use of any of these procedures. These methods are, nevertheless, tied with ethics which must necessarily be applied. They must simply be adapted to their circumstances, guided by the thinking that participants are “acute observers” and are also “well informed”. The propriety and “fruitfulness” of respondents must therefore be scrutinised. This work, however, heavily elicited data and interpretations through interviews, focus group discussions, and observation as the methods helped to unearth peoples’ understanding of health and health seeking behaviour.

1.6.2.1 Formal interviews

Following the spread of the Dente shrine in Volta (Oti) and Northern Ghana, the research (interviews) was conducted in various towns in the Krachi West Municipal in the Oti Region such as Kete-Krachi, Kadantwe, Nteususae, Monkra, Abujuro, Gyengyen, Gyankrom, Breweniase, Osramane, and Ehiamankyene. Interviews were also conducted in Dambai (capital of the Oti Region) as it had a long economic and administrative link with Kete-Krachi. Other important towns in Northern Ghana where the Dente shrines are

employed in healing include: Kpandai, Balai, Lesseni, Katiejeli, Kitare, Kabonwule, Nkanchina and Bladjai. In-depth interviews were conducted during the lean season, from December 2020 to April 2021, when there was not much work to be done on the farms, to elicit data needed for this research. Further interviews were conducted between May and December, 2021. One-on-one interviews were extensively used to elicit data as this allows respondents to freely express themselves without any form of intimidation.

The phenomenological approach – a non-probability sampling technique which ensures that the research is portrayed from the viewpoint of the research participants (Bonti, 2007, p. 1) – was greatly used in this study. Phenomenology is concerned with the systematic thoughts and analysis of phenomena that are linked with conscious experiences such as human actions, perceptions, and judgement, among others, meant to appreciate and describe social reality from diverse subjective viewpoints of research subjects. Besides, it seeks to understand the symbolic meanings that underly subjective experiences (Bhattacharjee, 2012). Phenomenological investigations require that researchers eliminate pre-existing assumptions and personal biases, and empathise with research participants and their circumstances, in order to fully understand the deep structures that propel conscious thoughts, feeling and behaviour of research subjects. The researcher focused on the experiences of the Krachi people during interviews as a way of understanding their reality, having in mind that the lived experiences of people constitute the foundation of knowledge. Empathic neutrality was therefore engaged in this study that ensured that the research emanates from the viewpoint of the research subjects, considering their sense of the past, present, as well as future. These lived experiences of people are essential in health research. In view of this, Kleinman (1980) indicates that clinical reality reflects the lived experiences

of people regarding sicknesses and health which is enacted within all its existential immediacy. Dealing with a peoples' lived experiences therefore include their beliefs, norms, behaviours, and communicative interactions that are linked with sicknesses and health-seeking behaviour, including therapeutic activities aimed at restoring health.

The phenomenological approach was, therefore, used to conduct extensive interviews with eighty (80) participants from different social backgrounds. Out of this figure, fifty (50) of the respondents were males while thirty (30) of the respondents were females. Since the study focused on shrines and healing, the research elicited data from the following in each community visited, traditional priests and priestesses, opinion leaders, heads of clans and shrine devotees. Other respondents include medical staff such as nurses and physician assistants. The third group of respondents encompassed the Municipal Assembly. While the first category (traditional priests and priestesses, shrine devotees, among others) provided data in relation to the practices in shrines, the second group (nurses and physician assistants) shared their experiences on how activities in shrines affect orthodox healthcare services in the area. The third group also focused on governments' interventions in the area, through the provision of healthcare, or through regulation. In furtherance, the group provided data on COVID-19 cases that complemented the oral narratives obtained from the field. This discussion thus led to the connection between the study and policy formulation.

In-depth interviews provided the researcher an opportunity to pose questions in any order that he considered appropriate. In-depth interviews were flexible to use in terms of sequence and structure of questions. Interviews enabled the researcher to pose follow-up questions. The respondents had ample time to respond to follow-up questions in any

direction they deemed fit. Follow-ups were made to seek clarity on key issues raised by the respondents. In-depth interviews allowed the researcher to pose questions hitherto unforeseen.

A limitation to interviews is the lack of chronological presentation of data. Interviews require a prolonged period of field studies as well as restructuring the data obtained to ensure a chronological order. This helps with a sequential flow of information obtained from the field. Besides this limitation, priests and priestess were, sometimes, unwilling to disclose their practices to the researcher who was a Christian. A priest and a priestess, with whom the researcher familiarised, were useful in explaining the purpose of the research to other healers.

1.6.2.2 Focus Group Discussion and observations

Focus Group Discussion (FGD) was also constituted to obtain data on shrines and healing in Kete-Krachi. The relevance of the FGD is aptly captured by Blumer in the following words:

... a small number of such individuals brought together as a discussion and resource group, is more valuable many times ... than any representative sample. Such a group, discussing collectively their sphere of life and probing into it as they meet one another's disagreements, will do more to lift the veils covering the sphere of life than any other device that we know of (Blumer, 1970, p. 33).

A group of seven (7), was therefore constituted in each community visited, especially in places where Dente shrines were found, to elicit data from people who have specific knowledge in relation to shrines and healing, or their effect on healthcare. Although this

method is often deemed to be time consuming, it ensures the credibility of the information obtained from the field. Protocols relating to COVID-19 were adhered to. Nose masks were worn, and social distancing rules were observed during Focus Group Discussions. That notwithstanding, the researcher was sometimes asked to remove his nose mask for purposes of identification and trust. An advantage of the FGD was that it often developed its own dynamics. It required little interference of the researcher. Outcomes which were not anticipated by the researcher were obtained in the course of the discussions. A disadvantage of FGD, however, was the difficulty of asking many questions for detailed explanations within a limited time. This was because of the method's openness to free expression of views, counterviews, and arguments with regards to the histories, beliefs and (healing) practices of the Krachi people, comparative to one-to-one interviews which could easily be regulated by the researcher. The communal nature of the Krachi people also affected FGDs. For instance, members of the community intruded upon the discussions and increased the number of the group.

To complement the interviews and focus group discussions, I engaged observation methods in shrines to observe and document healing practices. Here, the researcher participates in some of the activities of the people which allows him/her to gain insights into the problem. The researcher then observes the phenomenon in order to find answers to the research questions (Twumasi, 2001, p. 30). By way of obtaining a legitimate entry into the community, I respectively introduced myself to the traditional authorities and people of Kete-Krachi and other communities where data was collected. This approach is relevant as researchers often get the opportunity to socialise, which is a critical *sine qua non* for data collection. Observation methods offer researchers the opportunity to raise relevant

questions at the appropriate time, and when to vary styles of posing questions. This method has its own inherent biases, and researchers must be careful on the field. Caution was therefore taken not to allow personal biases to infiltrate the research. The researcher engaged observation methods where he attended performances of priests and priestesses, to seek clarification on rituals, and obtain first-hand information of practices in the shrines.

1.6.3 Sources of data collection

Two major sources of data collection were used in this study – primary and secondary sources. The primary sources of data are Public Records and Archives Administrative Department and newspaper publications. The secondary sources comprise published books and articles in journals.

1.6.3.1 Public Records and Archives Administrative Department (PRAAD)

Further research was conducted in the Public Records and Archive Administration Department both at the national and regional levels. Such archives encompass the National, Volta regional, and Northern regional archives. These archives are relevant in the study, as Kete-Krachi had contact with those jurisdictions either through commercial activities or as a result of the presence of the Krachi Dente. The National archive is also significant as it served, and still does, as the depot of all the archives in Ghana. The archival data obtained from the PRAAD complemented the information acquired through interviews. It further validated the information obtained via oral means. A limitation of the archival source,

however, was the difficulty in retrieving vital documents while other files could not be found due to inefficient record keeping. Some archival documents needed for this study had been pilfered. Although data collected from the national and Northern regional archive did not address shrines and healing, they nonetheless offered insights into the Krachi traditional and religious practices. The Volta regional archive provided critical insights into healing associations in Ghana, especially in the Kete-Krachi area and Volta Region, which was useful to chapter seven. Basic statistical tools were employed to analyse data obtained from the field. This helped to complement and validate the data obtained through the qualitative approach.

1.6.3.2 Newspaper publications

Articles in newspaper publications were used in this research. For instance, the Daily Graphic Limited, Accra provided much information on Dente and its practices among the Krachi people.

1.6.3.3 Published books and articles in journals

The researcher reviewed written sources relating to the subject of study. The study underscored that shrines and healing has not been adequately researched although evidence of literature on Krachi Dente exists. The secondary sources complemented the primary sources and aided the researcher in his analysis of the data collected from the field through oral means.

1.7 Identification of plants and methods

Twenty-four plants and herbal samples were submitted for identification at the Herbarium Unit of the Department of Botany at University of Ghana in July, 2021. Those plants were compressed and dried before identification (see appendix G.). The process prevented bacteria infestation of the herbarium. Out of the twenty-four samples, seventeen plants and herbs were identified. Seven of the remaining plants were identified at the Institute of Traditional and Alternative Medicine (ITAM) at the University of Health and Allied Sciences in Ho in the same year. Out of the seven plants, four of them were identified by the ITAM using <https://identify.plantnet.org>. This software helped in identifying the names and families of plants by uploading the photographs into the software. These medicinal plants constituted the basis for discussion in chapter six.

1.8 Delimitations

The study acknowledges that a study on shrines and healing systems, with special references to Dente, is broad and therefore needs to be delimited. Traditionally, the term ‘Kete-Krachi area’ includes places such as: Krachi, Nchumburu, Ntrubo, Adele, Chala and Achode. The study limited its focus to the Krachi people. As indicated earlier, in Ghana, Dente shrines are spread in many regions such as Northern, Volta, Asante, and Bono East, to state a few. This study focused on Oti Region. Even so, the study did not cover all the Dente shrines in the entire region. For instance, the study did not include the Krachi Nchumburu District in the Oti Region although there are several Dente shrines there. There are numerous shrines that constitute the *Lentekuo*, association of priests and priestesses of

affiliate shrines of Dente. As a result of the gender dynamics, however, the study identified and considered four affiliate shrines of Dente suitable for this study. These shrines include: Obourfa-Dadiefa, Akomagyo-Lente, Fofie (Fofie-Dente), and Kikpare. Obourfa-Dadiefa and Akomagyo-Lente are headed by priestesses while Fofie-Dente and Kikpare are headed by priests.

1.9 Limitations to the study

Although Nawuri, the language of the researcher, and Krachi (*Kaakye*) belong to the same Guan language cluster and are mutually intelligible, some of the expressions may not directly be the case. In this light, I recruited field assistants (translators) who are fluent in both Kaakye and English languages. The assistants in each community were acquainted with the nature and purpose of the research, including the research questions. They were taken through the designed interview guides, containing the items to be interrogated on the field. They were also trained on the research background. The field assistants ensured that information obtained from the field is representative of what the respondents said they do. The translator also helped in transcription from Krachi into English. Another limitation to this study was the refusal of some Christians to grant the researcher interviews. They indicated that they were 'born again' Christians and had nothing to do with the subject of shrines.

1.10 Instrument(s) for data collection

The interview guide was the main instrument for data collection in the various communities, as this is considered the most suitable instrument used in qualitative research (Akpabli-Honu, 2014, p. 50). The items investigated were captured in an outline manner. According to Patton (1990, pp. 288 & 289), this method of generating qualitative data increases its comprehensiveness and also makes the process of data collection systematic for each of the respondents. Different interview guides were employed to solicit data from respondents from diverse social backgrounds. The instruments contained designed questions on various themes organised in a systematic and sequential order. The guides include shrines and healing in the Kete-Krachi area, hospitals and clinics, Krachi West Municipal Assembly, and healing associations. The interview guide on shrines and healing particularly elicited data on histories and traditions, shrines, the link between shrines and healing, and uses of traditional medicines. The hospital guide helped to establish the link between shrines and orthodox healthcare, while the Krachi West Municipal guide helped to identify the healthcare systems in the municipality, and its interventions in disabilities and COVID-19 cases. Finally, the healing associations guide elicited data on traditional healing associations, and forms of support systems or social capital that members derive when in need.

The guides ensured easy data collection under the themes under investigation, as well as recording responses in a standardised style. Besides, the guides assisted the researcher to pose the same questions to respondents for detailed and diverse responses. It, again, aided the researcher to cover the objectives of the study. The open-ended questions made it easy for the researcher to incorporate responses which were initially not captured in the

interview guides. The researcher recorded responses from the field using notebooks and voice recorders.

1.10.1 Pre-testing the instruments

The instrument for data collection is essential in field research and therefore needs to be pre-tested (see Kumekpor, 2002). Before the final use of the interview guides therefore, the items were pre-tested on a cross-section of the study population to ensure that the questions addressed the purpose of the study. The first three days, beginning from 24th October, 2020 was therefore used to pilot the instruments. The responses received helped the researcher to identify and correct possible ambiguities in the phrasing of the questions. This ensured precision. The exercise resulted in appropriate editing, rephrasing and rewording of the questions on the interview guide which ensured clarity and simplicity and facilitated understanding of the text items. Additionally, the exercise led to inclusion of essential questions and reorganisation of questions that enhanced right sequence of flow of questions and thoughts. Questions that were not essential to the thesis were identified and excluded. Similarly, the voice recorders and cameras were piloted to ensure their suitability of usage.

1.11 Ethical considerations

A researcher conducting inquiry into shrines and healing is dealing with human subjects, collectivities and institutions and therefore needs to take into account ethical considerations. The information obtained through the research could either empower or

disempower affected individuals or society. For example, the use to which the data and findings could be put could have far-reaching consequences for respondents and others. Therefore, consent of respondents is absolutely essential. Beyond this is the unforeseen long- and short-term implications. This study was conducted under the University of Ghana Ethical Clearance Code: ECH 270/21-22, obtained from the College of Humanities. The nature of the research was duly explained to research participants. In this light, participants were able to exercise free power of choice, without the application of force or deceit. They also had sufficient knowledge and understanding of the subject matter involved. This is particularly essential as it granted them the ability to understand the nature of the research and also take decisions. Anonymity and confidentiality – two ethical requirements – were also employed in this research. The issue of confidentiality and anonymity is interlinked with the rights of beneficence, respect for human dignity and fidelity (Clarke, 1991). Anonymity is safeguarded when research subjects cannot be connected with personal response (Fouka & Mantzorou, 2011). In view of this, the use of pseudonyms where necessary and ‘disguising identity’ were used to conceal the identity of respondents who discussed sensitive issues when transcribing the tapes used. However, respondents were promised confidentiality, which is the management of private information in order to protect their identity and dignity.

Furthermore, the privacy of research participants was respected. Privacy refers to the freedom an individual has with respect to the determination of time, extent, including the general circumstances under which private information will be shared with or withheld from the audience of others (Fouka & Mantzorou, 2011). In this light, private information such as beliefs, attitudes, opinions, records, among others, were shared or reproduced with

the knowledge of the respondents. Research subjects who declined to provide personal information about variables such as age, income, marital status, and other details, were not coerced to do so. Burns and Grove (2005) have aptly noted that “an invasion of privacy may cause loss of dignity, friendship or employment, or create feelings of anxiety, guilt, embarrassment or shame”. Thus, due measures were followed to protect research subjects from potential physical, psychological, or social harm during the research and after the dissemination of the research findings through publication. Taboos regarding shrines were respected. This followed my understanding of ‘bad days’ and ‘good days’ pertaining to shrines, for which priests and other assistants may not be willing to discuss or share information with ‘outsiders’.

1.12 Organisation of the study

This study is categorised into thematic areas. The first chapter presents a conceptual understanding of the nature of health in Ghana and Africa at large and gives a general background to the study. It problematised the literature and, in so doing, created a gap for this study. Other key foci of the chapter include objectives of the study, research questions, significance of the study, and research methodology. The chapter also provides insights into the delimitations of the study, limitations to the research, and organisation of the study.

The second chapter reviews pertinent literature on shrines and healing. It examines shrines, illness and healing, and draws the interconnectivity between them. The third chapter, which is devoted to the study area, encompass the history of Kete-Krachi, highlighting pre-colonial, colonial, and post-colonial Krachi. It also examines Dente from the pre-colonial

through to the colonial era. The chapter provides critical insights into the Krachi and their worldview, which is relevant in discussing the nexus between society beliefs and traditional healing systems. It further reviews conceptual clarifications on health, illness, illness terminologies, and how these jigsaw into the thesis topic. The chapter finally stretches the discussion on the aetiology of illnesses in Kete-Krachi, exploring the Krachi concept of witchcraft, magic and sorcery, and the mechanisms through which sources of illnesses are determined.

Chapter four discusses Krachi Dente. The chapter carries the discussion to the nexus between Dente and its subordinate shrines in relation to traditional healing. It further explores the various fields of specialisation of the shrines, and the illnesses they are believed to treat. Although this thesis focuses on the Krachi people, the chapter considers some of the neighbouring communities in Oti and Northern regions where Dente shrines are located. Such a discussion also portrays the significance of shrines, and the extent to which they serve as a bond among the Guan. The chapter, more so, details shrines in the Kete-Krachi area to interrogate their interconnectivity and roles in traditional healthcare.

Chapter five discusses shrines and healing, and how social and religious constructs are woven into the broader framework on global health. It interrogates the factors responsible for patronage of shrines as alternative healthcare. It casts the discussion within the framework of the literature and theoretical perspectives such as the Social Determinants of Health Model, Health Belief Model, Helplessness Belief Model, and the Health Utilisation Model.

The sixth chapter is devoted to the use of herbal plants and medicines in shrines. This chapter particularly broadens the discussion on shrines and healing to biomedicine, thereby connecting the fields of the humanities and social sciences and biomedical sciences. Chapters five and six are therefore devoted to healing in the shrines. Chapter six, however, identifies and highlights key challenges facing traditional medical knowledge among the Krachi.

Chapter seven carries the discussion to social capital (associational life) among healers in the Kete-Krachi area. Paramount among these associations include: the Ghana Psychic and Traditional Healing Association, Ghana Psychic and Traditional Healers Association, the *Lentekuo* (Association of Dente Priest-Healers), Herbalist Association of Ghana, to state a few.

Chapter eight draws substantial conclusions to the research, highlighting policy imperatives and recommendations to improve Ghana's health burden. The recommendations are made to government, research institutions and institutes, civil society organisations, and healers.



CHAPTER TWO

REVIEW OF RELATED LITERATURE

2.1 Introduction

Existing literature is replete with shrines and healing systems in Africa.² A review of the related literature points out the gaps and provides their significance in this study. The first theme in this chapter operationalises the term ‘shrine’ and continues with a discussion of the concepts of ‘illness’ and ‘healing’, which are significant to this study. It points out that shrines in Africa have been studied from political, economic and religious perspectives, with little attention paid to healing. A review of the literature sets the tone for examining the interconnections between shrines and healing, which addresses this study. Finally, the chapter sheds light on health seeking behaviour, which refers to the preferred health approach, or a combination of health approaches in a single health condition or episode. The literature reviewed in this chapter provides a broad theoretical foundation and understanding, substantial to the discussions on shrines and healing among the Krachi of Oti region.

2.2 Shrine: a conceptual understanding

A shrine is a potential abode for a spiritual force, which may be represented by a brass-pan, a clay pot, or small statue. It may also be housed in a room in the residence of a priest

² A few that suffice here include Twumasi (1975), Draycott (2011), Werbner (2009), and Kodesh (2007).

or placed in a separate shrine house (Warren, 1976). Nukpe (2007) describes a shrine, in the context of Ghana, as an enclosure or a room created to contain artefacts meant for religious activities. He opines that shrines are believed to be charged with spiritual potency often deployed in diagnoses and healing of ailments. Unlike Nukpe, Dawson (2009) defines shrines as durable natural or man-made features of the landscape that include both the socio-political dimensions of the communities that own them. Shrines serve as receptacles for deities, ancestors, and other spirits, as well as places for offerings, often in the form of sacrifices during specific life events. These definitions inform the study to pose questions pertaining to the nature of the Dente shrine, which is discussed in chapter four.

In West Africa, shrines create a network in the ritual space when powerful shrines are acquired and established at new locations (Parish, 1999; Parker, 2004; Allman & Parker, 2005; Insoll, 2006; & Dawson, 2009). For Dawson, shrines double as a network of boundary markers. Dawson's edited volume focuses on two major themes: 'shrines of the land' and shrines as 'places of power'. The former refers to prominent immovable (sometimes movable) objects or fragments that stand out in the landscape containing spirits, and the latter – 'places of power' – denote those that are '*intrinsically sacred*' and stand out as natural features of the landscape, often linked to supernatural beings (Dawson, 2009). The study portrays shrines as powerful sources of autochthony. By extension, shrines are relevant in legitimising claims on an identifiable territory which people believe to own (Douny, 2010). Dawson and Douny affirm Colson's (1997) assertion that land shrines represent human settlements whose earlier inhabitants had come into contact with the land. Though relevant in understanding shrines, Dawson mainly focuses on claims and legitimisation of authority over land and people. Another weakness of the book is that it

projects shrines as territorial landmarks for purposes of allodial rights to land, hence, the ethnogenesis significance of shrines. As critiqued by Werbner (2009), Dawson's work – premised on Kopytoff's (1987) theorising of the 'Internal African Frontier' – heavily depends on 'territoriality', which dominates the interdisciplinary arguments about migration and settlement. Though these works are relevant in understanding the concept of shrines, regrettably, they do not delve into healing aspects of shrines, creating a gap in the scholarship.

Douny also points out Dawson's flaws, as the latter paid little attention to the concept of efficacy through the use of substances. This creates a gap for this study to fill. Shrines involve materials that serve as focal points for performances and as sources of efficacy that include offerings of various forms (Stahl, 2010). Shrines should not be reduced to mere "representations" of nonhuman agents, but rather as the loci through which nonhuman agents can be lured into efficacious action arising from certain performances (Stahl, 2010, pp. 192 & 194). The existence of bafflement, pain, and moral paradox drives people toward the belief in deities, spiritual forces, totemic principles, and the fear for witchcraft attacks (Geertz, 1973, p. 109). Religious beliefs thus serve as a foundation for understanding human afflictions and the consequent provision of sustainable panacea. Douny's assertion, therefore, opens up the examination of shrines and their efficacy in alleviating pain and suffering.

Janzen and Green (2016) conceptualise shrines and link them to healing. They point out the ways in which social codes and power of words shape the concept of health. These are clearly demonstrated in the concept of taboos and health and the intervention of shrines. They indicate that shrines in the West African subregion are associated with the earth,

water, nature and to the sky, as well as with deceased rulers, not excluding some shrines' associations with particular principles, such as twinship (for instance the Ibeji of Yorubaland), or diseases such as smallpox (Ipoona/Shapanna/Shapata). In Sub-Saharan Africa, traditional therapies centre around health issues such as fertility, twinship, women's reproductive health, and the general health and wellbeing of infants and children (Turner 1968, 1975; Devisch 1993). Other conditions include debilitating chronic health conditions, misfortunes and fortunes during hunting activities, mental illnesses (Janzen 1992; Nisula 1999), social and environmental issues, to state a few.

In the ensuing discussion, I attempt a review of the terms 'illness' and 'healing', which are two critical terms in the health discourse.

2.3 Illness and healing: A conceptual review

The conceptualisation of the term 'shrine' necessarily requires the conceptualisation of its associated functions: illness and healing. Both terms are assigned different connotations from one culture to the other (Payer, 1988). What may be considered an illness in one culture may not be considered the same way in another culture. This assertion is somewhat confirmed by de-Graft Aikins et al. when they pointed out that "... there are important cultural and ethnic variations in concepts of illness chronicity and incurability which may influence illness action strategies" (de-Graft Aikins, Agyei-Mensah & Agyemang, 2013, p. 129). In Ghana, for instance, the Akan ethnic group accommodate chronicity and use the phrase-name, *koa nkoro* ('difficult to fight'), while others like the Ga have no name for it (Atobrah, 2012; de-Graft Aikins, Boynton & Atanga, 2010). According to Nortey (2009),

Ga traditional healers believe that certain diseases that are said to be supernaturally induced are more difficult to fight than those that are believed to be physically caused which can easily be dealt with through the use of orthodox medicine. Atobrah (2009) points out that, among the Ga, illness is conceived as the fundamental manifestation of breach of harmony in an individual's being, which shapes attitudes and beliefs towards illnesses. She further notes that for one to be ascribed the sick role in the Ga society, such an individual must demonstrate signs and symptoms of bodily manifestation of ill-health, such as rise in body temperature, bodily debilitation and weakness and the lack of physical strength to embark on productive activities. Finally, she indicates the absence of dogma about physiological causation of illnesses among the Ga in their theorisation of illness. In effect, Atobrah indicates that in the Ga society, illness causation is attributed to diverse causes which falls within Murdock et al's (1978) classification of supernatural causation or Foster's (1976) personalistic medical systems to explanation of illnesses. In the Ga society, natural causations of illness or naturalistic medical systems are inapplicable (Atobrah, 2009). This study interrogates perception of the Krachi about aetiologies of illnesses and their approaches.

According to Pool (1989, pp. 116-117), terms which the Western world translates as 'illness' often have a broader scope of meaning in non-Western cultures. Such terminologies in non-Western societies, therefore, do not strictly refer to the physical or psychic ailments, but also encompass a broad spectrum of misfortunes. This view confirms Turner's (1967, p. 300) assertion of illness among the Ndembu of Zambia. Turner notes that illness is conceived as misfortune which may include bad luck at hunting, reproductive disorders, physical accidents, and the loss of property. This perception about 'illness' is

similar to that espoused by Scott (2010) who points out that, during the mediaeval period, illnesses confronted people with great religious and moral issues. This was due to the fact that illnesses were not ascribed to germs as causative elements but were associated with sin. Illnesses were associated with insults of saints, harm caused to shrines, or non-observance of events on liturgical calendar by working or engaging in other inappropriate activities on sacred days/holiday. Illnesses were thus construed as *prima facie* for the Christian notion of sin. A similar view is found in the African concept of ‘taboo’ days – ‘bad’ days on which individuals are restricted or refrained from working their farms or going fishing such as the Fofie and Akwasidae. Those who flout this taboo are believed to suffer from different kinds of affliction.

In view of this, unnatural misfortunes such as the death of a child or a young adult or chronic illnesses, including those that cause sudden death in healthy adults, are often associated with social or supernatural forces (de-Graft Aikins, 2013, p. 128). Focusing on science technology and anthropological analysis to reconsider what health and healing means, Langwick (2011) observed in the Newala area of Tanzania that pimple-like growths, known as *makanje*, are simultaneously given bodily and social meaning by those experiencing and addressing health concerns, situating a series of healing practices within political and historical context. The social interpretations and logic assigned illnesses assist the lay person deal with the medical, psychological, spiritual, social, and financial aspects of their condition. This is contrary to ‘medical logic’ which is guided by a disease-centric approach to illnesses. As pointed out by Janzen and Green (2016), scientific explanations of health are deficient as they do not answer African conceptions of the causes of illnesses, which are different from the ideas in natural causation.

Murdock et al. (1978) distinguished between theories of natural and supernatural causation of illnesses. Murdock et al. note that theories of natural causation account for impairment of health as physiological consequence of some experience of the victim in a manner not regarded as 'unreasonable to medical science.' Natural causation includes infections, stress, accident, and organic deterioration. As indicated by Foster (1976), in naturalistic systems religion and magic play only the most marginal roles as far as the aetiology of an illness is concerned. Even when religious rituals are found, they are essentially different from those that relate to spiritual aetiologies. Murdock et al. argue that medical science does not recognise supernatural causes. These supernatural causes, they note, include theories of mystical causation, retribution (such as violation of taboos), spirit aggression (that is, attribution of illnesses to hostile, arbitrary or punitive action of malevolent spirits or supernatural beings), and magical and evil causation. Their approach to understanding illnesses depended on anthropological analysis. Like Murdock et al., Foster (1976) indicates that in personalistic systems, diseases are explained in the context of active purposeful intervention of an agent such as human (example, sorcerer or witch) or non-human (a ghost, an ancestor or an evil spirit) or supernatural (example, deity or other powerful beings). He points out that in personalistic medical systems, the sick person is the victim – the object of aggression or punishment. Here, death and illness are said to be unnatural. The assertions of Murdock and Foster reveal some salient methodological clashes, between what is pragmatic and interpretive. For Langwick (2011), the traditional analytical distinctions between the objective and the subjective, the physical and the experiential, and the cultural and natural have been reinforced by methodological

differences in the study of those things that are deemed knowledge and those that are deemed belief.

The medical approach is characterised by practical routine procedures that focus on addressing the physiological aspects of the illnesses. Health promotion specialists emphasise the relevance of the complex and dynamic nature of the social logic as primary and secondary interventions of health (de-Graft Aikins, 2013, p. 129). Critical discussions on the conceptualisation of illnesses among the Krachi will be highlighted in chapters three and five of this study.

Atobrah (2009) observes that the terms ‘disease’ and ‘illness’ are often used simultaneously to describe the condition of ill-health. They may, nevertheless, have different implications, especially in the field of medical anthropology. The term ‘disease’ bears a link with the medical field, while ‘illness’ relates to behavioural fields (Kleinman et al., 1978; Eisenberg, 1977). For Kleinman, illness is the subjective response of a patient to being unwell; how his/her neighbours perceive the origin of the condition and how it affects a patient’s behaviour with other people, and the steps taken to remedy the situation. Helman (1981) indicates that ‘disease’ constitutes pathological entities that make up the medical mode of ill-health, such as tuberculosis and diabetes that are identified and described in relation to chemical, biological, and other available evidence. Helman further indicates that diseases can be abstract “things” and possess recurring identity. In effect, ‘diseases’ are determined using medical instruments, taking into consideration, certain physical and biochemical parameters such as haemoglobin levels, weight, height, blood counts, among others. Illnesses include experiences of people about the condition, including interpretations and symbols which are perceived in relation to society and family

response to ill-health. For Cassell (1978), illness is what a patient feels when he [or she] goes to the doctor. The terms “illness” and “diseases” are not separate entities, but as explanatory concepts, they overlap. Eisenberg indicates in that light that such concepts are ways of constructing reality and imposing meaning on the chaos of the phenomenological world (Eisenberg, 1977). Kleinman (1980) indicates the link between diseases and illnesses, highlighting chronic episodes in which a patient’s perception of physical symptoms is significant. The distinction between illnesses and diseases is critical to the Krachi concept of health.

The other term under review, ‘healing’, is conceived as the totality of activities and ideas geared towards correcting or alleviating disorders, or in the thoughts of Comaroff (1980), to reconstitute physical, social, and spiritual order. Monte (2013) asserts that ‘healing’ is a process that grants people the ability to incorporate the sacred in their efforts at attaining well-being. Indeed, via a plethora of processes of healing, namely: dance, songs, speech, media, arts, and writing, it is believed that the spirit enters the mundane realms of life and provides a sense of ‘wholeness’ (Monte, 2013, p. 404). Healing thus focuses on restoration of a high quality of life, when there has been alienation and spiritual breach. Both terms – ‘illness’ and ‘healing’ – as used here, largely take up the Afro-centric concept of health adopted in this study.

The concept of healing, as given by both Comaroff and Monte, has been adopted in this study, as healing in the shrines involves a series of activities geared towards alleviating disorders. Monte and Comaroff have, however, overemphasised the cultural context regarding healing. In so doing, they create a gap for this study to interrogate social change (via use of ‘modern’ medicines) on healing practices. The series of activities, including

reuniting society, pacifying supernatural entities, and offering treatment to patients suffering from illnesses, shall be clarified in chapter five.

2.4 The interconnectivity between shrines and healing

The nexus between shrines and healing is complex. In Roman North Africa, healers encompassed root cutters, drug sellers, midwives, and religious healers, including physicians (Lloyd, 1979). Ferngren (2009) confirms the presence of medical, religious, folk and magical practices in Roman North Africa. Cilliers (2019) also presents an intriguing account of shrines and healing systems. The book shares an account of the reciprocal influences of Greco-Roman and Christian views of healing. Before Christianity reached Roman North Africa, the religion of Rome comprised of deities such as Jupiter, Juno, Venus and Mars. Later, the emperor's cult was revered by everyone. Existing Berber and Libyan cults also exhibited Roman characteristics. Cilliers (2019) points out that healing was a unique attribute. A popular deity often consulted for healing was Asclepius. Each religion in Roman North Africa had a healthcare culture that comprised a variety of medical practices. During the Roman period, the distinction between acute diseases and chronic diseases informed the choice of healthcare. For instance, acute diseases were treated by the physicians, while patients suffering from chronic diseases and those considered as 'hopeless' cases were sent to the sanctuary of the healing deity (Asclepius) as last resort (Cilliers, 2019). Patients received their healing by sleeping in shrines, where it was believed that the deity would appear in a dream and provide remedy (Cilliers & Retief, 2013, pp. 75, 78). Cilliers and Retief's sleeping in the shrine healing, and Cillier's

hopeless cases scenarios provides a basis to critique the perspectives of healing in shrines in the Kete-Krachi area. Cilliers' (2019) observation about shrines opened up this study to explore, for instance, the extent to which shrines serve as 'health centres' in the Krachi area through the establishment of 'healing homes' to address the health needs of patients. Cilliers' hopelessness scenario was vindicated in this study. For example, it was confirmed that many of the cases sent to the Dente shrines were those which orthodox hospitals could not treat. A critical discussion of traditional healthcare facilities and healing in the shrines would be discussed in chapter five of this study.

Gore (2007) also discusses shrines and healing in West Africa. The book is a study of the art of urban contemporary shrines and the processes that underpin their recognition, whether visually or in performance. The study is devoted to urban contemporary shrines in Benin City, Edo State in Southern Nigeria, and the production and use of artefacts in shrines. The third chapter of the book focuses on the art of priesthood, processes of becoming a priest and the construction of shrines. The author links his study to broader issues pertaining to health. Gore points out that some forms of illnesses are diagnosed by the diviner and are resolvable through initiation into the cult of the deities believed to be the cause or remedy. Under such circumstances, initiation or apprenticeship provides a dynamic channel of rearticulating the notion of 'personhood' through a holistic performance process. This process is achieved through an individual's configuration that addresses the overlapping physical and nonphysical components of illnesses. Both therapeutic and holistic healing are part of the process of reconfiguration of the human person (Gore, 2007).

The efficacy of divination is confirmed by Janzen and Green who noted that “the pervasiveness of divination in treating African sicknesses and misfortunes attests to the importance of causation, ... from a mundane to a highly charged cause in the human or spirit realm” (Janzen & Green, 2016, p. 5). For Gore, when individuals acknowledge human relationship with deities, it is an important step in mediating and interpreting events and experiences. Failure to underscore human connection with deities may lead to sufferings or hardships in society. These sufferings, the author indicates, include illnesses, barrenness, disappearance of individuals into a spirit world over a period of time, personal misfortune and poverty, to state a few. New members are inducted into the shrine through an elaborate ceremony, including bathing with the protective and healing waters of deities. Gore’s findings confirm those of Onaiyekan (1983), who stated that special professional priests such as the healer (*babalawo*) invite or direct divine intervention in healing procedures. Thus, in the course of restoring health, little is attributed to the skill of the “doctor” or the healing powers often inherent in material ingredients. However, the greatest part of the efficacy of medicines is connected with spiritual agents who play roles during healing. In Onaiyekan’s view, a ‘native doctor’ is almost invariably a priest, and he prescribes medicines to be used, including rituals to be performed (p.46).

In Gore’s chapter devoted to shrines and deities, he points out further the establishment of Osun, the deity responsible for medicines, in many households. Osun shrines may be established in a household – sometimes several in the same household – which play diverse roles, including protecting or defending the occupants, especially children of the household, from physical illness or spiritual injury. A household Osun is owned by the head of the household. Its efficacy is achieved through bathing and drinking certain

concoctions, among other processes (Gore, 2007). The two dominant arguments of Gore in these chapters – the health impact of human connection with deities and the establishment of household deities for health reasons – serve as pointers to the conceptualisation of shrines. Gore's work, nevertheless, creates a gap for this study as he did not consider economic, just like the social and spiritual/religious, constraints in the use of shrines or choice of healthcare.

Werbner (2009) explores shrine dynamics in the Tswapong Hills of Central Botswana with references to some societies in Ghana. Werbner indicates that shrines are sites for the dwellings of the spiritual, where powerful sacred entities or ancestors reside. After their consultation, supplicants often carry from shrines offerings, relics and bits, including other relevant items such as 'replicas of their dwellings'. 'Mobile' shrines may be carried by travelers to serve as a powerful protective cover. Indeed, scholars in the fields of anthropology, history and archaeology are researching African shrines for how they differ in attraction, form and value, and their evolving significance in ritual and healing (Werbner, 2009). The author examines the connections between shrines across communities and cult substances through oracular advice and the flow of clients or supplicants who, although congregate as strangers, are bonded together materially and spiritually with the shrine.

Further questions posed by Werbner encompass how shrines and the desire for well-being motivate people through musical performances, and how supplicants become receptacles of motivation through healing sentiments and moral passion. Werbner argues that among the Tale of Northern Ghana, the sacred technology is expressed in the casting of 'the shadow of an existing source of ritual power or deity (*yihiyii*) such as Tongna'ab (Allman

& Parker, 2005, p. 49). Identified as a shrine, Tongna'ab represents the quintessential quality of the 'livingness' of the ancestors. This movable shrine, often carried in large leather bags, is used by supplicants to resolve intractable worries of well-being, including prolonged infertilities, increased infant mortality, famine and drought. Similarly, Sedimo or Komana shrine in Twapong Village in Botswana promotes the health and well-being of people. The amulets, which offer divine protection and direction, are believed to return attacks of malevolent people to their respective sources. Sedimo is again believed to facilitate supplicants' discovery of efficient doctors or even churches for further healing and blessing (Werbner, 2009). Considering the relevant roles that shrines play in Africa, the author calls for a fresh beginning – that is, the re-opening of the contentions on shrines and well-being in Africa.

Werbner's article is relevant to this study because it contributes to health anthropology. Further, in the Kete-Krachi area, the efficacy of healing is also premised on the efficacy of diviners who foresee the outcome of illnesses and their cures. This study, therefore, makes references to the literature on the roles of diviners in traditional healthcare systems. Again, though Werbner's study was limited to Botswana with few references to Northern Ghana, the work is important to this study as it discusses the nuances of mobile shrines, which serve as a basis to examine the Dente shrine, its geographical distribution and acknowledgement of its efficacies in various parts of Ghana. But what are the perceptions about disease aetiology for which shrines are consulted? The following review the literature on the subject.

The witchcraft question remains critical in Health Anthropology. Field (1936) has noted that witchcraft has entered deeply and increasingly into the mental and social life of the Ga

people. She pointed out that witchcraft is ‘bad medicine’ which is directed destructively against other people (p.135). The author has, nevertheless, identified some ‘harmless witches’ who put their crafts to useful ends (p.149). There is a growth of anti-witchcraft shrines in Ghana. Parish (1999) delineates how contemporary discourse on witchcraft among the Akan of Ghana represents an ongoing auto-critique of modernity and tradition among different generations of shrine attendees and Pentecostals. Witchcraft is believed to be an evil spirit that causes misfortune in society. There was therefore the proliferation of anti-witchcraft shrines such as Senyon-Kupa (Senya Kupo) (Ward, 1956; Goody, 1957; Field, 1960; & Olsen, 2003) to address these misfortunes, including illnesses/diseases and death. With its origin in the Northern Territories, close to the Gonja town of Bole in the town of Senyon, the Senya Kupo was introduced into Asante by the Banda people and proliferated in the entire kingdom at least by 1916. The shrine was the cardinal deity in the Gbanya (Gonja) kingdom (Olsen, 2003, p. 241). Olsen further indicates that:

The shrine became an immediate lucrative enterprise for the founders, since all others locally considered it to have the mystical capacities to protect its devotees, and especially their children, from witchcraft and to allow women to conceive and bear children without complications (Olsen, 2003, p. 241).

The above quote demonstrates the relevance of the Senya Kupa deity in protecting members of the society. Barrenness and difficult labour at childbirth are often blamed on malevolent spirits such as witches, which the deity is believed to combat. Such social interpretations of health render the deity significant. It is relevant to point out that, although in 1930 the British colonial administration issued an order against witch-finding shrines in the entire colony on the premise of ‘savagery’, ‘barbarism’ ‘heathenism’, ‘non-civility’ and extortion, there was the continued recognition by Ghanaians that the practice had both practical and medical relevance (Olsen, 2003, p. 244). The question that arises from the

review on witchcraft for this study is how conceptualisations weave into the discussions of health among the Krachi. Answers to this are provided in chapter three. These answers further serve as the basis to explore the social interpretations pertaining to health and ill-health and their various aetiologies among the Krachi.

Anti-witchcraft shrines offer protection to both the poor and the 'big man' (McCaskie, 1981). They also offer protection against malice. It is worth mentioning, however, that although Dente addresses witchcraft issues, it is not considered an anti-witchcraft shrine. Parish argues that following economic individualism, shrines have offered economic motive as people seek medicines and talismans to protect and promote their wealth. What matters in this review is the extent to which shrines proffer medicines that address peculiar human challenges. Amulets (*suman*) used by the Asante provide a good example (Owusu-Ansah, 1991) of these medicines. The man-made objects, *suman*, are believed to be objects inhabited by special spirits whose efficacy satisfies the needs of people (Owusu-Ansah, 1991, p. 118).

According to Parish, the anti-witchcraft shrines paved the way for potent talisman (*suman*) and a sub-collection of medicines (*aduro*) to predominate the shrine landscape. She further points out that priests (*okomfo*) intercede during times of incurable illnesses. Priests recommend secret medicines (*aduro*) obtained from *mmoatia* to cleanse witches of their malice (Parish, 1999, p. 432). Olsen's (2003) study on Asante also presents an intriguing account of the link between shrines and healing. Olsen gives an account of how the people of Mampong (in Asante) had become both business patrons and seekers of the medicines offered through anti-witchcraft shrines that had proliferated throughout the Gold Coast since the late nineteenth century, and which the British colonial administration and the

Christian clergy considered detrimental to the morals of their religion. The trope of medicines and other forms of ritual healing carried out in the shrines was greatly sought-after during illnesses (Olsen, 2003). Olsen recounts that one of the revered shrines, *Nkona*, introduced in Asante in 1917 was said to be harmless, but had the ability to heal. This created a passion for the shrine in Asante. The thrust of the above argument is that a shrine could serve as anti-witchcraft; that a shrine could protect people from ill-disposed persons using witchcraft; and that a shrine could nullify the powers of witches that became the shrine's devotees (Olsen, p. 235). This viewpoint provides a cue for this study to examine the extent to which the Dente shrine spiritually protects people in the various jurisdictions where its powers are acknowledged.

Another classic work that critically explores the link between shrines and healing systems in Ghana is Nukpe (2007). Nukpe's study points out how shrines are used among the Ewe of the Volta Region to cure the sick, among other functions. Nukpe notes that: "[t]here are various reasons apart from healing purposes why people possess these shrines. Their considerations may include security or protection, good luck, good health, charm, prosperity in life, defence, vengeance and sometimes to harm adversaries" (Nukpe, 2007, p. 132). He argues that insecurity, charm and vengeance, to mention a few, result in religious activities leading to the establishment of shrines in the society, where people consult them to address their peculiar needs. Field (1960) has earlier made a comparable observation when she indicated that the insecurity of the traditional African culminates in ancestral worship. In this regard, spiritual protection is often demanded from the ancestors through shrines to fulfil needs such as healing. Medicine men have been instrumental in

using the spiritual powers of shrines in spiritual-based ailments and mental derailments, an assertion which Twumasi (1975) has duly acknowledged.

Nukpe further argues that the ritual activities surrounding the diagnosis and healing through the power of shrines are relevant impetus that attract and protect the efficacy of the spiritual power. These activities prepare individuals and patients psychologically to receive healing, as buttressed by Herskovits (1948). This psychological relevance of shrines, as noted, also corresponds with Ranganathan's (2013) discussion of mental healthcare practices in contemporary Indian society and the role some practices, for example spirit possession, play in regulating, maintaining, and reproducing local forms of sociality. Women's trauma may be addressed through shrines (Venkateswaran, 2014). In view of this, the interconnection between shrines and mental health in Kete-Krachi was interrogated. For instance, the Fofie shrine at Abujuro is believed to deal with all manner of mental illnesses.

Nukpe's work further reveals the dimensions of health in Ghana. In his discussion of the spiritual healing power of the stool house shrine among the Ewe, Nukpe argues that the stool house is a significant foundation of spiritual power which is explored to heal diverse diseases. Miniature stools, which are recognised as an embodiment of the souls of the members of society, are found in the stool house. One such deity linked to stools, and yet/also significant to health is the Weto deity among the Ewe, which is also responsible for healing madness, asthma and chronic ankle sores (Nukpe, 2007). The deity is connected to the paramountcy of Goviefe in the Volta Region of Ghana. As a result of the relevance the stool offers, particularly in spiritual healing, the Ewes make sacrifices and donate sums of money in anticipation of steady recovery from their illnesses. In the Weto shrine's case,

the ancestors are believed to be equipped with healing powers. This current study does not, however, intend to delve critically into Krachi stool rituals. However, it is significant to point out that there is a stool house for the position of the *Dentewia* (owner of Dente), where periodic rituals are conducted. Nukpe's work points out the interconnectedness between healing, social and political institutions, like the Dente which is connected with the traditional, political (*Dentewia*), social and religious institutions in Kete-Krachi.

The difficulty involved in separating spiritual therapies from the physical is also made clear by Nukpe. In his discussions of the efficacy of herbal healing among the Ewe, Nukpe points out that herbs possess preternatural powers, owing to which they are prepared into medicines. Such herbs are used to either heal or prevent both spiritual and physical sicknesses (Nukpe, 2007, p. 137). However, Nukpe does not provide a detailed discussion of herbal medicine use in shrines. This lacuna shall be filled in chapter six of this study. The role of deities in revealing the use of herbs for certain illnesses cannot be overemphasised in a discussion on healing. In the same manner, medicines may be obtained by individuals through the intervention of 'dwarfs' (diminutive spirits believed to be audible but invisible to ordinary eyes). Field (1960), referencing Rattray (1959), also made a similar observation for the Akan. One attribute of dwarfs is their ability to abduct people into their realm (Nukpe, 2007). Nukpe makes a clear observation that "... the Ewe people and other ethnic groups in Ghana culturally benefit from the various traditional medical practices that evolve around ritual shrine practices" (p. 139). Indeed, Friedson (2010) presents a multifaceted and complex comprehension of religious practices through a historical and ethnographic study of a healing shrine, Brekete, believed to be introduced from Northern Ghana into Eweland. Friedson argues that in the Brekete shrine, music

functions as ritual and ritual as music. The focus of this study, however, is not on music; rather it is about the extent to which shrines are used for healing.

Rosenthal (1998) indicates that one of the explanations responsible for the use of the Gorovodu shrine in the village of Dogbeda is because it is a “medicine”, which is used in healing. Furthermore, Rosenthal observed among residents in Lome that even when some parents sent their children to the hospital, they still employed Gorovodu, with the belief that medicines from the clinics could only deal with physical diseases, but not the deep explanations responsible for causes of illnesses. Few illnesses are ascribed to the presence of bacteria, viruses, or parasites, for which the Ewe seeks to question why an individual becomes ill while another does not in a similar circumstance. Gorovodu, according to Rosenthal, is consulted to deal with the whole life of an individual, including the mind and the soul (Rosenthal, 1998). In the view of Rosenthal, the Gorovodu shrine provides holistic healing.

Following the spiritual relevance of shrines, Twumasi (1975) underscored the efforts made by the Traditional Healers Association of Ghana in researching the phenomenon of mysticism used by some medicine men in Ghana in advancing traditional healthcare. A similar observation was made by Akator (1988) that traditional medicines are believed to be playing roles in the psychic space. Akator further points out that in the psychic arena, ailments are given spiritual meanings. The general consensus in the discourses of the above scholars is that mysticism is rooted in the traditional healing process in Africa, whether the therapy is derived from deities or is a mixture of plants and herbs administered by medicine men. What is clear from Nukpe, Twumasi, and Akator is the difficulty in separating spiritual healing from the physical. This viewpoint provides a basis to examine and

interrogate mysticism in the healing process in Kete-Krachi. It also provides a basis to consider the extent to which mystical explanations to illnesses result in patronage of shrines. Finally, the observations made by Rattray (1959), Twumasi (1975), Akator (1988), and Nukpe (2007) invite researchers to interrogate traditional medicine and plant use in the shrines. As highlighted, traditional medicine cannot be separated from the healing process.

Unlike Nukpe, whose work is greatly premised on religious interpretations of illnesses, Twumasi's (1975) study explores healthcare systems from a sociological point of view. Twumasi postulates that traditional beliefs and customs pertaining to illnesses have undergone change. In certain contexts, both traditional and scientific medicines may offer different panacea to illnesses. Using the institutional theory, Twumasi argues that medical practices take place within an institution. Exploring critically the Asante cosmology, Twumasi makes some inspiring observations concerning shrines and healthcare. He acknowledges that routine pilgrimages are made to shrines to request from a deity, through a medicine man, yearlong protection. Familiar with the cultural traditions, the traditional medical practitioner allays the fears and addresses the wishes of his clientele. This serves as a form of psychotherapy (Twumasi, 1975, p. 32). Ventevogel (1996) also points out that, among the Akan, priests- or priestess-healers are specialists in the Akan religion, whose appearance sets them apart from other members of the society. He translated the Twi word, *akomfo* as 'priest-healers' or 'priests', while Christaller (1933, p. 247) translated the word *akom* as 'to dance wildly in a state of frenzy or ecstasy, ascribed by the natives to the agency of a fetish'. Initiation into priesthood among the Akan is marked by 'initatory illness', during which initiates develop strange behaviour and suffer from fits of convulsion or seizures. An experienced *akomfo* is therefore able to discern cases of 'vocation by a

deity' from ordinary illness or madness (Ventevogel, 1996, p.33). Though there is no possession in the priesthood of Krachi Dente, Ventevogel's study provides the basis to examine the mechanisms via which illnesses are determined in the shrine.

Twumasi has further identified the intricacies of traditional medicine and social institutions. Based on this idea, he discusses three themes in the context of traditional medicine. First, he underscored the social organisation of the people from where social interactions and the recognition of healers is emphasised. Second, he delineated the method of treatment and the various mechanisms being taken to prevent the occurrence of illnesses and accidents which are considered as major threats to society; and thirdly, he painted a picture of the concept of the preternatural world – the foundation on which belief systems are grounded.

Indeed, both Evans-Pritchard (1937) and Kluckhohn (1956) have indicated in their earlier studies the centrality of belief systems as components of the cultural life of people. Similarly, Malinowski has demonstrated that belief in the preternatural forces fills the gap in the practical life of society. Given these belief systems, the Asante of Ghana explain certain conditions, in the absence of scientific theory, beyond the domain of naturalistic explanation.

Among the Asante, the traditional medical theory satisfies their needs as it offers explanations to certain occurrences, and the correspondent need for society to offer support by offering explanations to supernatural causation of ill-health and misfortune (Twumasi, 1975). However, Twumasi's study did not pay much attention to social change from the perspective of shrines. It therefore leaves a gap for this current study to fill. Though Twumasi's work is largely a sociological exploration of traditional health and healing

processes, however, it is significant. First, it gives insights into the existence of various traditional healers. Secondly, it gives insight into the Akan conceptualisation of sickness. This insight provides a basis to evaluate the work of traditional healers and the conceptualisation of illnesses among peoples such as the Krachi people. Besides, the study explores the link between traditional institutions and traditional healthcare systems which are useful to holistic studies of shrines. In addition, his discussion of the connection between social change and traditional medical practices in Ghana is a basis to examine the impact of social change on traditional healing practices among the Krachi. Indeed, shrines in the Kete-Krachi area are dynamic, as they incorporate modern mechanisms of healing in their practices. This dynamism of shrines in terms of healing is discussed in chapters five and six.

Like Twumasi, the link between social institutions and traditional healing systems is further highlighted by Kodesh (2007). Kodesh noted among the Buganda that there is a continuous connection between healing and politics in historic Ganda, where narratives on the Ganda capture momentous developments relating to public health. In the late 17th and 18th centuries, for instance, there were efforts to establish control over the collective conditions of health. Public healers thus operated as political leaders, and healers' shrines also emerged as places for creative ambition, where leaders fused ritual and political power. Social order was therefore maintained by healers, creating an atmosphere for communities to pursue collective well-being (Kodesh 2007). Kodesh's politico-medical perspectives of shrines provide this study with a nuanced dimension by which to examine the interplay between traditional healing and its institutions to determine the extent to which healing systems are woven into socio-political institutions among the Krachi people.

Many scholarly works have also been devoted to shrines and ritual bondage system (*trɔxovi*) among the southern Ewe in Ghana's Volta Region. A few that suffice here include Glover (1992), Azumah (1996), Nukunya (2003), and Akusah (2009). These studies have stretched the scope of knowledge on human behaviour, although the works of Azumah and Nukunya have considered the practice of *trɔxovi* as abusive. Akpabli-Honu's (2014) study, however, provided a theoretical basis for *trɔxovi*, positing that it is rooted in functionalism, conflict perspective and feminist orientations. Although the literature on *trɔxovi* has tilted towards the suppression of girls, human right abuses, and enslavement, Nukunya & Kwafo (1998) and Nukunya (2003) have opened another line of thought pertaining to the practice, where health issues are discussed. They point out that cases relating to barrenness, continuous miscarriages, still births or frequent deaths were often sent to the deity for redress. During barrenness, for instance, couples promise to present their children as servants or wives of the deity if priests help those children to survive. According to Amevor (1987), a male child born as a result of the shrine's intercession is called 'Klu' (literally a slave), while a female is named 'Kosi' or 'Dzatugbi' (Dzatu) among the Ewe (Akpabli-Honu, p. 36). Though these authorities did not focus on the Krachi people, their works are relevant to this study.

The usefulness of shrines in contemporary times are contained in many works. For instance, within the broader Ghanaian perspective, Kankpeyeng, Nkumbaa and Insoll (2011) have noted the usefulness of shrines and healing in contemporary Northern Ghana. They note that traditional medicines used in shrines are deeply embedded in African religious beliefs where the notion about illnesses are said to be broad. They found in their study that healing involves identification of aetiology of illnesses before medicines are

applied based on the knowledge about efficacious plants and other factors. Their study uncovers the dual knowledge traditional medical practitioners have regarding diseases and patients in order to establish a balance between human and the spirit entities.

Discussing spiritual and indigenous healing practices among the Asante of Ghana, Adu-Gyamfi (2016) argues that the beliefs of people regarding the preternatural causation of diseases, both in the past and in contemporary times, account for the explanations why people continue to rely on priest healers to diagnose and also treat diseases. The broad spectrum of approaches to healing of diseases, asserts Adu-Gyamfi (2016) include, incantations, exorcism, spells, preparation of potions, and largely, via the invocation of deities. He notes that, even with the introduction of orthodox medicines into Northern Ghana, people continue to rely on spiritualists, herbalists, and other specialists, collectively known as “indigenous healers”, for medical services to meet their health needs (Adu-Gyamfi, 2016).

Adu-Gyamfi (2015) also observed that in Ghana and some West African countries, people suffering from psychosomatic conditions are often sent to shrines for intervention of healers. He asserts that the spiritual approaches pertaining to mental health is attributed to its spiritual aetiology; for instance, mental health conditions are attributed to jealousy, competition or hatred, a belief that is firmly held when orthodox methods are unsuccessful. Drawing insights from field respondents, Opoku (2016) also makes reference to the Black and White power shrine at Meduma in Kumasi, highlighting the intricate connection between spirituality and herbs that are combined to deal with madness and epilepsy. Adu-Gyamfi argues that one of the main reasons why spiritual healing has gained prominence is the belief in witchcraft. Adu-Gyamfi’s views guide this study to interrogate the

explanations responsible for the use of shrines as the alternative healthcare choices among the Krachi people.

Like Adu-Gyamfi (2015, 2016), Opoku (2016), and Kankpeyeng, et al. (2011) whose studies focused on the efficacy of shrines in contemporary Ghanaian healthcare systems, Nrenzah (2015) observed that, in Kwaku Bonsam's shrine, patients are received in the "waiting room" where they take turns to consult the priest. Nrenzah compares the experience of clients who seek assistance from Kwaku Bosom's shrine for what they refer to as 'physical' ailments to a formal medical setting where patients wait patiently for the doctor to call them. Nrenzah points out Bosam's readiness to modernise healing or shape traditions to suit emerging needs. She further argues that indigenous shrines are being revitalised by priests and priestesses to make them significant to the emerging needs of both modern and traditional clientele. She cites examples from the Oforiwaa shrine, which is consulted to deal with illnesses in contemporary time. Nrenzah's views call for the need for this study to interrogate emerging trends in healing, in the context of social change.

Using the Ga of Ghana as a case, Nortey (2009) argues that in contemporary times, sicknesses can be healed and curses can be countered at the shrine of Nai Wolomo, and those who desire peace participate in the purification ritual. Nortey made a critical observation during the Homowo Festival of the Ga that traditional healers rely on both physical and spiritual concepts in the diagnosis and treatment of illnesses. During the celebrations, patients tell their predicaments, including illnesses and they are expected to receive healing according to their belief. He argues that there is the general belief that diseases of supernatural origin cannot be dealt with using Western medicine. During the celebrations, therefore, traditional medicines meant for dealing with all manner of illnesses

are made available for use by people. Nortey's observation guides this study to raise the following questions: How are diseases and illnesses conceived among the Krachi people? and in which way are herbal medicines used in the shrine(s) of Dente to deal with ill-health?

2.5 Illness and health seeking behaviour

This theme discusses approaches to illness. Health-seeking behaviour refers to an action (or a combination of actions) resorted to by an individual suffering from a (perceived) health problem in an attempt to provide a lasting solution to the illness (Olenja, 2003). A multiplicity of factors such as: socio-cultural, environmental, community norms and expectations, availability of healthcare providers and associated factors influence health-seeking behaviours (Ihaji, Eze & Ogwuche, 2014; Oberoi, Chaudhary, Patnaik & Singh, 2016).

Patients in the developing world resort to a health approach referred to by Kroeger (1983) as 'healer-shopping'. Healer-shopping was also studied by de-Graft Aikins (2005). It refers to the use of a second healer without due referral from the previous healer for a single episode of illness. Studies have confirmed this phenomenon among chronically ill people in Africa. De-Graft Aikins argues that the existence of healer-shopping in the healthcare system in Africa is as a result of the spiritual aetiology associated with chronic illnesses and the search for cure. Indeed, explanations to spiritual causes of illnesses are found in African traditional religion and other indigenous religions in the developing world (Twumasi, 1975; de-Graft Akins, 2005). The notion of spiritual illnesses renders the traditional healer the only individual equipped with the expertise to treat and heal these

illnesses. Although cultural notions account for traditional mechanisms as alternative sources of healing, Twumasi (1975) and de-Graft Aikins (2005) do not deeply interrogate this in the context of shrines. De-Graft Aikins further argues, contrary to the dogma pertaining to healer-shopping and its dependence on cultural and other theories of the causation of illness, that economic constraints of modern healthcare system and the inadequacy of health facilities for treating and caring for chronic illnesses in Africa render traditional or ethno-medicine a fundamental healthcare choice for most populations in Africa. The findings of Kroeger (1983) and de-Graft Aikins (2005) are relevant to this study as they offer meaning into health choices.

Explanations pertaining to the choice of treatment are guided by a conceptual framework of health utilisation, developed by Andersen and Newman (1973), Aday and Andersen (1974) and Dutton (1986). Key focal points of the health utilisation model include predisposing factors such as socio-cultural characteristics that exist among people before their illness, and health beliefs such as attitudes and values towards health care systems, and demographic characteristics, including age and gender. It includes enabling factors such as family/individual, community and genetic factors. Finally, the model emphasises need factors, which is the cause of health service use. The health utilisation model has, however, been critiqued because it does not incorporate the health belief systems into their analysis of health needs, from the perspective of developing worlds (Bour, 2004). It is in view of this that a holistic conceptualisation of health should include the spiritual needs of patients (Amegbor, 2014, p. 40).

Indeed, the social determinants of health have been shown to influence health choices and outcomes (WHO, 2003). Factors such as low levels of literacy, unsafe neighbourhoods,

unstable housing, poverty and unemployment, and the lack of social support systems and amenities are known to affect health behaviour (Braveman & Gottlieb, 2014; CDC, 2017). Expanding the health utilisation model, Amegbor discusses some key factors of health behaviour or utilisation namely: the characteristics of patients, the socio-cultural environment of the patient, health policies, health resources, illnesses/sicknesses and accessibility of health resources that determine the behaviour of people when seeking healthcare. He also points out that a sixth factor which determines attitudes to healthcare is the perception of physicians or healers. Policies in the health sector impact patients and their health choices. On the other hand, socio-cultural factors also affect accessibility of health resources, just like illnesses and sicknesses. The model, as indicated, is a modification of Aday and Anderson (1974) and Bour (2004). The model is essential because it views the patient from the perspective of society or social being who is influenced by the environment in which he/she lives. The model also suggests that different types of illnesses may receive different treatments depending on the aetiology of illnesses, history, and information about illness (Amegbor, 2014, p. 41). The health seeking behaviour model is pertinent in this study as it serves as a foundation on which explanations to the reasons why the Krachi consult the Dente shrine for healing shall be given.

Like health-seeking behaviour, Awedoba's (1998) study on help-seeking behaviour and coping with people living with onchocercal skin diseases reveals various help-seeking strategies. He opined that people suffering from the disease resort to self-help which includes local recipes, herbs, enemas, ointments and pharmaceutical products. Pharmaceutical products might have been borrowed or were old medications acquired for some other conditions (Awedoba, 1998, p.7). He pointed out that for general help-seeking

for all cases of ill-health, drugstores are most often relied upon. He noted that explanations for the choices of help-seeking of rural people in southwestern Ghana ranged from the issue of cost to proximity (p. 9). He further argued that in order to understand why local people might or might not seek treatment for their skin lesions, one need to understand more about a people's perception about diseases, awareness of availability of treatment, the perceptions of people regarding the outcome of treatment or non-treatment, to state a few.

Sugar, Kleinman, & Heggenhougen (1994) rightly noted that the factors impinging care seeking are diverse, including belief systems and stigma attached to particular symptoms, previous experiences in seeking healthcare, accessibility of care providers, education and economic levels, among others. Awedoba (1998) noted that for onchoceral diseases, self-help and home care are more frequently relied on than drugstores. This phenomenon, he indicated, could be attributed to the inability of the affected or their family and associates to determine what pharmaceuticals are efficient for onchoceral skin diseases. Awedoba's study is significant to this study because it provides insights to the phenomenon of help-and health-seeking behaviours. For instance, he noted that people suffering from onchoceral diseases depend on drug sellers, herbal preparations, hospital treatment, hot bath complex and ingestion of fluids, among others. His work is, however, limited to onchoceral skin diseases. The views of Sugar, Kleinman & Heggenhougen (1994) and Awedoba (1998) inform this study to consider the factors responsible for health seeking in the Dente shrine.

Nuhu (2018) also notes that consumers of healthcare in Ghana resort to any of the following six main channels as a first point of call to heal their health challenges: seeking medical cures in a government healthcare facility, a private health facility, herbal or traditional

healthcare services, self-medication with herbal medicines, self-medication with drugs and other pharmaceutical products, and faith-healing. With regards to faith-healing, which is the attention of this thesis, Senah (2004) highlights that Ghanaians have gained notoriety for their religiosity (Senah, 2004). Religion has been identified as a crucial socio-cultural determinant of health-seeking behaviours (Nuhu, 2018). It was found by Mwabu (1984) that Christians were more likely to solicit medical care from orthodox healthcare providers comparative to believers of traditional African religion, who are more likely to seek treatment from traditional healers. Faith healing is expressed variously in Ghana through individual/group levels, and in shrines, mosques and churches. Faith-healers are believed to possess supernatural powers to cure all manner of diseases ranging from conditions believed to be caused through curses and evil spirits. These illnesses include mental disorders, diabetes, hypertension, infertility, to state a few (Nuhu, 2018). While faith healers enjoy a large following from segments of the population and are used as a first point of call for illnesses, there is generally no scientific basis to support their claims of efficacies (Miller et. al., 1998).

The link between shrines and orthodox healthcare also abounds in the literature. Nrenzah (2015) points out that most Ghanaians select the illnesses that are either sent to the hospitals, shrines and herbalists. The choice of treatment is predicated on disease aetiology. She notes that some people indicated that physical sicknesses are referred to the Oforiwaa or other shrines for two reasons; it is believed that a person who has an arm or leg fracture and uses herbal treatment has a better chance of healing than allopathic medicine. Besides, most of the clients in her study had also underscored the relevance of underlying supernatural causations in most ill-health conditions, even when the physical causes have

been revealed. Nrenzah (2015) cites her respondents who pointed out that allopathic medicines are only potent at healing the physical aspect of the illnesses, but shrines provide a holistic healing. Clients therefore have greater confidence in shrines to restore holistic health (Nrenzah 2015). Cilliers (2019) makes a similar observation by first drawing the distinction between acute and chronic diseases which are relevant in the choice of healthcare, where chronic diseases receive the attention of shrine priests and priestesses. Choices of the modalities of treatment are often predicated on the concept of the aetiology of illnesses, premised on the spiritual beliefs of the people (Danquah, 1982). Sicknesses believed to be caused by malevolent spirits (witches or magic) are often deferred to shrines to overturn the impending calamity. Danquah further points out that individuals combine shrine and herbal treatment methods. Illnesses (including mental) that are difficult to assign mundane interpretations to are often believed to be caused by the metaphysical (Omonzejele, 2008). The Oforiwaa deity healing scenario helps to discuss the reasons and logic behind the patronage of the Dente shrine for healing. Danquah's assertion about the combination of treatment approaches also opens this study to herbal medicine use and healing in Dente.

2.6 Conclusion

From the above discussion, it is clear that much work has been conducted on shrines and healing in Ghana, and elsewhere. Apart from Cilliers' (2019) study, much of the literature does not consider or make references to shrines as healthcare centres. Nonetheless, the literature has highlighted some critical issues. Shrines address the physical and nonphysical

components of illnesses, which Cilliers' work confirms. Shrines provide medicine and protect people from the attack of malevolent spirits. In a similar vein, Werbner's (2009) reference to shrines in Northern Ghana is relevant as the Krachi people use shrines to combat human suffering such as infertility and infant mortality.

Critical in the literature is the existence of anti-witchcraft shrines. Patronage of shrines has increased following economic individualism and confirms that traditional priests offer medicines. It can be gleaned from the discussions so far that shrines are multi-functional. The review also sheds light on health seeking behaviour, as it highlights the connectivity between shrines and hospitals, which is central to this thesis. Health roles may have been a byproduct of some shrines, which may not be the major functions for which they were established. Whatever the case may be, the broad nature of the concept of health qualifies shrines in the discussion pertaining to traditional healthcare systems. Another theme explored in the literature is the evolution of social events. This aspect of the literature directs the study to the changes and interpretations that have taken place regarding traditional healing systems. Medical practices take place within an institution, which informs this study to examine traditional healing within the traditional Krachi institution. Although the studies have pointed to the centrality of shrines and healing, much of them is devoted to different societies in Ghana and Africa at large. There is, therefore, a paucity of the literature on shrines and healing among the Krachi people, necessitating a study among them. A critical study into shrines, healing and traditional institutions (social, religious and political) will shape the views of people about the African concept of health.

CHAPTER THREE

THE KRACHI IN HISTORICAL AND CONTEMPORARY PERSPECTIVE

3.1 Introduction

This chapter focuses on the Krachi people, highlighting their evolution and land.³ Other themes that will be discussed in this chapter include chieftaincy, environment and climatic conditions, and religious activities as units of analysis. Both the environment and religion are significant in traditional healthcare practices, and therefore deserve to be discussed. The chapter further interrogates the Krachi perception of the supernatural with specific focus on the Krachi concept of the human person. This view of the human person has consequences for the treatment of people suffering from various illnesses, including disabilities. It highlights the Krachi concept of ‘twinship’, which is linked with the Krachi concept of health. It provides deeper interpretations that the Krachi assign to certain categories of the human person. Other themes examined in this chapter include the Krachi concept of health and illness aetiology. The chapter provides a general foundation for the discussion of the Dente shrine and its associated healing activities in subsequent chapters.

³ Kete and Krachi existed separately. The name Kete-Krachi refers to a merger of the two towns – Kete and Krachi. Kete-Krachi is the traditional and municipal capital of the Krachi people. It is sometimes referred to as Krachi. The people speak *Kaakye* (Krachi), a Guan language. Guan falls under the Volta-Comoe languages. These languages, both in Northern and Southern Ghana, include: Gonja, Nawuri, Nchumburung, Yeji-Prang, Dwang, Krachi, Nkonya, Larte, Kyerepong, Anum, and Effutu (see Awedoba, 2007, *Culture and development in Africa*, pp.69-70). Others include Eguafo and Achode.

3.2 Kete-Krachi

Kete-Krachi is a popular town in the Oti Region (formerly a major part of the Volta Region)⁴ of Ghana. It lies on the geographical coordinates, 7° 48' 0" North, 0° 10' 0" West. The population of the Krachi West District (now Municipal) is 49,417, comprising forty-nine percent (49%) females and fifty-one percent (51%) males. An estimated eighty-two percent (82%) of the population is rural (PHC, 2010). The name 'Krachi' refers to the town as well as the people. The origin of the Krachi people has been documented by many authors. For instance, Ampene (2011) indicates in an interview with the Krachiwura that:

[The Krachi] were Etsi people who lived somewhere near Awutu on the Coast. They migrated to Larteh Akuapem to join a number of Guan-speaking people who had established pocket communities there. At Larteh, they became heavily indebted to Akyem overlords who used to send messengers to collect tributes in the form of anything which they favoured. Because of these exactions, my ancestors decided to pull out. They were noticed by the Akyem overlords who teased them by saying "ka-akye-won" meaning they had become insolvent. It was a corruption of this statement that the people had the name as Kaa-Akye anglicized as Kratchi (Ampene, 2011, p. 118).

The origin of the Krachi people, as captured above, is further bolstered by the following oral narrative:

The Krachi people were believed to have migrated from the Central Region at Enchi (Eti). In view of this, one of the appellations of the paramount chief of Krachi is *Eti Patampram*. From Enchi, they moved gradually to Winneba, then to Accra Plains, and finally to Larteh Kubeasi. At Kubeasi, the Akyem exacted royalties such as young girls (virgins), whom they married, and gold from the Krachi people. The demand for royalties compelled the Krachi to move again from Kubeasi towards the upland regions for protection. When it was time for royalties, the Akyem people

⁴ On the 27th of December 2018, a referendum was held in Ghana leading to the creation of six more regions, in addition to the existing ten regions. Before the referendum, Kete-Krachi was an integral part of the Volta Region. Some major towns in the Oti Region include Kete-Krachi, Kadjebi, Jasikan, Dambai, Nkwanta and Kpassa.

did not find the Krachi people; so, the former asked in Akan, *mo ahun omo'a eka akye omo no?* to wit, 'have you seen those who are indebted?'⁵

As indicated, the refusal of the Krachi people to pay royalties to the Akyem people led to their migration from Kubeasi. Their indebtedness (*eka akye* in Akan) was corrupted into *kaa akye*, and finally – *Krachi*. It is clear from the two narratives that the Krachi people migrated from the present-day Central Region of Ghana. While at Ewutu in the present-day Central Region, they were also referred to as the 'Eti' ('Etsi') people.⁶

A contrast to the debt (*eka akye*) narrative is the view that the name Krachi (Kaakye) rather referred to their migration history. Krachi traditions relate that *Wuruboare*, the Sky-God or Supreme Being created both men and women at the same time. *Wuruboare* settled the men and women on the right bank and the left bank of the *Frao* (Volta) river, respectively. The right bank of the river became known as Nkomi. The settlement of the women on Nsugnae, the left bank of the river, however, embittered the men who said, *katye* or *kaa-kyi*. *Kaa* (to migrate) and *akyi* (women), to wit, 'migrate to the side of the women'. The migration of the men to their female counterparts gave rise to the name, *Kaakye* or *Krachi* (Ampene, 2011). The settlements to the right and left banks of the Frao river, respectively, occupied by the men and women, is collectively referred to as 'kitakpanda' [kitakpandida], which is still visible to date (Ampene, 2011). It is believed that the migration from Larteh Kubeasi to Kitakpandida was led by the Dente deity. The deity, it was believed, provided the Krachi with spiritual protection throughout the journey. The phobia and suspicion that the Akyem might pursue them led to further migration by the Krachi to Ope (Old

⁵ Interview with Jackson Beherwah Donkor, former Registrar, Kete-Krachi Traditional Council, Kete-Krachi. 26th October, 2020.

⁶ The migration from Larteh, according to Krachiwura Mensah, was under the leadership of Tsotobi.

Krachikrom)⁷, the original capital of the Krachi. The establishment of the new capital at Ope, at the eastern bank of the Volta River, brought advantages such as trade and wealth. The original Kete-Krachi was inundated by the Volta River in 1964. This precipitated the Volta resettlement project by the government of Ghana that greatly affected the Krachi. The construction of the Volta dam at Akosombo also affected the shrine, leading to its relocation (Moxon, 1969, p. 167). Trading activities were equally disrupted. A replica of the market has, however, resurfaced and has greatly impacted on the town's economic activities.⁸ Major towns in the Kete-Krachi area include, Kete-Krachi, Kadantwe, Gyankrom, Kwakuae, Abujuro, Dadekro, Monkrae, Ohiamakyene and Nteususae (see map 1).

Kete-Krachi has had a long interaction with many ethnic groups, one of which is the Nchumburu (Guan). The Sonwiae clan was the first among the Nchumburu to arrive in Krachi land. The royal house of Krachi had known, and developed close ties with, the Sonwiae (Akaniem) clan before the arrival of other Nchumburu clans such as Bedjamso, Bora (Nchanki Clan) and Chanchae (Papatia). The quote below buttresses the long interaction between the Krachi and Nchumburu:

On their arrival, they [Nchumburu] served the Krachi Paramount Stool and the Krachi Dente through respective Traditional rulers under the directives of the Krachiwura, who is the custodian of the Paramount Stool. E.g., all the Sonwiae, Wanka [Banka], Agyembra and Bora Clans served the Krachiwura directly, and as such are regarded as royalists even though they can not [*sic*] mount the Krachi Paramount Stool.⁹

⁷ Ope was closer to the Volta Lake than Kete. The town was later nicknamed 'Kaakye Krom', (later Krachikrom), the seat of the Krachi people by the Asante immigrants.

⁸ Kaakye State Yam Festival Brochure on the theme, "Strengthening Local Governance for Development", 2018.

⁹ PRAAD, Ho. VRG/NA/012, Krachi Traditional Affairs, 1967-1973.

Available records indicate that the Bedjamso and Chanchae clans served the Krachiwura and Krachi Dente directly through the Dente priest. On the other hand, the *Odikro* (landowner) of Boraë and the Bedjamso chief served the Krachiwura and the Dente priest, respectively. In the 1960s, during the time of Osagyefo Dr. Kwame Nkrumah as the premier president of Ghana, Bedjamso was granted a paramount status, bringing the Nchumburu at par with the Krachi. This implied that Nchumburu who, hitherto, paid allegiance to the Krachiwura, now owed allegiance to the Bedjamso chief. In spite of the political separation, the Nchumburu still fell under the authority of the Krachi through Dente which served the spiritual needs of the Nchumburu.

It is important to provide a historical background to the names ‘Kete’ and ‘Krachi’. Tracing the historical development of the town, Maier asserts that Kete-Krachi is a fusion of two settlements – Kete and Krachi. The former was the name of the *zongo* (Muslim quarters), while Krachi (Krachikrom) was the original village. Both colonial and oral evidence justifies her assertion. Available evidence points to the fact that Kete-Krachi is an amalgamation of distinct settlements – Krachi or Krachikrom, which was located at the bank of the Volta River and that it was comparatively smaller and contained the seat of the Krachiwura while Kete, a larger settlement lying two and half miles away, served as an important trading centre. Kete was largely inhabited by Hausa and other immigrant traders. The government station was located between Kete and Krachi.¹⁰ Kete was established in

¹⁰ PRAAD, Ho, D/DA/503. United Nations visiting Mission to Togoland under United Kingdom Trusteeship, (1952). This assertion was further confirmed by Mr. Beherwah Donkor, a former Registrar at the Kete-Krachi Traditional Council during an interview session. He notes that Krachi had two capitals, Krachikrom, the traditional capital, and Kete, the administrative capital and trading centre. Both the Germans and British settled at the administrative capital because of its economic activities.

1877; and prior to that date no available records were found on Muslim trading *zongo* close to Krachikrom (Krachi) (Maier, 1980, p. 35).

Some Akan, notable among them were the Asante of Nsuta, migrated to Krachi in the 1870s and 1880s as refugees during the reign of Otebrebe as Krachiwura. These Akan groups were incorporated into the Krachi ethnic group after the death of Otebrebe (Ntewusu, 2015). It was particularly the Nsuta that introduced the *kete* dance to Kete and its name subsequently given to Kete-Krachi. Indeed, Williams (1971) notes that it was the *kete* dance that finally metamorphosed into “Kete-Krachi”. As pointed out by Ntewusu (2015), the refugees from Nsuta were mandated to entertain guests with the *kete* drums at the Dente shrine. Besides, they played essential roles in disseminating the popularity of Dente to Akan settlements, including Nsuta (the traditional home of Dwaben) and Atebubu in Ashanti and Brong Ahafo Regions, respectively. The construction of the Dente shrine in Atebubu reinforced the political authority of the Krachi. The people of Atebubu consulted the Dente deity for security and finally migrated to serve the Krachiwura (Kumah, 1969).

Ntewusu recounts that at the time of the German in Krachi, the town had several clans such as Batae, Dentewiae, Nkyunya, Otapoae, Keanae, Bruwiase, Sawakye, Koswiae and Gyamboae. Apart from these autochthonous clans, ethnic groups that have settled in Kete-Krachi include trading groups such as the Hausa, Kotokoli, Zambrama, Dagomba, Mossi, to mention a few. The geographical location of Kete-Krachi was suitable for trading. For instance, it was located on the trans-Saharan trade route which connected many parts of Ghana. It was thus easily accessed through Yendi in the north, Salaga in the west, Lome (in Togo) in the east and also connected to Accra through water transport (Ntewusu, 2015).

As pointed out, the town also rose to fame through its religious activities, particularly the presence of the Krachi Dente shrine. As a result of its religious importance, therefore, Kete-Krachi developed a robust political institution capable of controlling economic activities in the area. Historically, apart from the Dente deity, the popularity of Kete-Krachi was linked with Islam. According to Lovejoy (1971, p. 538) and Hiskett (1976), the Gonja city (Salaga) that literally metamorphosed into a Hausaphone and an entrepot for the trade in kola nut began to decay following the Asante revenge for the massacre of their people in Salaga. Hiskett further points out that the decline of Salaga as a major entrepot was as a result of the civil war in Salaga in 1892. This stirred the migration of many Hausa (clerics) from Salaga to Kintampo and Kete-Krachi. Kintampo and Krachi thus replaced Salaga as major commercial and Islamic centres. The famous Hausa poet and scholar, al-Hajj ʿUmar pointed out that the civil war in Salaga led to migration of the Hausa people to Kete at the end of the nineteenth century (Weiss, 2002). In summary, the Civil War in Salaga in 1892 which culminated in the destruction of the town as a central business hub contributed to the peopling of Kete-Krachi.

Kete-Krachi provided a convenient avenue for Islam. As pointed out by Lovejoy (1971), pre-existing commercial networks facilitated the proliferation of Islam. Mallams capitalised on petty trading activities to reach out to people and embarked on their religious activities (Lovejoy, 1971, p. 543). Mallams also financed themselves by trading in charms. Charms were needed by traders to attract customers. They were also needed by chiefs to boost the power that they wielded. Besides, charms were used by the public for spiritual and personal protection. Marabouts were consulted to heal different diseases. Even though migration, Islam and trade contributed to the development of Kete-Krachi, another

important historical imprint on the town was German colonialism which will be discussed later.

Kete-Krachi established a vibrant political institution interlaced with its economic and religious activities. Power was shared between the Krachiwura, the secular chief under whom ferries and trade caravans were vested, and the Dente *Bosomfo*, priest of Dente. The priest of Dente, the keeper of the Dente Oracle, was responsible for the spiritual upkeep of the town. It is noteworthy that, prior to the emergence of Kete, Krachikrom (i.e., Krachi town) was already grounded in commercial activities, mainly in salt, slaves, and shea butter, which were traded in the important Asante market of Salaga, some 100 km north. Kete-Krachi eventually became popular in its engagement in the slave trade. In fact, one could infer that there was a symbiotic relationship between politics and the economy in Kete-Krachi; trade was bolstered through the political institution, just as the vibrant economy of the town also popularised the priestly institution. Kete-Krachi was also popular because it served as a German station.

In an article in the *Mirror* of May 1, 1971, Kwame Penni, a native of Hohoe, pointed out that Kete-Krachi used to be a busy business centre, due to its strategic location between the Ewes and the Twi-speaking peoples. The inhabitants were mainly farmers, hunters, traders, fishermen and cloth weavers. To date, agriculture constitutes the backbone of the Krachi economy. Penni argues that the fame of Kete-Krachi in the Gold Coast was not premised on the occupation of the inhabitants – commercial, agriculture, fishing or its ancient trade in slaves – but primarily on the presence of the famous Dente. According to Penni therefore, the popularity of Kete-Krachi was found in a religious institution. The relevance of the Dente shrine was captured in many stories and dirges. Melancholy songs sung by

women also captured the efficacy of the Dente deity (The *Mirror*, May 1st, 1971). Nonetheless, Kete-Krachi was also essential because of its economic activities.

Apart from economic explanations, health reasons also led to the growth of Kete-Krachi. Nana Kofi Donkor Gyinae, Head of the Kadantwe settlement and retired educationist, in an interview confirmed the health factor when he noted that:

... some people who have received healing in the Dente shrine have refused to return home. They believed that their illnesses were spiritually caused and therefore did not want to return home. After healing, such individuals who opted to stay were often given pieces of land to settle on¹¹.

Gyinae further pointed out that, in the past, people from Attebubu consulted the shrine for healing. Some patients (men) who had recovered refused to return to Attebubu and settled in Kete-Krachi where they finally married Krachi women. Traditional healing thus bolstered the population of Kete-Krachi.

3.3 Chieftaincy in Kete-Krachi

Shrines and healing in Kete-Krachi are woven into social and political systems and therefore require a critical discussion of the subject. It is significant to note that a priest of Dente functions as a chief in his own right. Besides, the *Odikro* in every Krachi town acts as the priest of *kokosi* and could conduct healing. Krachi has a complex chieftaincy system. The Krachi people categorise themselves into three broad groups, with nine principal stools

¹¹ Interview with Nana Kofi Donkor Gyinae, former Non-Formal Education Director of Sene District, at Kadantwe, Krachi West Municipal, 28th October, 2020.

among them. The groups are Tsoboae (Krachiwura's group), Dentewia (Nifahene), and Nkyunyae. The nine principal stools, except the Krachiwura's, are headed by divisional chiefs.

Selected towns from the Tsoboae group occupy the paramountcy. Towns largely occupied by the Tsoboae group include, Kantankofuri, Odiefour, Breweniase, Borae (in the Krachi area), Gyengyen, Abujuro, Dadekro and Monkrae. Other towns include: Kwakuae, Adankpa, Motodua and Abuikonor. Within the paramountcy is *Kakyipa*, the stool for the Gyasihene. The Gyasihene administers Old Osramane. The Gyasihene receives visitors on behalf of the paramount chief, and relays information to him.

The Dentewia clan doubles as the Nifahene and priest of Dente. During the yam festival and *Akwammao Nanaba*, the Dentewia (owner or priest of Dente) sits at the right side of the paramount chief. It is important to note that, in state activities, the Dentewia is identified and addressed as a chief, but not as a priest. Towns controlled by the Dentewia (Nifahene) include Kadantwe, Ofoase, Gyaesayor, Ehamankyene and Tworeso.

The Nkyunyae group occupies six stools in the Kete-Krachi area. These include: Kronte, Benkum, Adonten, Kyidom, Frao (Otapo) and Mentia. Towns administered by the Krontehene include Tantu, Akprenkpetor, Yabroae, Kpatsu, Nteususae, Mpusator, Odamankoma and Lotri. The Krontehene sits next on the left of the paramount chief. The rest of the divisional chiefs who sit on the left of the Krontehene include: Adontehene (Kono clan), Benkomhene (Kiana clan), Kyidomhene (Pawia clan), Frao *Bosomfo*, priest of the Volta River (Frao clan), and Mentiahene, chief of horns (also from the Kronte clan), sits to the left of the paramount chief. Communities that constitute Adonten division

include: Woroto, Tsantae, Kofi-Owusuae, and Yabeng. Other Adonten towns are Dobiso, Banka and Atafie. Towns under the Benkumhene, on the other hand, include: Agyanae, Krenkuasi, Gyanekrom, and Dadiese. Frao, the priest and chief of the Volta River, administers the Nana Esewiae, located across the Volta River. Okrae, Ayeae, Odiefour at Tokroano, Kaputراسي and Kpenfuri towns are administered by the Kyidomhene. The Mentiahene's group is dotted across Krachi towns. The Krontihene plays critical roles in the selection and installation of the paramount chief. The proximity of each stool to the paramount chief shows its relevance.

When a stool is vacant, the division supplies two or three candidates to the king makers, the body responsible for scrutinising the candidature of the individuals. Fraudsters, prisoners, rapists, and those with physical deformities, among others, are disqualified from holding traditional chieftaincy offices.¹² A candidate is also disqualified when he is unable to speak the Kaakye language. Other reasons for disqualification include blindness, leprosy and mental derailments.¹³ These infirmities bolster the understanding of the Krachi concept of health and political office. Chieftaincy among the Krachi is rotational.¹⁴ At the divisional level, nomination is done by the stool father, queen-mother, and the king makers with approval of the traditional rulers of Krachikrom. Similarly, the stool father of Tsoboae, Queen-mother and the elders (the Kingmakers) at Krachikrom, install the Krachiwura. In the installation of the paramount chief, all kingmakers of each division are required to be present. Customary rites before installation of a chief include libation and slaughtering of

¹² Interview with Mr. Jackson Beherwah Donkor, former Registrar, Kete-Krachi Traditional Council, Kete-Krachi, 26th October, 2020.

¹³ PRAAD, Tamale, NRG8/2/69. Appointments, depositions and deaths of chiefs (Krachi district), 1935-46.

¹⁴ Several communities, except a few, constitute a division. For instance, Tsoboae is made up of Kantankofuri, Odiefuor, Abuiornor, Adankpa, Gyengyen, Dadekro, Abujuro, Monkrae and Kwakuae, among others. The stool father hails from Abujuro-Tsoboae.

a sheep. The new chief may also be required to pay an agreed amount. Rituals of installation are completed when a new chief takes the oath of allegiance before the kingmakers, the elders of Krachikrom, the queen-mother, and the subjects and is officially recognised by the government through the gazette.¹⁵

Chiefs may be destooled when they are involved in theft cases, seduction, violation of sacred oath, and if they marry a traditional priestess. A chief, preferably, should not marry anyone from the following ethnic groups: Hausa, Dagomba, Kabre, Kotokoli, Konkomba, Gruma or a person considered as a 'foreigner'. The preference for Krachi women is related to rituals associated with chieftaincy. Besides, it is associated with the power struggles between settlers and indigenes following the re-regimentalisation of power at the time of the Germans. A chief can also forfeit his status if he fails to perform the yearly festivals without any tangible reason.

Apart from the social and religious explanations, a chief can also be destooled on economic grounds. For instance, chiefs can be destooled for misappropriating Krachi state funds. Destooled chiefs have their paraphernalia confiscated, followed by the performance of rituals of purification of the stool. Similarly, an occupant can also abdicate the Krachiwura stool on account of a contagious disease or terminal illness, and strained relationship between a chief and his subjects. This may be as a result of insubordination, arrogance, and disrespect to the stool by the chief.¹⁶

Unlike the stool chiefs who dwell in Kete-Krachi, the *adikromfo* (land priests/owners of land), reside in the various towns. In Krachi towns, the *adikromfo* have been lifted to the

¹⁵ PRAAD, Ho, RAO/C/76. Krachi-Nchumuru Joint Traditional Council, 1963-1962.

¹⁶ PRAAD, Ho, RAO/C/76. Krachi-Nchumuru Joint Traditional Council, 1963-1962.

status as chiefs. All stool or divisional chiefs must settle in Kete-Krachi. The land priests of each community are responsible for the ritual administration of the land and waters. When bigger trees are to be felled, the *adikromfo* consult the stool chiefs. Cases such as suicide and crossing water bodies with corpses are under the remit of the *adikromfo*. However, in Kete-Krachi, this falls under the domain of the Dente priest, except cases of drowning or dead bodies found in the Volta River, where the Frao priest performs critical rites. Both the chieftaincy institution and the *adikromfo* are interlinked. The Krachiwura, together with his council of elders and the *adikromfo* of a particular traditional area, must agree in principle that an *odikro* (sing.) has contravened the traditional rites or violated an oath. An *odikro* could be destooled when he fails to pay a traditional fine. Difficult cases pertaining to destoolment of an *odikro* are usually referred through the Krachiwura or a relevant government institution to the Chieftaincy Secretariat for final ruling. In the case of the Krachiwura, his *adikromfo* are always led by the stool father. The stool father gives assent to the decisions taken by the *adikromfo*, leading to destoolment of the Krachiwura. Destoolment against the Krachiwura must be carried out by a two-third majority of his *adikromfo*, with the consent of the stool father. It is after this stage that the matter is referred to the council of chiefs at Krachikrom (Kete-Krachi).¹⁷ The traditional leaders have played significant roles in Kete-Krachi. For instance, the Grade B court established there in 1935 had the Krachiwura, Dente priest, *Asasewura/Odikro*, Frao priest, among others as members.¹⁸ It is worth noting that the *adikromfo* at the divisional level preside over the subsidiary Dente deity (*kokosi*) and are also responsible for healing. As pointed out, all the

¹⁷ PRAAD, Ho, VRG/NA/012. Krachi Traditional Affairs, 1967-1973.

¹⁸ PRAAD, Accra, GH/CSO.21/7/40. Native courts in the Krachi Division Establishments.

adikromfo are under nine principal stools in the Kete-Krachi area, headed by the paramount chief.

In sum, healing among the Krachi is deeply embedded in the traditional polity. The Dente priest is critical in the traditional healing system. This explains why shrines and healing, and the traditional political institution among the Krachi people cannot be discussed in isolation.

3.4 Climatic conditions, land administration and mode of production

Climate refers to the average weather or the statistical description of weather conditions of a place over a period of time (IPCC, 2007 Report). Climate contributes to healing systems. A discussion of the climate in Kete-Krachi is therefore necessary. Kete-Krachi is characterised by a tropical climate with both arid and humid weather conditions. Like much of southern Ghana, the double-maxima rainfall normally from April to July and from September to October characterises Kete-Krachi climate. However, due to climate change caused largely by human activities, rainfall from April to July has become sporadic, with torrential rains occurring from September to October. The annual rainfall in the area is estimated to range between 922mm and 1874mm. The arid season falls between November and March. The mean annual range of temperatures fall within 24°C and 39°C, while the mean annual maximum temperatures range between 11°C and 26°C. The hottest (highest) and coolest (lowest) temperatures are usually recorded from January–April and in December respectively (Yaro et al., 2009, p. 21).

The Krachi area, including other places in the Oti Region such as Kpasa, Bonakye, Sabu, Chai, and Asukawkaw, has a vegetation that ranges from semi-deciduous forest on the eastern and southern parts, and savanna woodland sandwiched between the northern grassland savanna and the semi-deciduous zones.¹⁹ The western part of the area is covered by the Volta Lake. Beyond the lake is the Sene West District. The Kete-Krachi area has a variety of useful plant species such as *wawa*, *odum*, and *Antiaris africana/toxicaria* or the backcloth tree, referred to in Twi as *kyenkyen* (Yaro et al., 2009), and ebony. The timber is largely extracted by the local people and sold to neighbouring districts such as Kpandai and Krachi-Nchumuru. Other trees introduced into Kete-Krachi by the Germans include mangoes, mahogany, teak and neem. The bark, root and leaves of mahogany and neem trees are largely used as traditional medicine because of their medicinal efficacies. These forest resources were protected through customary rules. For instance, under Section 17(1) of the Native Authority (Northern Territories) Ordinance of 1932, all Agricultural Officers prohibited cultivation of soil and grazing of land in some areas.²⁰ Farming along riverbanks was also prohibited under the Ordinance. The intense timber lumbering, coupled with fuel wood cutting and the devastating bushfires in contemporary times has, however, reduced the canopy of the once thick forested vegetation (Yaro et al., 2009). The double maxima rainfall and the suitable vegetation cover in Kete-Krachi offer good medicinal products for traditional healthcare. This thesis will delve into plants and their medicinal efficacies in chapter six.

¹⁹ See the 2010 Population and Housing Census.

²⁰ PRAAD, Tamale, NRG8/2/71. Northern Territories Krachi Native and Administrative rules and orders, 1935-1948.

Land management in Kete-Krachi is entrusted in the hands of the *odikro*. By holding allodial rights to Kete-Krachi lands, the *odikro* has the prerogative to resolve conflicts, especially those arising from lands. Conflict resolution, nonetheless, does not elude priests of Dente. Before and during colonialism, the Dente priests commanded authority over land in Kete-Krachi.²¹ Conflicts (including land-related ones) were accordingly resolved by these priests. In contemporary times, however, the Dente priests have been subjugated under the Krachiwura, and in land administration, the priests account directly to him (Yaro, Yankson, & Asiedu, 2009, pp. 25 & 24). Allodial rights to land in Kete-Krachi have shifted from the Dente priests to the Krachiwura. All lands in the Kete-Krachi Traditional Area are therefore stool lands, with the paramount chief holding allodial rights to lands. Management and use of these lands therefore fall under the Krachiwura. As indicated, while secular matters are brought under the domain of the chiefs and the Krachiwura, all cases of land pollution (such as murder, suicide, and accidents during hunting) and drowning remain under the remit of the *odikro*. The Krachiwura has many divisional chiefs who assist him to rule the Krachi state. Although priests of Krachi may still deal with issues arising from land, difficult cases are, however, deferred to the divisional chiefs, and where a resolution is difficult to reach, such cases are further deferred to the paramount chief, the Krachiwura.

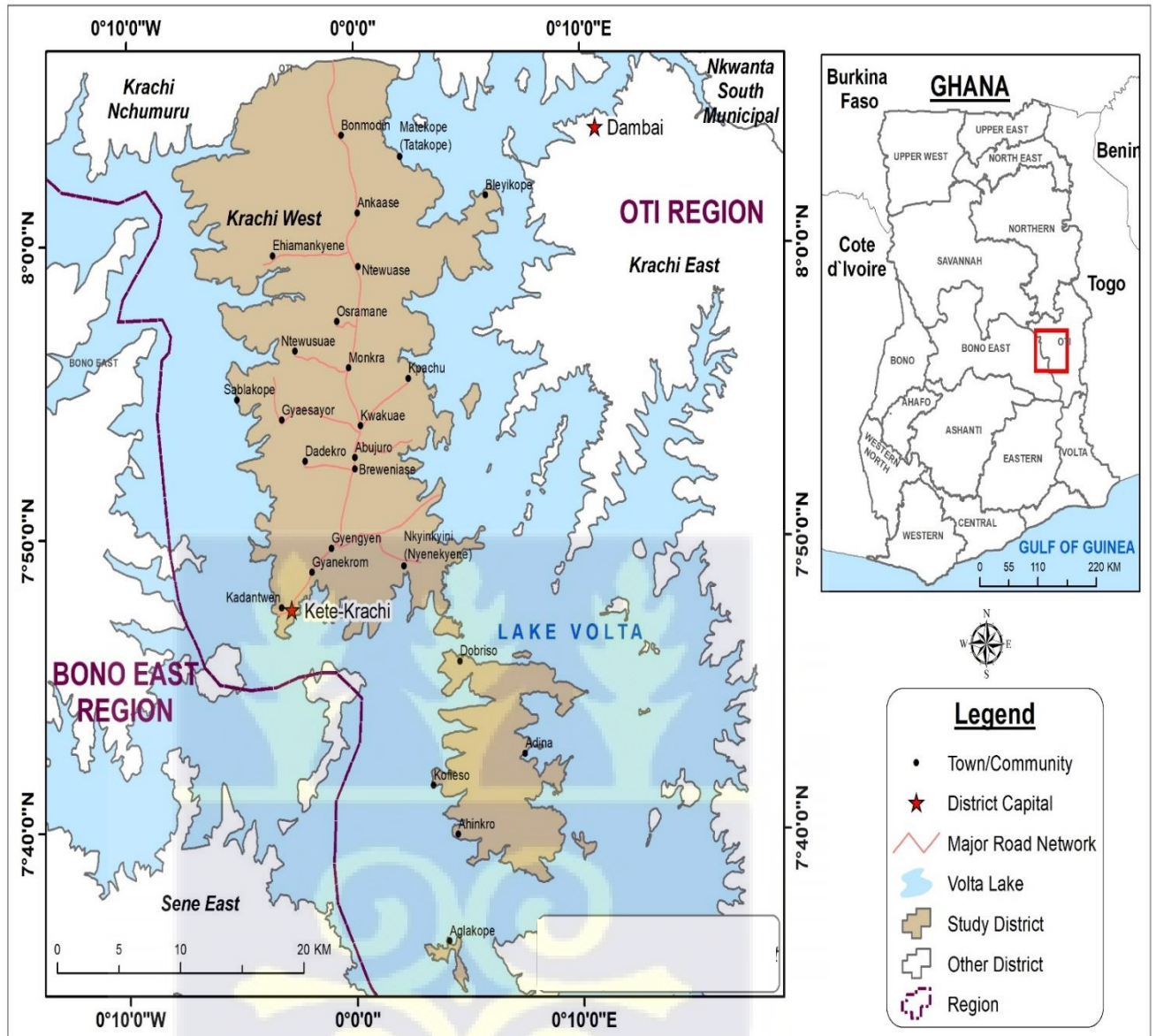
As noted earlier, agriculture greatly constitutes the backbone of the Kete-Krachi economy. Yaro et al. (2009) estimate that about eighty percent (80%) of the people in the Krachi area are engaged in agriculture. Food crops cultivated in the area include cassava, yam, maize,

²¹ Until 1932, the Krachi District, and ultimately, the Krachi Traditional Area, was made up of five divisions, namely, Kete-Krachi, Nawuri, Nchumburu, Achode and Nanum divisions.

and cowpea, while cash crops such as oil palm and cashew are least cultivated. Livestock in the Kete-Krachi District (initially encompassing Dambai) include the following: cattle, sheep, goats and poultry. Just like their vegetation, traditional medicine is also largely dependent on domestic animals, as patients are often required to present them for the performance of some mandatory rituals. These animals, whether for purposes of taboos or sacrifices, shall be indicated later (see p.214). Another germane economic activity in the town is fishing in the Oti River.



Map 1: Map showing major towns in the Krachi West Municipality



Source: Author's creation, 2021.

3.5 Kete-Krachi under German colonialism

In 1894, Kete-Krachi recorded its first colonial penetration on the arrival of Germans in the town. As administrators and missionaries, the Germans faced initial opposition from the indigenous Krachi. The Germans therefore struck an alliance with the migrant traders

and Islamic group – the Hausa, Gonja and Yoruba. As a trader group, the migrant community provided the needed economic footing required by Germans. The presence of a *Sarikin zongo* helped the Germans to establish their administration. Unlike the migrant group, the Germans were hostile to the indigenous Krachi.

Kete-Krachi, from 1898, was administered as an essential component of the larger German colony of Togoland. The German interest in Kete-Krachi was due to its strategic location; it was close to Salaga and not too distant from it is Lome (Ntewusu, 2015, p. 7), capital of Togo. Kete-Krachi's economic fortunes were also a source of interest to the Germans. Before the German presence in the town, priests of Dente exercised great power over major trade routes that connected considerably large inland markets, including Salaga. The presence of the Germans in Kete-Krachi deflated the powers of the Dente priest. The priest had the power to instruct individuals and communities to participate in the rituals relating to the Dente festival, *Akwammao Nanaba*. In 1894, Gyantrubi instructed a closure of the Krachi market in honour of the festival, in which rituals the Muslims were expected to participate. However, the Muslims flouted the orders of the priest and engaged in trading activities. This led to violence in Kete-Krachi. The Muslims sought support from the Germans (Maier, 1980, p. 43). These events laid the foundation for execution of the Dente priest.

A significant event that marked the German occupation of Kete-Krachi was the execution of the Dente priest. Several reasons may have also accounted for the execution of the Dente priest by the Germans. These reasons include the exploitation of the Hausa traders, and the German observation in 1894 that Gyantrubi fomented trouble by enraging the Hausa via

harassment and “robbery”. These occasional harassments were exemplified by the periodic roadblocks at the north, towards Salaga (Herold, 1894, cited in Maier, 1980, p. 42).

This influence that was exercised by the priest was considered by the Germans as a great threat to their economic pursuit. For instance, the Germans were interested in the revenue accrued from the trade in Kete-Krachi. It was, therefore, under the Germans that the Krachi Dente suffered greatly. For instance, Gyantrubi was executed for resisting the German colonial administration. His execution was consequently followed by the destruction of his (Dente) shrine. Additionally, most of Gyantrubi’s entourage were exiled (Maier, 1983, cited in Venkatachalam, 2012, pp. 56 & 57). The worship of Dente was finally banned by the Germans. Shrines were believed to operate contrary to the criminal laws of the country (PRAAD/GH/CSO.21/10/23). Similarly, in 1912, a German lieutenant, in explaining why the shrine was dynamited, claimed that priests of Dente had abused their powers. They further hanged the priest along with his successor elect, with two of his linguists committing suicide in the cells while one was imprisoned (Maier, 1983, p. 169).

The presence of the Germans in Kete-Krachi, as pointed out, reduced the powers of the Dente priests. The Germans claimed rights over taxation and judicial fees, including communal labour that hitherto was controlled by the Dente priests. Muslims, however, continued to exercise control of the caravan trade and its labour, whereas the Krachi people attempted a control of the agricultural production and its labour. It is clear that the search for power and wealth continued competitively (Maier, 1980, p. 49) even at the time of the Germans in Kete-Krachi.

Further, the local agricultural policies of the Dente priests were hindered by the Germans. For instance, in responding to the influx of migrants and the rapidly increasing population, the priest of Dente engaged the services of slaves in the agricultural system to supply food. The priest of Dente also organised a formidable alliance, popularly known as the 'Bron Confederation' as a tool against the incursions of the former Asante rulers. This confederation was sustained through heavy taxation of Muslim traders, which subsequently resulted in the increased tension and antipathy between Muslims and the Krachi. These policies in Kete-Krachi were terminated by the Germans in 1894. Thus, the Germans broke the traditional power of the priest of Dente and altered the political landscape of the town. The Muslims became allies with the Germans, and subsequently, the power of the Krachiwura began to wane (Silver, 1985, p. 190). Consequently, the worship of Dente was banned.

Before World War I, Kete-Krachi was under German colonialism. After the War, however, the town came under British rule and was administered on behalf of the League of Nations as British mandated Togoland. The renewed interest in the worship of Dente and its allied activities only re-emerged during the British era. In spite of the fact that the British closely monitored religious cults, they allowed the Krachi people to revive the worship of Dente. This followed the backdrop that the suppression of cults was surreptitious and detrimental to colonial efforts.²² In the early 1920s, for instance, Dente was reinstated in Kete-Krachi, leading to the establishment of many 'satellite shrines' devoted to the deity, particularly in the central and coastal Ewe settlements of the Volta Region (Venkatachalam, 2012). Power

²² PRAAD, Accra, A/ADM 11/1/751. Letter from the Secretary of Native Affairs to the Acting Colonial Secretary, 28th September, 1921.

returned to Krachi at the end of World War I, when the British staged a return to Krachi and reinstated the Krachiwura as the ultimate source of authority (Silver, 1985, p. 189).

The legacies of German colonialism cannot be underestimated. The presence of the Germans in Kete-Krachi brought some developments in the town. The German administration provided a police force to ensure security on the roads, ensured the standardisation of market and caravan taxes, and also constructed wells and roads (Maier, 1980). Another economic achievement of the Germans was the introduction of formal banking in Kete-Krachi. Moneys of traders were, hitherto, kept in homes or buried (Ntewusu, 2013, p. 240).

In the field of horticulture, the Germans introduced mangoes, mahogany, teak and cotton into the Kete-Krachi and Nawuri areas (Mbowura, 2013; Ntewusu, 2015, p. 12). The cotton scheme in the Nawuri area and Kete-Krachi districts did not thrive, owing largely to pre-existing subsistence farming (Mbowura, 2013, p. 211). However, the horticultural schemes of teak and mango were relatively successful. For instance, mango trees were planted along the Kete-Krachi-Kpandai-Bimbilla-Yendi road. The traditional authorities, through the conduct of periodic communal labour, ensured a successful implementation of the horticultural scheme of the Germans. The Germans also resorted to ruthless approaches at ensuring compliance. These approaches encompassed forced labour, beatings (Mbowura, 2013, p. 210), and burning of villages and markets in communities that resisted. Traditional authorities in Kete-Krachi and Nawuriland were thus required to furnish the German colonial administrator with labour to advance the horticultural scheme of the Germans. The utmost effect of these ruthless methods was the destruction of Kete-Krachi's trade and the

subsequent reduction of the population of the town between 1899 and 1900 (Maier, 1980, p. 49).

The culture of planting of trees in the German territories served a variety of purposes; it greened the environment and enhanced aesthetic quality (Ntewusu, 2015, p. 13), while the mahogany, neem and teak trees were noted for their medicinal value. Burnt teak leaves was also used as medicine. The potash was believed to heal skin-related diseases. A detailed discussion of plants and healing shall be handled in chapter six. The horticulture scheme also improved the economic life of people. The improved varieties of mango introduced by the Germans were transportable over long distances and could be preserved for longer periods, unlike the existing local varieties of mango (Ntewusu, 2015, p. 13).

A social intervention instituted by the Germans in Kete-Krachi was the introduction of Western medical practices (Ntewusu, 2013, p. 240). Medical therapies in respect of scorpion and snake bites were sometimes handled through unconventional ways, such as burning of the spot with cigarettes where individuals were bitten, with some patients made to drink tots of alcoholic beverages (Klose, 1964; in Ntewusu, 2013). Nwokeke and Igwillo (2020) point out that in local African setting, heat from fire is used extensively in the treatment of various ailments and diseases. Heat therapy, including the use of fire, is used primarily to expand blood capillaries, increase blood flow to the affected part and provides nutrients and oxygen to facilitate healing. The medical services provided by the Germans explained the patronage of the hospital in Kete-Krachi by the Nawuri, Nchumburu²³ and

²³ Nchumburu, Nchumburung, Chumuru Nchumuru spelt variedly refers to the same people. Except for purposes of quotations and references, the spelling *Nchumburu* shall be used in this thesis.

Achode (Ntewusu, 2013). The German presence is critical in the explanation of social change and changes in traditional healing in Kete-Krachi.

3.6 Other Krachi towns

Two major factors accounted for the emergence of other settlements in the Kete-Krachi area: hunting activities and the construction of the Volta dam. Kantankofuri (literarily, ‘the big rock’) is believed to be the earliest settlement in the Kete-Krachi area. Like many towns in the area, Dadekro developed through hunting activities. Nana Yachun, Sanahene of the Krachi traditional area recounted that the name Dadekro is a corruption of the Akan terms, *ɔdádíe* (*Adansonia digitate* (baobab)) and *kro* (one).²⁴ Literally, the town refers to the ‘big baobab’ tree. The baobab tree was a landmark for hunters in the Kete-Krachi area.

Nana Yachun, ancestor through whom the present Sanahene descended, is believed to be the founder of Dadekro. There are two principal shrines in that town, the Boame-Kuma and Akomagyo-Lente, the latter shall be discussed in the context of healing. Boame-Kuma (‘younger Boame’) is believed to be the ‘younger brother’ of Boame at Breweniase, near Abujuro. Boame, sometimes referred to as Boame-Peni (‘older Boame’), was introduced in the Kete-Krachi area before the Boame-Kuma.²⁵ Yam festival is celebrated in Dadekro and Breweniase either October or November to thank those deities for protection and

²⁴ Interview with Nana Yachun, Sanahene (Chief of Treasury) in the Krachi traditional area, Krachikrom. 7th August, 2022. Nana Yachun hails from Dadekro.

²⁵ Interview with Nana Akosua Nkrumah, priestess of the Akomagyo-Lente shrine, Dadekro, 21st March, 2021; Interview with Nana Yachun, *ibid.*, 7th August, 2022.

provision of bumper harvest. Towns in the Kete-Krachi area cultivate yam, groundnut and corn.

Dadekro, Abujuro, Kwakuae Monkrae and Old Osramane laid on a major German route to Togo. In view of their geographical location, members of those towns served as head porters for the German colonial administrators. For instance, the Krachi people at Dadekro carried the luggage of the colonial administrators to Abujuro. The Abujuro further carried the luggage to Kwakuae, in that order till the administrators arrived in Togo. Common shrines in Abujuro include: Fofie (a subject of attention in this study), Adare, Yentumi Ogyeabour and Gyenata. During the World Wars, Dente was consulted by the Krachi people to protect them from enlistment for the wars. It was highlighted in Dadekro that members of the town were not enlisted for the wars because they consulted Dente against recruitment.

Towns such as Gyaesayor, Tworeso, Yabroae, Kpatsu, and Gyengyen, developed due to hunting activities. Similarly, Monkrae, Kwakuae, Adankpa, and Old Osramane emerged through hunting activities.

As pointed out in previous discussions, the construction of the Volta dam by the Kwame Nkrumah government led to inundation of the original Kete-Krachi. To compensate them, the Nkrumah government established resettlement apartments for communities that were affected by the construction of the dam. Fifty-two (52) resettlement towns were built in the Kete-Krachi area, many of which were occupied by the Krachi and the Nchumburu people.

Resettlement towns in the Kete-Krachi area include: Ofoase, Motodua, Ehiamankyene (formerly known as Kipatiso or Tarieso), Tantu, Ntewusuae, Akprenkpetor, Woroto and

Mpusator, Tantu, Akprenkpentor, Mpusator, and Odamankoma were resettled at Ntewusuae resettlement quarters. The Woroto Krachi also occupied Osramane resettlement town. Although Tantu and Akprekpeno were resettlement towns, the outbreak of guinea worm in the area caused the Krachi residents there to migrate to their present locations.²⁶ The ancestors of the Krachi people at Motodua were believed to have migrated from Asante due to the frequent wars at the time. The town is characterised by the Akan *asafo* groups. In the past, the *asafo* served as warriors for the Asante (Akan) kingdom. The title of the stool in Motodua is Twafohene (chief of execution). The name *Ofoase* is believed to be associated with the presence of the *efum wano* (*Schrankia leptocarpa*) plant and *ase* (under) in Akan. The names *efum* and *ase* then corrupted as ‘Ofoase’.

The Volta floods obstructed the Tamale-Chinderi-Ehiamankyine-Kete-Accra and the Tamale-Chinderi-Ehiamankyine-Krachikrom-Kumasi trade routes. Kete and Krachikrom (Krachi) were suitable economic towns for traders from Accra, Tamale, and Kumasi. The routes boosted trading activities in the area.

The floods caused the Krachi people at Kipatiso to move further west to their present location. They have since assumed the name, *Ehiamankyene*. The name *Ehiamankyene* emanated from the Akan words, *ehia* (poverty) and *nkyene* (salt).²⁷ Although inhabitants of the town were regarded as poor, the place was blessed with abundant salt. The ‘poor’ status used to describe inhabitants of the town was attributed to the Volta floods which inundated their assets. Ehiamankyene is close to the Volta River. It was due to the town’s

²⁶ Interview with J.B. Donkor, Retired Registrar of Krachi Traditional Council, Kete-Krachi, 6th August, 2022.

²⁷ Interview with Nana Kwaku Asumadu, son of the paramount chief of Kete-Krachi, Nana Besumuna III. Kete-Krachi. 8th August, 2022.

suitable geographical location that Hon. Joseph Kudjo, then Member of Parliament and Minister for Health, and subsequently Deputy Volta Regional Minister who hailed from Ehiamankyene, persuaded the Nkrumah government to construct a port in the town. It was in view of this that the residents envisioned and nicknamed the town, Las Palmas in mid-1960s, after the largest city, port, and capital of the Las Palmas province in the Canary Islands of Spain.

For residents of the town, goods from Akosombo in the Eastern Region and Makongo in Northern Ghana would have boosted commercial activities in the town. It was pointed out by a respondent that it was in view of this expectation that the elite of the town persuaded administrators of the Volta River Authority to resettle them along the Volta River (VRA). Although the VRA granted their request by resettling them along the Volta River, their expectation of a port did not materialise as the Nkrumah government was overthrown in a coup by the National Liberation Council in 1966. Many educated personalities arose from Ehiamankyene as a result of the catholic missionary activities who built schools in the area.²⁸

Other towns that emerged in the Kete-Krachi area as a result of the resettlement include: Tsantae, Kofi-Owusuae, Yabeng, Dentemanso, Dobiso, Agyanae, Krenkuasi, and Dadiase at Osramane. As indicated earlier, Old Osramane is not a resettlement town. Towns such as Banka and Atafie were a result of resettlement in the Dambai and Tokroano areas respectively. These towns were equally affected by the floods of the Oti River. Kpenfuri, Okrae, Ayerae, Odiefuor, and Kaputrasi in Tokroano are resettlement towns. Many of the

²⁸ Follow up interview with J.B. Donkor, Retired Registrar of Krachi Traditional Council, Kete-Krachi, 7th August, 2022.

resettlement towns in Tokroano were occupied by the Kyidomhene's group. Similarly, Odiefour, Krachi-Bòrae, Breweniase, and Abuikonor in the Kajaji area are resettlement towns.²⁹

Kajaji is located in Bono East Region. The Krachi people at Kajaji share a common historical origin with those in Kete-Krachi. The Kajaji people have their own paramountcy and Traditional Council. Kajaji is an important commercial town. While Odiefour in the Kajaji area is under the Krachiwura's group (Tsoboae), the one in the Tokroano area falls under the Kyidomhene. It is worthy to note that the Krachi people established the *kokosi* shrines in those resettlement towns as a symbol of allegiance to the Dente deity and the Krachi state. Affiliate shrines of Dente were also established in many of the resettlement towns.

There were a few groups in Kete-Krachi who declined occupation of Nkrumah's resettlement facilities. These include: Kadantwe, Lotri, Gyankrom and Odiefour, Bòrae, Breweniase, and Abuikonor. Lotri at Tokroano refused resettlement at Ntewusuae. A detailed explanation for this refusal shall be discussed soon. Lotri was affected by the floods of the Oti River, a tributary of the Volta River. The Krachi people at Gyankrom refused occupation of government bungalows at Osramane resettlement site. Similarly, Odiefour, Krachi-Bòrae, Breweniase, and Abuikonor refused resettlement at Kajaji. Those who refused or accepted resettlement were compensated for their inundated lands caused by the Volta dam.

²⁹ Interview with J.B. Donkor, 6th August, 2022.

Several explanations accounted for the reasons many Krachi people refused occupation of Nkrumah's resettlement project. It was claimed by respondents that the buildings were poorly constructed. For instance, respondents indicated that bricks were moulded in the morning and used for construction in the afternoon or evening the same day. The roofs could not withstand storms. Examples were cited of residents who were hurt by collapsed buildings. Furthermore, the buildings did not have enough space to accommodate large families. Other reasons were malfunctioning pipe borne facilities, compounded by severe droughts in those resettlement towns. The attendant effect was that a few families who dwelled in the apartments had to resort to use of other water sources leading to the outbreak of guinea worm infections. Similarly, since Krachi people from different towns were resettled together, the problem of peaceful coexistence arose. They wished that those resettlement projects would be occupied according to affected towns, rather than people from different places. Additionally, many Krachi people refused to occupy the resettlement structures because of attachment to their ancestral lands. Finally, the Krachi were angry at Dr. Kwame Nkrumah as they felt he was responsible for the floods that inundated the original Kete-Krachi.³⁰ Many people therefore refused occupation of the resettlement project.

The impact of migrations, caused largely by the Volta dam can be felt today. For instance, there is a dialectical difference between the Dentewia and Tsoboae clans on the one hand, and the Nkyunyaie clan on the other hand as they stayed apart from each other. Similarly, there are contestations over land which are attributed to the impact of the construction of

³⁰ Interview with J.B. Donkor, Retired Registrar of Krachi Traditional Council, Kete-Krachi, 6th August, 2022.

the Volta dam which led to several divisions among the Krachi people. The floods affected the population of Kete-Krachi. Migrants in Kete-Krachi were, as a result of the floods, resettled at their respective places of origin. For instance, the Pai (Pai-Appaso) and Akrosu were resettled at Katanga and Asukawkaw in Oti region respectively while the Ayamoso were resettled in Eastern Region. Ghanaian soldier returnees from DR. Congo who were stationed at Pai nicknamed the town as Katanga after the largest province in the Democratic Republic of Congo (then Belgian Congo) established in 1914. The Otiso (nicknamed Adunkwanta by the VRA), however, refused to return to Eastern Region, from where they migrated.

3.7 The Krachi belief systems

This subtheme discusses religion and spirituality among the Krachi people. It provides further insights into how belief systems shape the Krachi view about (ill-)health, twins and the human person in general, with particular references to the so called ‘spirit children’.

3.7.1 Religion and spirituality in Kete-Krachi

It will be difficult to discuss Kete-Krachi without recourse to religion. Religion plays an essential role in the everyday life of the Krachi people. Besides the Krachi Dente, popular deities which were worshipped included Bruku, a shrine of Achode (Shiari) origin. Bruku was, and still is, regarded as the ‘father’ of Dente. This proclamation is rooted in an oral tradition that the Krachi people once resided in Shiare, before their movement, under the directive of Bruku, to their present location in Krachi. Deities such as Osorewia – Ginato,

Pa, Kponawia, Kosoe and Kpono were worshipped by the Krachi. Water deities such as Obonsebe and Pɔnyɛ are also interlaced with the Volta River, and are periodically worshipped (Kumah, 1969, p. 26 & 27). This study does not seek to venture into a discourse on the religiosity of the people of Kete-Krachi and the plethora of the deities; the study focuses on the Dente shrine as it has enormously impacted on traditional healthcare systems in Kete-Krachi and other Guan communities.

3.7.2 The Krachi concept of personhood

According to Krachi tradition, ‘Living Man’ comes from the Supreme Being, *Wuruboare*. It is believed that the Supreme Being first created the *kra* (soul) which, for them, is analogous with *blood*. This belief relating to *kra* and *blood* sets it apart from most societies in Ghana. It is also believed that the creation of the *kra* was followed by the *konokra* (destiny). One’s destiny thus regulates his or her daily activities. The existentiality of the ‘destiny’ is grounded in Krachi mythology that *kra* severally petitioned the Supreme Being regarding its manifold responsibilities on earth and accountability of its stewardship, which led to the creation of the *konokra*. Unlike the *kra*, *sunsun* appears to be inseparable from the material. This inimitable trait accorded the *sunsun*, ‘protector’ of the *kra* and the body. It is important to note that the *kra*, *konokra*, and *sunsun*, according to Krachi tradition, are salient aspects of every male person, while the female is believed to possess, in addition, a fourth attribute – *fertility* of the womb (Kumah, 1966, p. 33).³¹

³¹ Critical insights into fertility and shrines among the Krachi shall be provided in subsequent chapters.

Like many Ghanaian conceptualisations, the *kra* is considered the most important spirit which constitutes the real life of a person. The *sunsun*'s pertinent role therefore accords it the accolade, 'protector'. Sometimes too, the *kra* is viewed as a coward and a weak spirit requiring constant protection. The cowardice of the *kra* is demonstrated by its readiness to abscond from its hosts during looming dangers such as accidents and in wars. Although the *kra* in many Ghanaian societies is expected to serve as a guardian spirit, its roles sometimes become ambivalent. *Kra* may cause some misfortunes that retard progress. Such explanations are often rooted in failure on the part of individuals to pacify it with sacrifices (Kumah, 1966). For the Krachi people, the *kra* goes hidden in places such as water bodies and under the rocks. Its hiding place is only known by the *konokra*. The *kra* is said to have no connection with the Supreme Being after creation, except its departure from the human body at death.

The *konokra* is believed to gather intelligence and reports directly to the *kra*. To execute its role sedulously, it is believed that the *konokra* mingles with both evil and good spirits to obtain information, with which it feeds the *kra*. Besides, the *konokra* serves as the link between *Wuruboare* and the *kra*, and reports the latter's activities to the former. However, the *kra*, according to Krachi conceptualisation of personhood, is believed to be the most fearful spirit as it could be 'bribed' by malevolent spirits working against it. This happens, as is believed, when the human personality transgresses the spiritual and the material-man (Kumah, p. 34).

The ability of the ‘human person’ to continue to enjoy life on earth depends on their ability to keep to personal promises while on earth. A contravention of the union with one’s maker is manifested in the occurrence of poverty, diseases, accidents and other misfortunes. Properly explained, the *konokra* has been employed by the ‘enemies’ of the *kra* to work against human efforts. Human frailty may thus cause individuals to consult shrines for verification of the bad omen. The identification of the *konokra*, through divination, as the chief cause of human suffering leads to pacification rituals – normally involving the slaughter of a sheep, goat, fowl, canary bird, and tortoise (Kumah, 1966, p. 35). The sacrificial blood is said to be carried to the Supreme Being by the *konokra*. Death and the thereafter also constitute an essential component of the Krachi religious experience.

The *konokra* is believed to either die with the body or depart from it to reside on a tree. One could argue, therefore, that the serene vegetation in Kete-Krachi, as pointed out earlier, also emanates from the existing belief systems since some trees are associated with human souls/destinies. This belief bodes well with the general African belief in spirits inhabiting objects in/of the natural environment. The *sunsun*, which is believed not to die, remains with the body and eventually results in the *osoman-okyemempo*, the ghost (Kumah, 1966, p. 36).

Some Oti and Northern Guans believe that each star symbolises the human soul. The movement of some stars may therefore be interpreted as looming death in the community. The shooting of a bright star among the Nawuri-Guan, for example, symbolises the death of a chief or an eminent member of the society. Heads of clans or communities may investigate, through divination, the cause and effect of movement of stars. Like the Nawuri-Guan, the Krachi people also study stars in order to determine the periods of farming,

celebration of events, time, and deaths of prominent people in society. Similarly, the shooting of a large star symbolises the death of a priest, a chief or renowned person among the Krachi (Kumah, p. 39 & 40).

The concept of personhood weaves into traditional healing systems. Among the Krachi, healing involves identifying, via divination, the souls and destinies of individuals. Apart from its direct implication on rights to life, the concept of ‘personhood’ is used to deny people access to both allopathic and traditional care. A detailed analysis will, therefore, be presented to establish the link between the Krachi concept of personhood, shrines, and healing.

Awedoba and Denham (2012/2013) assert that personhood is a significant component of morality that is used to justify who is socially recognised within the community. It is in respect of this that families establish a foundation of personhood which is linked with some specific notions of normality and individual’s value with the family. Although significantly reduced, this practice is also observed by a few people in the eastern zone of the Nankani community in Ghana (Amenga-Etego, 2011). The practice undermines individual rights and has adverse impact on child mortality rates, and no efforts are made to address it. A basic reason why Western donors are not usually interested in ‘spirit’ children is because the practice has been given a cultural interpretation (Amenga-Etego, 2011). Nonetheless, this practice still lingers on and offers shrines a role-play and should be given considerable attention in this chapter.

3.7.3 The concept of the ‘spirit-child’ and shrines among the Krachi

The belief in the existence of the spirit child dates back to antiquity. The Krachi expression, *ɔngye nyigmisa*, to wit, ‘he or she is not a person’ is critical in the understanding of the classification, rights, privileges, and treatments of individuals in the society. When the Krachi use *ɔngye nyigmisa* in their daily expression, it, however, refers to the ‘anti-social’ behaviour of people (for example, those who do not show kindness in society). However, when used on children, especially those living with disabilities, the expression assumes a different meaning. Awedoba and Denham note that efforts to understand the phenomenon of the spirit-child must consider cultural and social features, such as the distinction between the house, the bush, and notions of personhood (Awedoba & Denham, 2012/2013). Members of the community consider the house and settlements as safe, predictable, and habitable, while the bush is considered as unsafe, unpredictable, and a habitat for predators and spirits that are antagonistic to humans (p. 48). Indeed, among the Krachi, spirits loiter in the bush or wind and can find their way in society through sexual intercourse in the bush. This can lead to the birth of spirits in human form, popularly referred to as spirit-children.

These children have many deformities such as hydrocephaly, difficulty in walking, inability to think properly, speak or cry at birth and many more. The distinction between spirit-children and non-spirit-children is only made through divination. Sometimes, the plight of these children is ascribed to the offense of their parents. For instance, when a woman is pregnant, her thighs must not be seen. Sitting on mortars, walking while eating, exposing one’s belly when pregnant, among others, are means believed to invite evil spirits

to the home.³² It is in view of these that Dente shrines are consulted to correct the anomaly.³³

Spirit-children are perceived as a threat to society. The popular perception is that, apart from the worries which they are believed to bring to their families, spirit-children can also convert into dangerous animals and carry out certain nocturnal misadventures. It is believed, therefore, that if they are not detected and either corrected or killed early, they would destroy their families through poor harvest, illnesses, infertility, drought, to state a few. It is believed that spirit-children can change their colour or convert into substances. For this reason, the rooms of spirit-children must not contain a lot of items.³⁴ The concept of the spirit-child is tied with livelihoods, and continuity of the society. Poor harvest of yam may be blamed on the presence of a spirit-child. To improve yields therefore calls for the killing of spirit-children when they are suspected to be the cause of poor harvest. This may arise because of the pressure by society to execute such children. As members of the society want to continue to enjoy peace and harmony, they would want to witness the cry of newborn babies so as to determine their personhood status and ensure that spirit-children are not a threat to the continuity, progress and peace of the society.

The popular perception that the presence of spirit-children does not bring *kayiwusi* (peace/wellbeing) is also germane to the Krachi. Spirit-children are believed to disunite

³² Focus group discussion with the Dente priest and his subjects, Dente priest's house, Kete-Krachi. 6th January, 2021.

³³ For another account of the subject of 'spirit children' see Awedoba A. K. and A. Denham (2013). The perception of abnormality in Kasena and Nankana infants, *Ghana Studies* 15-16 (2012-2013) Special Issue: Health and Health Care eds. Sjaak vander Geest and Kristine Krause.

³⁴ Interview with Nana Kofi Donkor Gyinae, Former Non-Formal Education Director of Sene District, at Kadantwe, Krachi West District, 28th October, 2020.

families or society through disputes. It is believed that their frequent ill-health is meant to drain families of their resources. The very survival of spirit-children is viewed as a major threat to societies' health. Spirit-children are believed to cause all manner of illnesses, particularly to their hosts or parents. It is believed that people who take care of them, by feeding and bathing them, and washing their dirty clothing, are often attacked by the same child. A respondent reiterated the phobia for spirit-children as they are believed to cause illnesses as follows:

Spirit-children, particularly those who cannot walk, demonstrate their malevolent spirits by inflicting harm to their hosts by first crippling them. I remember a woman whose son got married to a lady and gave birth to one. The boy could not walk, had wavering eyes, and could not also talk. The grandmother refused her family's request to 'see the boy off' into the bush. The result was that the spirit-child finally attacked the grandmother and caused harm to her by crippling her. Although the baby was killed, the grandmother could not be healed until she also consequently died.³⁵

The narrative above enhances an understanding of how spirit-children are perceived as causes of illnesses. They are believed to cause blindness to their hosts. For the Krachi, spirit-children represent evil forces and the medium through which evil forces operate. As a medium therefore, the evil forces attack the society through nocturnal activities. A medium through which the malevolent attacks of the spirit-child is brought under control, if it is proven to be 'true' via rigorous consultation at the shrines, is by killing them. The fear of death seems to be the greatest factor accounting for the killing of spirit-children. The Krachi fear that the existence of spirit-children can lead to deaths of close relatives through illnesses and accidents. Their conduct must therefore be monitored closely. A respondent captured it aptly: 'kill them first before they kill you'. This idea is so engrained

³⁵ Interview with AKAP (Anonymous), Kete-Krachi, 6th January, 2021.

that, upon realisation of the status of their children as spirit-children, through the diviner, parents would try to murder their children before they grow up.

Children born with special needs are often sent to Krachi Dente to foretell their future and prescribe the necessary actions. Rituals may be conducted to convert such children back to normalcy. It is believed that malevolent spirits can convert normal children into spirits. It is against this reasoning that priests/healers convert them back to normalcy. Priests visit members of the communities from time to time, with the intention to identify and redeem/rectify children who are about to be converted into spirits. The perception that when children are born, evil spirits possess them, and take their good destinies away, seems to be commonly held among the Krachi people. It is important to indicate that, although priests of Dente foretell the fate of children, the execution of such children solely depends on other traditional priests, whose duty it is to kill children with some specific deformities.³⁶ For example, the executioner priests in Kadantwe are not Dente priests. Although it has been argued that priests of Dente do not execute such children, the priests in Abujuro held a contrary opinion. They argued that for illnesses that are caused by spirits and are non-reversible, priests of Dente may send their *okyeame* (executioner) to ‘return’ spirit-children to the bush, from where they came. The expression: *ale ya sun okpa*, “we are seeing [it] off [back into the bush]” justifies how the Krachi people do not consider the act as killing. In seeing them off, only the family and the ritual experts are informed. This is done in secrecy. Individuals fear to execute such children, but priests are called on to do so because shrines cannot be pursued by spirits.³⁷

³⁶ Presently, Kadantwe, a division of Krachi, is known for ‘eliminating’ such children.

³⁷ Focus group discussion in the house of priest of Dente, Kete-Krachi, March 25th, 2021.

Different mechanisms are engaged in the killing of the spirit-child. A noxious concoction is force-fed the spirit-child. Killing such children, as noted earlier, requires a spiritual approach. Nonetheless, such approaches may be combined with physical force if spiritual approaches are believed to be deficient. The belief that the execution of spirit-children requires strong spiritual office holders is particularly seen during their burial. There are four modes of burying spirit-children. First burial of the corpse; second is burying the affected alive. The third, is burying living spirit-children together with the executioner/priest. As a respondent indicated, ‘sometimes, some spirit-children are so powerful that, it may require the burial of both the spirit-child, and the presiding priest’. Although the two are buried together, it is believed that as a result of the power of the priest, he would disappear from the grave and return home, where he undergoes some mandatory ritual bath. Finally, burying an effigy as a ‘true’ representation of the spirit-child.³⁸

Although spirit-children are usually killed at a tender age, there have been reports of some ‘spirit-children’ killed when they were adults. This is the case when their status as spirit-children was not detected early. The Krachi believe that ‘spirit-children’ are smart and may hide their malevolent acts, making it difficult for early detection by parents.³⁹ Spirit children are not given befitting burials. Their deaths are often not announced.⁴⁰ Women are not supposed to attend the killing rituals of spirit-children. The belief is that by so doing,

³⁸ Ibid.

³⁹ Interview with Nana Kofi Donkor Gyinae, Former Non-Formal Director of Sene District, at Kadantwe, Krachi West District, 28th October, 2020.

⁴⁰ Parents respond to greetings and indicate that their wards – spirit-children are asleep.

defaulting women would give birth to spirit-children. In some instances, the parents of the child are banned from following to the ritual grounds.

The Krachi West Municipal Assembly has a Disability Unit under the Social Welfare Department, but a few families know of its existence. The unit is resourced from the Municipal Assembly's Common Fund. In some instances, however, the social and religious interpretations given to children/people suffering from disabilities make it difficult for their families to consult the Assembly for assistance. Families may be ridiculed for keeping such individuals.

3.7.4 Twins and divinities among the Krachi people

In the past, twins (*mbrabi*, pl.) were believed to possess some special powers that could bring calamities to homes. Thus, parents had to get rid of them after their birth. Twins were therefore dumped in rivers. The strong relationship that the Krachi have with the Ada people is traced to twins and taboos among the Krachi people. The Ada people who traded in salt with Salaga through the Volta River often came across twins and rescued them. Such twins were brought up and incorporated into the Ada state. Before the Volta River, Krachi had key places at Ope where they embarked on certain customary practices. For instance, the *Nta (mbrabi) kofori* (twin rock), was where twins were sacrificed, while the *agyina kofori* was the flat rock at Ope reserved for cabinet meetings composed of the Dente priests and the heads of clans. It is believed that the *dabogna*, a noise produced at about 12 O'clock noon at Ope (submerged by the Volta River), is associated with certain spirits. To date, rituals are performed to the Volta River by the Frao priest as a result of its ritual

significance.⁴¹ As would be indicated in chapter four, twins were so revered among the Krachi that a special day known as *kabrabi* was set aside for their worship.

3.8 The concept of health: The Krachi perspective

According to Ademuwagun (1978), *alafia*, which translates as ‘peace’ is the Yoruba generic concept for ‘health’. *Alafia* embraces the totality of the individual, whether physical, social, spiritual, and psychological well-being in his or her total environment. To the Yoruba therefore, to be healthy means to possess *alafia* which results from the dynamic interaction of all these variables. The word *al-afiya* is a Hausa word that was borrowed into some northern Ghanaian languages such as Nawuri (*alenfia*), Dagbani (*alaafé*) and Likpakpaln (*lafé*).

The Krachi concept of health is not completely dissimilar from the Yoruba example. The Krachi concept, *kialin*, is synonymous with the Arabic, Yoruba, and Hausa concepts, *al-afiyah*, *alafia* and *lafiya* respectively. *Kialin* is derived from two terms, *kia* (leg) and *lin* (strength). For the Krachi, when people are ill, they may not be able to stand on their feet or walk. The ability of an individual to stand on his/her feet therefore implies ‘strength’ or ‘sound health’. *Kialin* is the generic concept of health and well-being among the Krachi people which can be obtained through the performance of libation, prayers, respect, leisure, and the consumption of medicinal products. In furtherance, shrines are consulted to receive

⁴¹ Interview with Nana Kofi Donkor Gyinae, Former Non-Formal Education Director of Sene District, Kadantwe, Krachi West District, 28th October, 2020.

alafia. Shrines serve as intermediaries between the Supreme Being and humans. It is in view of this that the Krachi people ‘send’ their deities to *Wuruboare* to plead for long life.

The Krachi believe in two streams of life appropriately termed as *nkpe danbrase* and *nkpe*. The former refers to life that is wealthy and healthy, while the latter refers to life that is needed to keep the individual alive or provide ‘breath of life’. Prayers are made to request for *nkpe danbrase* which is also composed of bodily strength. In Krachi tradition, like any other, bodily strength is needed for production. It is here that the link between health and mode of production can be found. Food production requires good health to till the land. On the contrary, the absence of good health (ill-health), in the view of the Krachi people, can result in low productivity. It is against this backdrop that during greetings, the Krachi tries to find out the health of their neighbours. The expression, *ndi me kiba si* in Krachi/Kaakye, which translates literally as ‘I slept on my hand’ implies ‘sleeping on an empty stomach’. Hunger implies the absence of *kialin*. Although the Krachi pray for life (*nkpe*) in general – the one that is required for a living – their prayers often emphasise *nkpe danbrase*. Poor harvest, drought, illnesses, to state a few, are signs of the absence of *kialin*.

Kialin is also clearly demonstrated in ‘reproductivity’. The number of children born in a year are considered in the determination of health and well-being. This confirms Owoahene-Acheampong’s (1998) view of a relationship between *reproductivity* and health in Third World nations. It is believed that *kialin* can be affected through the evil machinations of witches, sorcerers, and magic.

The concept of health is also demonstrated in ritual performances during the celebration of Dente festival, *Akwammoo Nanaba*. The first is *kyenla-potipoti* (literally, rituals associated

with *Parinari curatellifolia*), which is conducted from September to December, during which traditional heads, including village chiefs and traditional priests (*akomfo*), are expected to fast. *Parinari curatellifolia* is common in the path leading to the Dente shrine. The second ceremony, *Nanaba*, involves the clearing of the paths leading to the Dente shrine. During the festival, the concept of *kialin* is expressed in rituals of libation as captured by Kumah (1969) as follows:

Nana Amawu Lente, ..., today is your yearly feast of “Kubun Kowe”. ...
We beg for long life, ... good luck and prosperity.

Women and children, we beg for their long life, [and]... good luck; You are implored to protect fertile and pregnant women who should not suffer deaths in child births.

We invoke your benediction to protect us from all serpents, animals and pests destroying our crops, including carnivorous animals, reptiles, and transgressors whom we ask you to suppress and break their adversaries.

Accidental deaths, deadly diseases, misfortunes and shooting one another by accidents, should be controlled and let such incidents be quenched with water (Kumah, 1969, pp. 30-31).

The above incantations illustrate the vitality of life to the Krachi people predicated on ‘well-being’. It highlights the role of the supernatural in healing. As noted, long and good life, prosperity, luck, and protection are critical components of human life. The concept of *kialin*, as pointed out, is made up of a multiplicity of factors. The vitality of life among the Krachi people is also premised on food security; hence, the need to solicit protection from Dente. It is in view of this that animals and pests that threaten production are prayed against. Similarly, dangerous reptiles like snakes are prayed against in libations. Further, the ability of Dente to intercede in accident-related deaths, and the outbreak of deadly diseases is highlighted during libation. Life-threatening challenges such as accidents,

diseases, and other forms of misfortunes such as murder are brought before Dente for intervention.

The Krachi do not speak of good health when there is no continuity of life. Children are essential agents for social continuity, and the cry of newborn babies is symbolic of that continuity. This conviction is carried in the request for children and their concomitant protection during libation. It is not surprising, therefore, that people consult the Dente deity for children and healing. The promise of maximum protection from Dente and other deities culminates in the turning upside down of a calabash, symbolising the sealing of evil spirits in that year (Kumah, 1966, p. 32). It is when the needs of society – social, religious, economic – are met that the Krachi speak of *kialin*, a term which is synonymous with ‘health’ or ‘well-being’.

3.8.1 Krachi perspectives on the concept of illness

This study has earlier noted Helman’s (1981) view about illnesses which include experiences and interpretations of people concerning conditions and signs from the perspective of society. Indeed, views of the Krachi people regarding illnesses are essential in their conceptualisation of illnesses. The Krachi people explain misfortune in many ways. While diviners, priests and other ritual entities are responsible for explaining illnesses, individuals who are afflicted also do so. Illnesses are discussed everywhere, in the homes, at meetings, at prayers and other social events when people meet to share their life experiences. The layperson’s perspective of illnesses constitutes a critical point which feeds into health- or treatment-seeking behaviour. The term *kulɔ* in *Kaakye* (language of

the Krachi people) means, illness, a concept which is difficult to segregate from ‘disease’. For that reason, when yam seedlings are attacked by diseases, the Krachi say that the seedlings are ‘sick’.

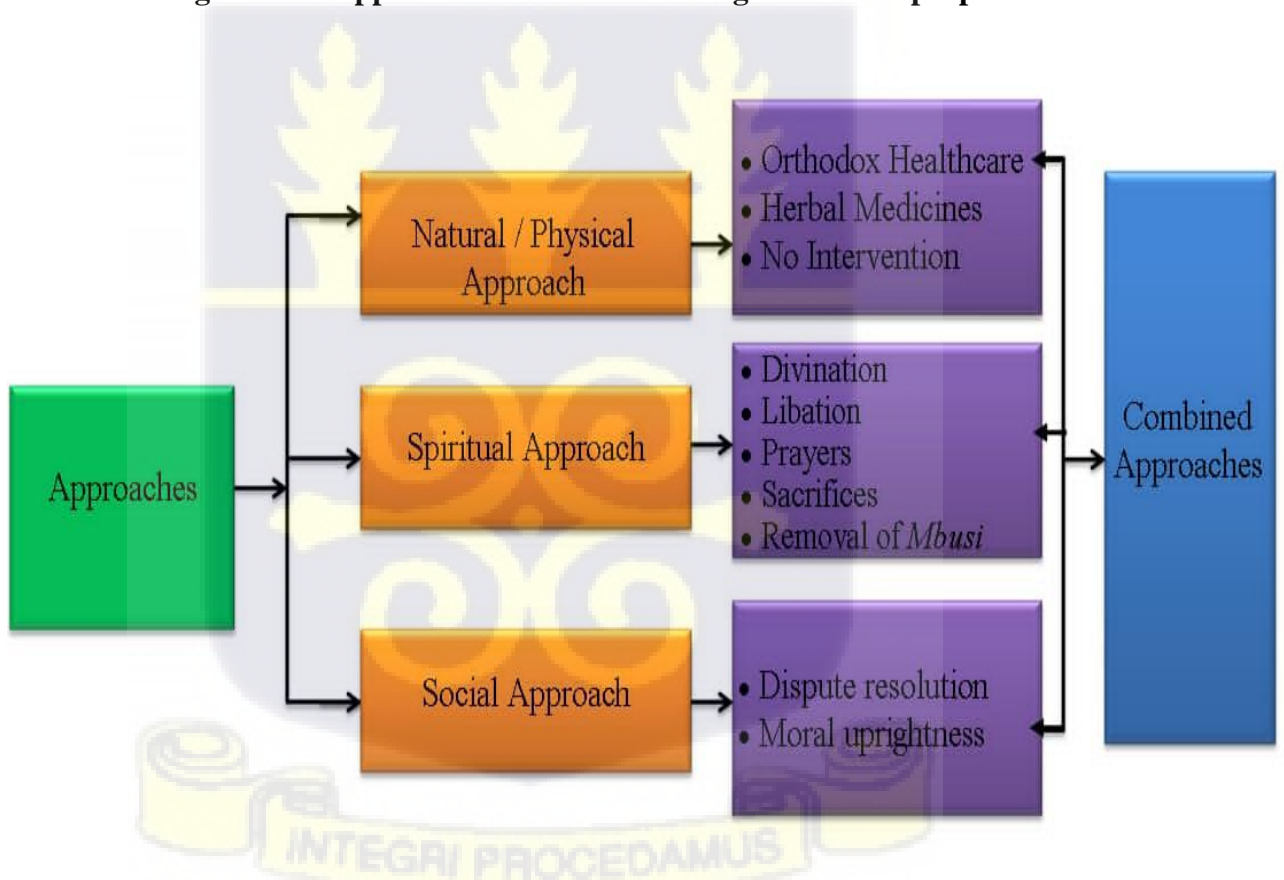
Illnesses among the Krachi are largely categorised into four: *afu kulɔ/sunsuntor kulɔ/afu bɔin* (spiritual illness), *kulɔ gyiga* (normal/physical illness), *kra kulɔ* (soul illness), and *kananatɔ kulɔ* (inherited illness). Such a classification requires different approaches to deal with illnesses (see fig. 3.1). As indicated in figure 3.1, physicians and herbalists are consulted to combat physical and/or natural illnesses. In some instances, physical and natural illnesses may require no intervention. Physical illnesses may be sent to the herbalist (*odunsini*); nonetheless, priests can also examine for illnesses, tell their aetiologies and also prescribe remedy. It is from this point that some cases may be referred to the hospital. Physical illnesses are believed to be surmountable by individuals themselves, while spiritual- and soul-related illnesses are believed to be combated with the help of a spiritualist. In some instances, however, soul-related illnesses are believed to be unsurmountable.⁴² In that regard, such illnesses, considered as ‘spiritual’, cannot therefore be healed.

The third category of illnesses, *kra kulɔ*, is tied with the concept of the ‘destiny’ which can be healed through spiritual means. These spiritual approaches of mitigating illnesses include prayers, libation, divination, sacrifices, and removing of impending calamities referred to by the Krachi as *mbusi*. Priests go into the spiritual realm to determine causes of illnesses. Illnesses may be associated with people or offense against shrines and

⁴² Interview with Nana Kwame Owusu, retired educationist, chief and Odikro of Kwakuae, 29th October, 2020.

ancestors. Such circumstances also call for a search for spiritual solutions. However, some illnesses are believed to be mobile or suspended in the air for which they are referred to as *afu bɔin* or *nframa bɔni* ('bad wind') in Krachi and Akan respectively. These winds are also viewed as spiritual, such as those associated with *sasabosam* (a spirit often believed to move with heavy wind). Winds associated with spirits are considered as dangerous and cause illnesses to people who encounter it. Illnesses may also be associated with stealing. For instance, farmers 'trap' their crops with charms (See figure 3.2).

Figure 3.1.: Approaches to illnesses among the Krachi people



Source: Author's creation, 2022.

Because illnesses are believed to attack individuals through social breaches, the Krachi resolve disputes between the parties involved, and encourage members of society to be morally upright to facilitate healing or to avoid illnesses. These approaches are, however, not discrete. Although a diviner may confirm the spiritual causes of illnesses, physical approaches may be engaged in the process of healing. Similarly, although an illness may be said to be physical, a patient may be asked to live at peace with persons he/she fought. This illustrates a combined approach in traditional healthcare. As indicated earlier in this study, *kananatɔ kulɔ* – illness suffered by biological parents or some other persons with whom the sufferer is related – is combated through spiritual means.



Figure 3.2: Amulet tied around a coconut tree believed to cause illnesses to people who steal coconut fruits from it. Photograph taken by the researcher at Nteususae. 29th October, 2020.

3.8.2 Illness terminologies and perceptions in Kaakye

Like many Ghanaian societies, several illnesses affect the Krachi people. A discussion of these illness terminologies, from historical and contemporary perspectives, is essential as such terms can influence health choices. Examples of illnesses that affected the Krachi people in the past are *sankyunkpa* (measles) and *gyatɔ* (scabies/the ‘Job syndrome’). Itching and pimple-like rashes caused by mites are symptoms of scabies. Signs of measles identified on the field on the other hand include sore mouths and other body parts, and a reddish mouth. Scabies – a communicable disease – was considered so abominable that its treatment was conducted in the bush.⁴³ Apart from the perception that the disease was communicable, treatment of scabies was conducted in the bush because it is believed to be the abodes of demonic spirits.

Apart from measles and scabies, *kwataa* (leprosy), also referred to as *kulɔpipɛ* was a major illness in the Kete-Krachi area, particularly communities along the Volta River. *Kulɔpipɛ* translates as ‘red illness’ since the lips and other body parts of lepers become reddish. The Krachi people consulted the Dente to curb these diseases.⁴⁴ The cause of leprosy was attributed to the bad deeds of victims. This perception has implications for treatment of lepers in society. Society seldom cares for individuals whose suffering is attributed to their bad behaviour.

Common illnesses among the Krachi people in contemporary time include: *susu* (convulsion/fainting fits), *ɔgyɔn-ɔwursu* (tuberculosis), and *akyana* (chicken pox). *Susu*

⁴³ People suffering from scabies developed sores all over their bodies.

⁴⁴ Interview granted by J.B. Donkor, retired registrar, Krachi Traditional Council, Kete-Krachi. 8th August, 2022.

means ‘up/space’. Literally, the illness is believed to be suspending in space and is therefore given spiritual interpretations. The cause of convulsion is attributed to old men who, they believe, occasionally cause the illness to attack children by conducting rituals at a crossroad or at a place where children normally play. These old men are traditional healers believed to possess the cure to the illness. It is therefore believed that those old men cast the illness on children in order to later cure them for money, fowls and other items.

The name or term *ɔgyɔn-ɔwursu* (tuberculosis), is used to describe the manner in which patients suffering from tuberculosis squat on animal skins (mats) to cough. Although spiritual interpretations are not ascribed tuberculosis, it is generally held that the illness can easily kill patients if necessary steps are not taken by healers to combat it. *Akyana* on the other hand means ‘communicable’ or ‘infectious disease’, characteristic of chicken pox. Largely, communicable diseases may be associated with offense committed by society. It is believed that when the offense is not detected and brought under control, it may affect the larger society. In this context, infected individuals are believed to be associated with the offense committed in the society. Other illnesses include: *Ikpobia* (anthrax)⁴⁵, a term derived from ‘swollenness’. Inexplicable cause of swells is feared as it may be ascribed to evil forces. As noted in chapter three, swells involving all body parts are usually attributed to evil machination.

The Krachi people believe that anthrax is caused by insects in the bush. The bush, as noted earlier, symbolises abodes of evil forces. Anthrax is also referred to as *tuuma* in Kaakye. The term *tuuma* means ‘shot’ by an evil force or a sorcerer. Anthrax is likened to boils

⁴⁵ Anthrax is a communicable disease common in animals, but it can affect humans too. In humans, the disease is believed to attack any part of the body, sometimes in the throat, which for the Krachi is considered dangerous as the victim finds it difficult to eat food.

which may affect the throat. It is believed to be hidden in the head of patients, rendering treatment difficult. *Tuuma* is believed to appear on the head of victims after death. These explanations reflect the spiritual perceptions for anthrax.

Other illnesses are *asram* (marasmus) and *afokyu* ('high fever').⁴⁶ The latter illness is believed to be characterised by aggressiveness, restlessness, incoherent speech, and lack of cooperation of patients in the treatment process, which may be attributed to malevolent spirits. *Afokyu* may be likened to mental illness. Patients suffering from *afokyu* are usually sent to the Fofie shrine for healing since such patients exhibit signs of mental problems.

Kipri (prolapse rectum) is believed to be common in children, although this may occur in older people. Prolapse rectum is the protrusion of the mucous membrane (lining) of the rectum (lower part of the large intestines) outside the anus (Beers, Fletcher, Jones, Porter, & Berkwits, 2004). *Kpanti* (haemorrhoids/piles) was mentioned as a major illness among the Krachi people. Though *kipri* may affect adults, it is generally believed by the Krachi people that the condition is prevalent in children. Haemorrhoids/piles refers to swollen and twisted veins inside the rectum or around the anus. Haemorrhoids usually affect people between the ages of 45-65 years. Nevertheless, haemorrhoids can affect early stage adults (Beers, et. al., 2004). Piles is believed to affect a man's ability to have sexual intercourse.

In the past, *dawu* (hernia)⁴⁷ was believed to be life-long condition until the introduction of orthodox healthcare. Indeed, the name *dawu* is derived from the Akan words *da* (sleep) and *wu* (die) or *owuo* (death). The term *da* may be used to refer to death. The Krachi people

⁴⁶ Interview with Mr. Matthew Obimpeh Donkor, GILLBT officer, Kete-Krachi, 8th August, 2022.

⁴⁷ Hernia is the protrusion of a part of a structure or an organ through an abnormal opening in the walls of the cavity containing it.

therefore believe that hernia disappears from individuals only after death. This points to the Krachi understanding that hernia cannot be cured. The belief that hernia is incurable cannot completely be out of place, particularly with reference to scrotal hernia. It is believed, for instance, that scrotal hernia cannot be completely cured as it may recur after surgery (Kukleta, 2006).

Other illnesses in the area are *nyema* (anal wounds), *kametɔɔ* (stomachache or ulcer) and *kikpinkpin* (epilepsy). Sugar is believed to be the cause of *nyema* which is thought to spread in affected victims. Diabetes is associated with the concept of the ‘big man’ (‘the haves’). It is believed that those who are well to do suffer from diabetes. Respondents indicated that diabetes is associated with urban dwellers. Urban dwellers are perceived as people who can afford varied (sugary) foods that account for their vulnerability to the illness. For a few respondents, diabetes is communicable and urban dwellers are believed to have introduced the illness to the Kete-Krachi area.⁴⁸

The belief that illnesses can be ‘closed’ in shrines is held by the Krachi too. The use of deities to prevent the occurrence or recurrence of illnesses is described as *alɔgyi kitii* (“closure of illnesses”). Viral diseases “closed” in the Dente shrine(s) include HIV/AIDS, Ebola, and COVID-19. Multiple deities may be consulted to “close” illnesses because of the general fear that wicked people may “open” them. Powerful deities at different places may thus be consulted to “close” illnesses. This, it is believed, renders it difficult for evil minded individuals to “open” them. The term – *alɔgyi-kibuki* describes the “opening of illnesses” by malevolent spirits or individuals to attack members of society or specific

⁴⁸ Interviews by J.B. Donkor, retired registrar, Krachi Traditional Council and Mr. Matthew Obimpeh Donkor, GILLBT officer, Kete-Krachi, 8th August, 2022.

targets. When asked why they wore nose masks when the deities were petitioned to protect the town, respondents associated it to the fear of punishment by the government. However, a few individuals were adamant to wear the nose mask because they felt that the disease had been “closed” in the shrines. It is necessary to also consider the aetiology of illnesses (witchcraft, magic and sorcery, and *mbusi*) from the Krachi perspective.

3.8.3 The concept of *kakpe* (witchcraft), sorcery and illnesses among the Krachi

Witchcraft was a common phenomenon in the Gold Coast (PRAAD/GH/CSO.21/1/202). A brief insight into the concept of witchcraft will aid understanding. Witchcraft is a psychic act. Evans-Pritchard (1937) notes that the Azande of Central Africa believe that witchcraft is a substance in the bodies of witches. Witchcraft is a spiritual force which is rooted in antiquity. In the perspective of the Krachi, witchcraft is a malevolent force which is used to ‘spoil’ people in diverse ways, including causing illnesses and death. It is a common belief that witches cannot be seen physically with the naked eye. The popular expression, “it takes a witch to determine another,” points to the spiritual nature of witchcraft. As noted by Sarpong (2002, p.101), it is believed in Ghana that a witch can only bewitch a relative. Witches are believed to change their sexes in the spiritual realm, making it difficult for them to be easily identified spiritually. It is believed that anybody can become a witch, especially those with weak spirits. Witchcraft may also be given to those who are interested in the practice. Although this assertion is held among the Krachi people, it is believed that witchcraft can be given to people against their wish. It is important also to note that sometimes people may not request it, but they acquire it through friends unnoticed. Among

the Krachi, it is believed that witches give out their spirits to their friends as a sign of appreciation. Thus, *kakpe* can be put into food and when one consumes it, he or she becomes a witch. Apart from this, it is believed that witchcraft can be hidden in someone's clothing, which, when worn possesses the wearer. Although it is believed among the Krachi that people can request to become witches, they believe that witchcraft is hereditary, which makes it possible to be passed on along family lines. Here, the head of the family is regarded as owner of the spirit, which may be used to protect the family, via provision of good health, wealth, or otherwise. Thus, when family heads or individuals are about to die, they transfer the craft to their loved ones. The spirit is often given to the next of kin or those who respect them.

The familial inheritance of witchcraft is confirmed by Sarpong (2002, p.2) among the Asante who believe that a witch can automatically pass on the craft to his or her children. It is believed that people go for the spirit to strengthen their authority and also speak with power. From that perspective, witchcraft bolsters the political institution. As indicated previously, witchcraft among the Krachi can be used for good or evil. It is in this view that the Krachi divide witchcraft into *kakpe tima* and *kakpe boin*, good and bad witchcraft, respectively.⁴⁹ Hunters are believed to use the *kakpe tima* medicine for protection and successful hunting.

In Kete-Krachi, women are accused of witchcraft because they are believed to be weak spiritually. Their weakness therefore makes it possible for the spirits to possess them. Given this conception, the Krachi view bodies of women as spiritual hosts. Witches are

⁴⁹ Interview with Nana Kwame Owusu, retired educationist, chief and *Odikro* of Kwakuae. Kwakuae, Kete-Krachi. 7th January, 2021.

often accused by the priests of shrines such as Tigare and Konde. Such priests are believed to arrest witches spiritually.

Witches are believed to be a source of ill-health or good health. They are believed to cause spiritual illnesses, popularly referred to in Akan as *sunsum yadie*. Sarpong notes that witches are believed to inflict harm through death, sterility, sickness, and misfortune in businesses. Specifically, among the Asante, witches are believed to draw the blood of their victims until they die (Sarpong, 2002, p.2). From the perspective of the Krachi, illnesses caused by witches cannot be healed by a physician. This belief justifies the use of traditional mechanisms of healthcare, encompassing consultation of witchdoctors and shrines/priests. Witches are also believed to use their nocturnal misadventures to cause infertility to both men and women. Infertility among the Krachi is frowned upon. In view of this, the Krachi people go an extra mile to overturn such conditions in the shrines. The reality of the belief in witchcraft is that it affects health-seeking behaviour. People are unwilling to visit the hospitals anytime they suspect that their illnesses are spiritually caused. For instance, during the field research, some of the patients disclosed that the cause of their affliction was revealed to them in dreams, leading to an open confrontation with the accused witches. Their illnesses were thus blamed on witches. It is as a result of this that priests and priestesses are consulted to find lasting cures to their illnesses. It is when this approach fails that they visit the hospital. References to witchcraft as a cause of illness shall be made in chapter five.

The concept of sorcery has already been briefly alluded to in the conceptualisation of health. Unlike witchcraft, sorcery and magic are based on learnt techniques. Sorcery (black magic) is believed to harm people. The magician is believed to charge an effigy with certain

powers that may improve on the lives of people. This is similar to what Sarpong describes as magic among the Asante, where a magician would take a needle and bread and mention the name of someone and say, "... may she develop stomach cancer" or "... may she have a fertile womb when she eats it". When magic is used for evil intent, it is called "sorcery" (Sarpong, 2002). For instance, it is believed among the Krachi that a sorcerer could use an effigy, representing someone, to cause blindness to him or her by piercing the 'eyes' with a needle. The Krachi people believe that sorcerers can charm people with their effigies to become unconscious. Sorcerers are also believed to cause illnesses and death to people. It is for this reason that during treatment of some patients, some consultations may be made with the diviner to discover the cause.

Closely tied with the concept of sorcery is the Krachi concept of *atukpe/tukpe*. *Tukpoe*, one of the Ewe originated forms of magic, is referred literally to 'a short gun' (Gavua, 2000, p.92).⁵⁰ Questions pertaining to the concept of *atukpe* (a corruption of *tukpoe*) elicited interesting responses among the Krachi. For the Krachi, *atukpe* is feared, and is believed to be 'fired' by an enemy or adversary. Sometimes, the rival may have had a grudge with someone for which reason the *atukpe* has been 'fired'. This concept was clearly alluded to by Mr. J.B. Donkor, my host at Kete-Krachi who indicated that a Dagomba chief from Yendi fired one of the *atukpe* to a Krachi chief. The effect of the *atukpe* was a prolonged infirmity suffered by the Krachi chief. *Atukpe* can thus be used to distinguish powerful traditional political office holders from the less powerful ones. The general perception for

⁵⁰ Knowledge about the efficacy of the *tukpoe* is also common among the Akyem Abuakwa. It is said that this form of magic is normally placed under people's farms to shoot various sharp objects into the bodies of victims who trespass the farmland. Victims of *tukpoe* among the Akyem Abuakwa are usually sent to a suman shrine where the skin of the patient is cut and a magical medicine – often blended with alcohol and herbs – is put into the wound. Priests may also suck out magical objects including pieces of glasses and other sharp nails or keys (Ishii, 2005, p. 276) from the bodies of victims.

atukpe as an illness-causative agent cannot be overemphasised. For the Krachi, when the *atukpe* is shot, the victim may hear a sound or a burning sensation at the targeted spot. This immediately causes severe pain needing urgent attention of traditional healers. There is the general belief among the Krachi that *atukpe* is highly spiritual which may be different from the medicines which are usually buried in the ground or on the farm.

3.8.4 The concept of *mbusi* (impending calamity) and healing among the Krachi

Mbusi (in Kaakye) is a corruption of the Akan term, *mmusuo*. In tracing the etymology of *mmusuo* in Akan, Nsiire and Prempeh (2019, p. 6) have noted its relationship with *busude* ('a wicked thing') and *busufo*, wicked individuals or people. They also relate the concept to *abusua*, the lineage. This last relationship is significant in the Krachi perspective of *mbusi*. *Mmusuo* has been defined by Christaller as 'mischief, misfortune, disaster, misery, calamity, and adversity' (Christaller, 1933, p. 323), while Gyekye (1995, p. 133) views it as 'extraordinary moral evil'. Similarly, in Kete-Krachi, *mbusi* refers to an impending calamity (illnesses, diseases, accidents, and death, to state a few) resulting from human behaviour. It is believed that *mbusi* can haunt individuals or society when it is not detected and brought swiftly under control. This brings deleterious consequences on society, leading to human suffering such as ill-health. Terminal illnesses may, therefore, be blamed on the misconduct of relatives. When *mbusi* is broken, individuals must confess for the performance of some rituals. It is believed that *mbusi* is transferrable, making it a general suffering. It is due to this fear that rituals are conducted among the Krachi to prevent human suffering. Breaking *mbusi* is regarded as a grievous offense. Thus, when someone dies as

a result of *mbusi*, children are not named after that deceased person, to avert any pending curse.

Mbusi among the Krachi is categorised into two; lineage and shrine related *mbusi*. The former is subdivided into the *ɔsae* (patrilineal) and *enyae* (matrilineal) *mbusi*. The patrilineal nature of the Krachi compels them to view the *ɔsae* (patrilineal) *mbusi* as more dangerous. It is believed that the *enyae mbusi* – though generally feared – cannot have much effect on individuals compared to the *ɔsae mbusi*. In both cases, respect is critical in preventing individuals from committing the lineage *mbusi*. Insults of one's parents are regarded as *mbusi*, with dangerous impending consequences on the perpetrator. Although the *enyae mbusi* are often not considered too grievous compared to the *ɔsae mbusi*, the Krachi believe that they can affect individuals greatly. The Krachi are also customarily required to respect the elders (*abilisa*) in order not to commit *mbusi*. The second category, shrine-related *mbusi* – referred to in Krachi as *okisi mbusi*, are also considered to be dangerous and can affect society greatly. When individuals solicit the help of shrines in moments of bareness or ill-health, they are expected to follow the rules strictly. Children born as a result of intercession of deities are referred to as *Okisi-migy*. Even when such children commit adultery, they are clad in *nyura fufuri*, a white calico cloth, as a sign of purification.





Figure 3.3: A ritual bowl at a crossroad to combat impending calamity (*mbusi*). Photograph taken by the researcher at Osromane Motodua, 7th April, 2021.

As indicated, individuals' health is associated with *mbusi*. Patients' slow response to treatment may be blamed on *mbusi*. In view of this, diabetic patients are believed to have broken certain *mbusi*, whether intentionally or unintentionally, for which they are suffering. It is in view of this that rituals relating to *mbusi* are interrogated and performed during ill-health. To receive healing therefore, patients are expected to confess their crime or misbehaviour for the necessary rituals to be conducted. *Mbusi* rituals are often performed or climaxed at a crossroad with some ritual food (see figure 3.3.) believed to attract the spirits to nullify the impending disaster or illness. Slow or non-response to treatment results in referrals to powerful healers to find out whether *mbusi* has been committed by members of the society. Deities, including Dente, are crucial in the removal of *mbusi*. The ritual water from Dente that is used for the removal of *mbusi* is believed to

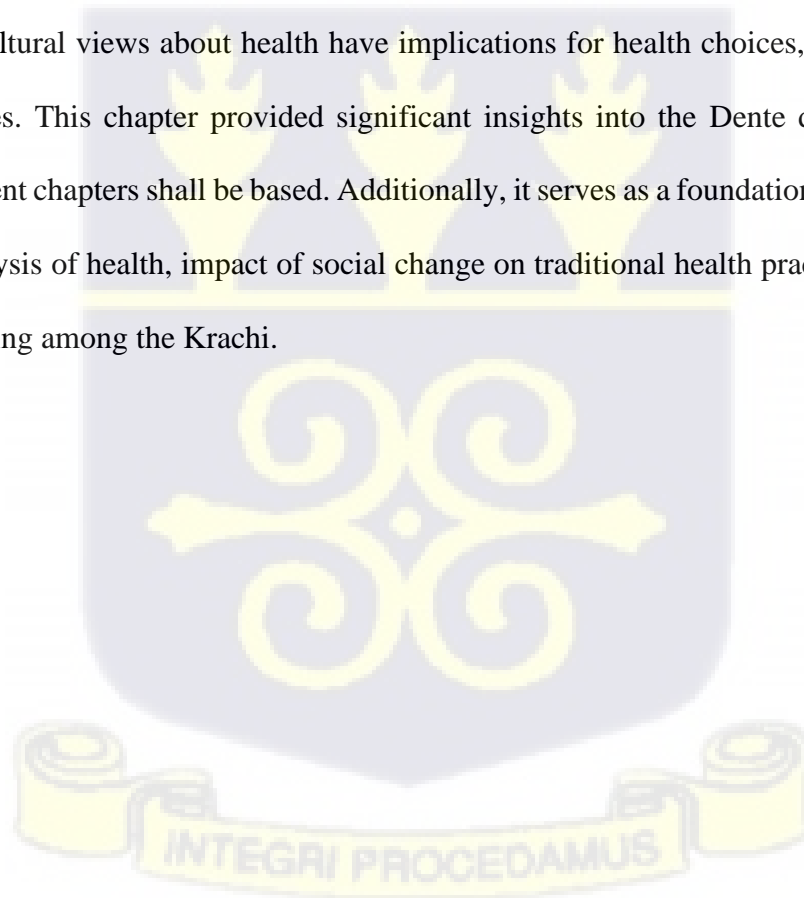
be efficacious. This spiritual water is, thus, offered patients for bathing, drinking, and sprinkling in the room and farm.

At the divisional level, there is a pantheon of divinities that are worshipped. But the one that is symbolic of the Krachi Dente is the *Kokosi*. When members of the community or division are ill, such illnesses are overturned at the *Kokosi*. Some of these illnesses are believed to be curses from the supernatural. Offences, for which individuals are ill, are therefore sent to the *Kokosi* for removal. Individuals may remove their own *mbusi* with drink or water, to state a few. Pito and palm wine can also be used in the performance of *mbusi* – whether personal or communal.

3.9 Conclusion

The chapter has presented a broad overview of Kete-Krachi, highlighting the pre-colonial, colonial (with much reference to German colonialism), and some insights into contemporary Kete-Krachi. These discussions are crucial in understanding shrines and healing. Towns which hitherto were under Kete-Krachi introduced the Krachi Dente shrine in their respective jurisdictions. These subsidiary shrines and their roles in healing shall be dealt with in chapter five. The horticultural scheme instituted by the Germans has improved the environment in Kete-Krachi. Trees such as neem, teak, mangoes, and cotton are still visible in the area today. These trees (especially neem and mahogany) are significant in the traditional healing system, as priests and priestesses make use of teak and neem trees during healing.

Health issues are woven into social systems and therefore require critical social interpretations. Health from the perspective of the Krachi people is complex, making it possible to include economic, social, and religious issues. Conceptualisation of the individual from a social perspective is critical in the understanding of health and well-being. The concept of ‘personhood’ is, therefore, tied with treatments, rights, and privileges that individuals enjoy as a member of society. The chapter drew attention to illness terminologies and conceptions in Kaakye. These conceptions about illnesses can inform health choices. The concept of witchcraft, magic, sorcery and *mbusi* also shape and enhances the understanding of the social and religious context of health. These social/cultural views about health have implications for health choices, including the use of shrines. This chapter provided significant insights into the Dente deity, upon which subsequent chapters shall be based. Additionally, it serves as a foundation for interpretation and analysis of health, impact of social change on traditional health practices, and shrines and healing among the Krachi.



CHAPTER FOUR

THE DENTE SHRINE

4.1 Introduction

The Kete-Krachi area, like most societies in Ghana, is characterised by several shrines. This chapter is a study of the Dente shrine. In addition, it attempts a classification of shrines in the Kete-Krachi area and delineates their uniqueness and commonalities. By doing so, it lays the foundation for understanding the interconnectivity between Dente and some principal shrines such as Frao, Kyanyiŋi, Mprah, Tano, Fofie, Bruku among others in the Kete-Krachi area. This link accounts for referral of patients from those shrines to the Dente shrine, which will be discussed in chapter five.

It is significant to note that the shrine has remained resilient, even with the influx of “foreign” shrines and religions. The Dente deity has also ‘produced’ many subsidiary deities in contemporary times that operate in the name of Dente. It is imperative to indicate that although shrines derived from Dente in recent time may not be considered as indigenous because they have a Krachi ancestry, their priests/priestesses are ethnically Krachi or have Krachi associations. To understand the Dente deity and its roles in the study area, this chapter is categorised into thematic areas. The first theme focuses on a broad classification of shrines in the Kete-Krachi area. The second theme focuses on the Krachi Dente shrine, which is connected to the next (third) theme which sheds light on shrines referred to by the Krachi people as “children of Dente”. Affiliate deities (subsidiaries of Dente) are used to heal patients sent to them by the Dente priest. The fourth theme provides an understanding of the link between Dente and other indigenous shrines such as Pɔnyɛ

and Kyanyiŋi. Dente does not exist in a vacuum, as petitioners (patients) may be sent to the rest of the indigenous shrines for healing. Dente is considered as supreme in the chain of healing. This supremacy takes the form of upward referral. There are, however, cases of downward referrals too. Due to the interconnectivity between Dente and some key indigenised deities (somehow independent of the Dente deity), the chapter discusses shrines such as Mprah, Fofie (at Krachikrom), Bruku (at Kwakuae), and Akoadehye. Terms such as “indigenous”, “indigenised” among others, have been operationalised in subsequent discussions. This chapter deepens an understanding of the interconnectivity and power dynamics between Dente and other shrines in the Kete-Krachi area.

4.2 Classification of shrines in the Kete-Krachi area

Before discussing the Krachi Dente, it is critical to give an insight into the classification of shrines in the Kete-Krachi area. The researcher identified and categorised shrines in the Kete-Krachi area under four themes, namely: indigenous, indigenised, anti-witchcraft/settler and personal shrines. The indigenous shrines category – to which Dente belongs – encompass the Chanyiŋi, Pɔnyɛ and Aterifrao (Frao). *Frao* (in Twi) refers to the name of the Volta River. The Frao priest is responsible for cleansing the river. Crossing the river with corpses is considered as a taboo which requires cleansing. Before corpses can be sent across the Volta River, a bottle of schnapps and sheep (*santi*) are used to conduct pacificatory rituals.

The indigenised shrines, on the other hand, refer to shrines that were introduced originally by settlers (some of whom are of Akan origin) and have since been adapted by the Krachi

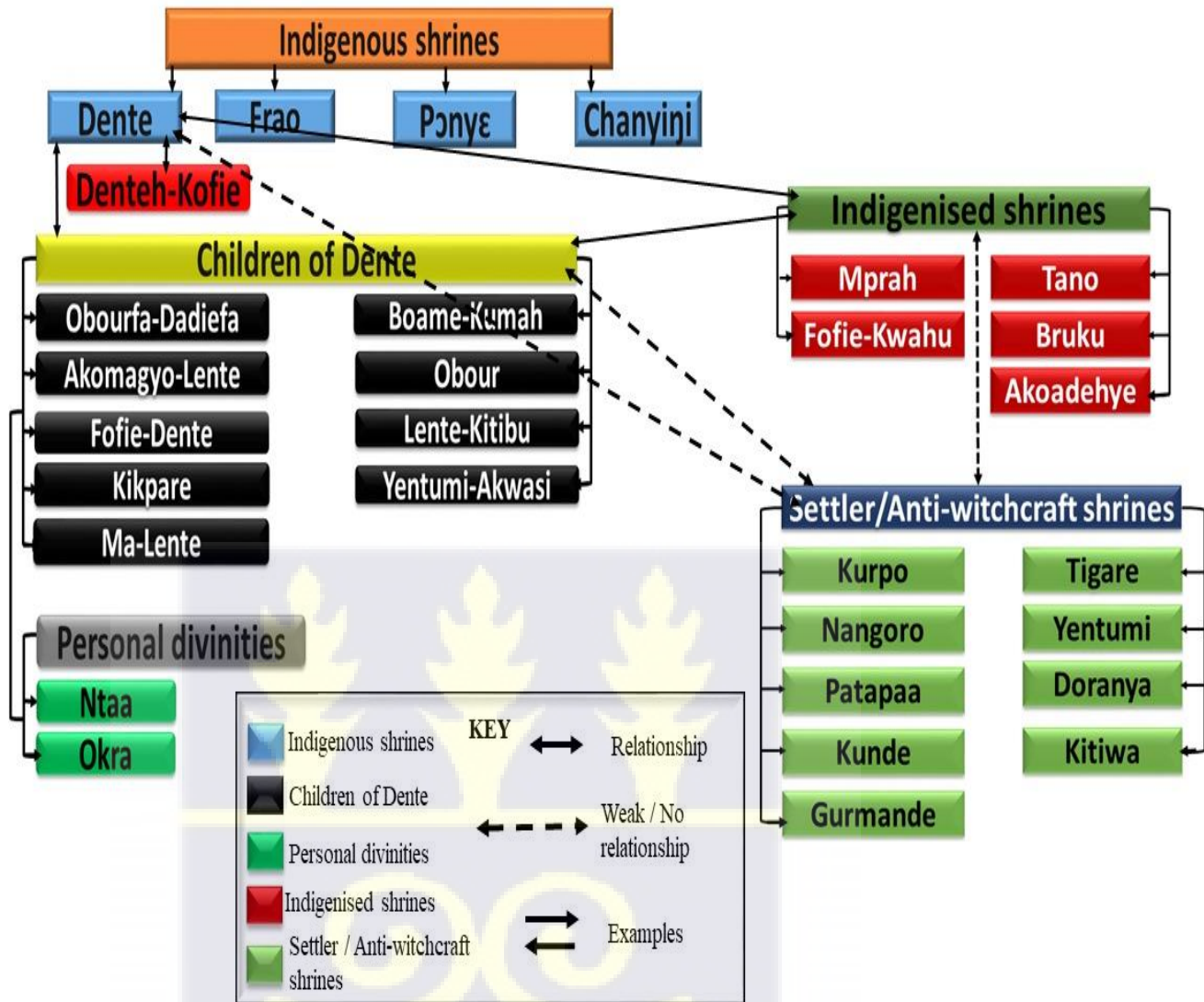
people. Indiginised shrines have different modes of operation and practices. Nevertheless, the Dente deity and the indigenised ones/shrines have some common taboos involving the consumption of monkeys and goats.

The third category of shrines – the anti-witchcraft/settler shrines – includes shrines such as Patapaa, Kurpo, Tigare, Kunde, Nangoro and Yentumi. The anti-witchcraft/settler shrines are believed to arrest witches and also neutralise their powers. Though anti-witchcraft shrines are not the focus of this study, some of the indigenised shrines perform similar functions as anti-witchcraft shrines, to which critical attention has been paid. Personal divinities, the fourth category, include the Nta and Okra, often found in the houses of individuals. Healing by these divinities requires investigation of souls of the victims.

Dente is the state shrine among the Krachi, under which are affiliate shrines referred to as “children of Dente”. Some of these shrines were spiritual objects found by individuals who came into contact with them. These spiritual objects were consequently submitted to the priest of Dente for identification and naming. Priests of Dente may also instruct their assistants to establish shrines for individuals possessed by certain spirits.

The Dente-Kofie shrine is found in all Krachi communities. The deity is regarded as a representation of Dente. Individuals consult Dente-Kofie at the divisional level, rather than the Dente deity itself. The connection between Dente and Dente-Kofie will be highlighted in subsequent discussions (see p.143). Figure 4.1 presents a summary of shrines in the Kete-Krachi area.

Figure 4.1: A diagram of shrines in the Kete-Krachi area



4.3 The Krachi Dente deity in focus

The name ‘Dente’ is believed to be a corruption of ‘Larteh’, from where the Krachi migrated to their present location. According to Nana Kofi Gyinae, an elder in Kadantwe, however, the word ‘Dente’ is derived from the Krachi expression, *belɛ fo beli fonyi kemɛɔ, ntɔfra, ɔka tɛ dada*, translated as, ‘before you were brought out of your mother’s womb, it [Dente] was already seated [present]’. The phrase *ɔka tɛ* (“already seated” or “present”)

was subsequently corrupted into “Lente”. The founding of Dente is rooted in oral tradition. According to Kumah (1964), Dente was believed to have been founded by Gyampo, a spiritual hunter, who hailed from the Ansa Worobe Abrewa lineage at Larteh-Akuapem in the Eastern Region of Ghana. He encountered the deity in a cave located in a dense grove. The spirit in that cave was believed to have transfigured into *sasabosam* (a spirit associated with the wind) and possessed Gyampo. The spirit was believed to have spiritually ‘bathed’ Gyampo with herbs. Gyampo was further given some ear and eye treatments by the spirit. These treatments were to enable him to heal, ‘see’, hear and interpret voices of the supernatural. It is not surprising, therefore, that the efficacy of Dente would be tapped for healing.

Basing his evidence on oral tradition, Kumah (1964) recounts that the original name of the Krachi Dente (Lente) shrine/deity is ‘Mente’. He further asserted that, on its founding, the Dente deity revealed to Gyampo the taboo regarding menstrual blood. It also revealed sexual prohibitions to Gyampo. Information gathered from a few respondents in Kete-Krachi, however, points to a different founder. Krachi Dente was believed to have been founded by one Mosia, a woman from the Tsoboae or Batae clan, while the Krachi were still at Larteh-Kubease. This narrative is grounded in a myth that the deity assured Mosia of a successful migration of the Krachi people from Larteh-Kubease, where they were extorted by the Akyem, as pointed out in chapter three. Mosia was also believed to have informed the rest of the Krachi people that the migration of the Krachi from Larteh-Kubease would be led by the Dente deity. Proponents of that narrative noted that women served as priestesses of the Dente deity in antiquity. They pointed out that priesthood to the Dente deity consequently shifted to the men because it was discovered later that

menstrual blood could reduce the power and efficacy of the Dente deity. This narrative is, however, problematic. For instance, it raises the question of why the Krachi did not allow post-menopausal women to occupy the priesthood of the Dente shrine.

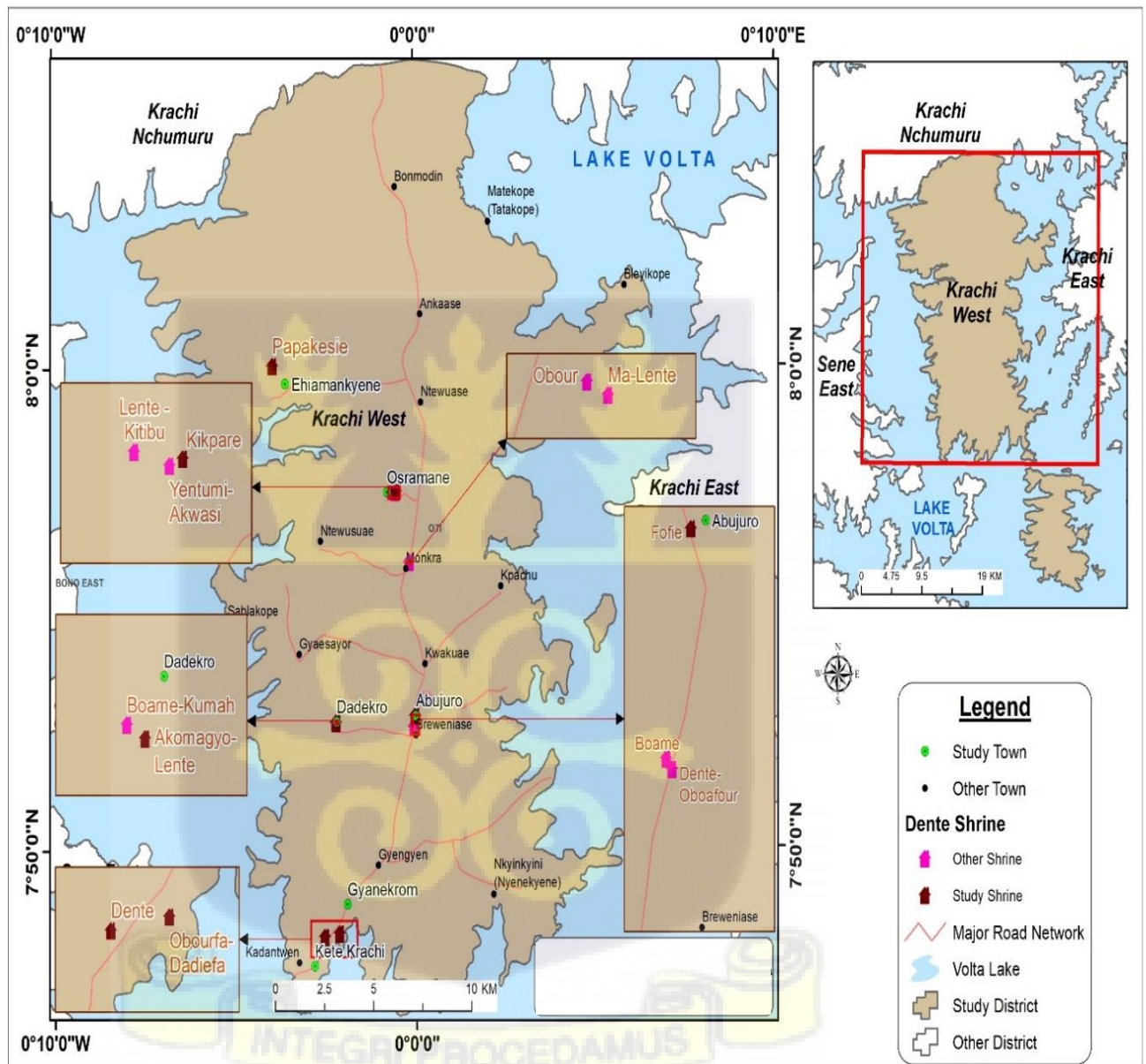
Some respondents also noted that the Krachi society is patriarchal. It was in view of this that the priesthood consequently shifted from the women to the men. Another reason given was that the women became economically powerful as people began to consult Dente for assistance. In that regard, consultation fees began to enrich the women. It was in view of this that the men 'usurped' the shrine from the women.

The Dente deity resides in a cave called 'Kofuribulawu' (the 'noisy rock'), a name associated with the noise with which the deity is believed to 'appear' during consultation. It is believed that Dente speaks, but its language, believed to be Dwan can only be interpreted by the priest. It may seem surprising that Dente does not 'speak' Kaakye but Dwan. Kaakye and Dwan are linguistically related as they both belong to the Guan language cluster. The Krachi and the Dwan had a long interaction through migration, trade, and marriage with each other.

In the past, and now, nationals from Nigeria, Togo and Benin consulted the deity to expand their businesses, among other reasons. Some of these nationals who consulted the Dente deity finally settled at Kete, which bolstered economic activities there. The Asante also sought protection and victory from Dente during wars. For instance, Nana Akuamoa Boateng I of Kwahu was believed to have solicited the intervention of Dente against his enemies in the frequent warfare at the time (Kumah, 1964, p. 5). It can be argued that by the 18th Century, Krachi Dente was established in Kwahu, Ashanti, and the Brong-Ahafo

areas. Apart from seeking protection, Dente was consulted for good health and agricultural output.

Map 2: Map showing Dente and its affiliate shrines in selected towns in the Kete-Krachi area



Source: Author's creation, 2021.

Members of society are prohibited from uttering the name of Dente in daily conversations.

It is a prohibition to invoke Dente in curses. This is regarded as provoking *mbusi*, which

requires quick ritual performance to overturn the curse. Individuals who invoke Dente in curses are fined. Other priests who attempt a ‘removal’ of such *mbusi* are also fined a cow. The perpetrator, it is believed, would suffer from prolonged illnesses. In such cases, it is only the priest of Dente who conducts necessary rituals to pacify the deity to avert the calamity.

Closely related to the Dente shrine is the Dente-Kofie shrine. The Dente-Kofie or Lente-Kofie, also known as ‘Kokosi’, is found in all Krachi communities. The Dente-Kofie deity represents Dente and is therefore not considered ‘autonomous’.⁵¹ The establishment of Dente-Kofie in Krachi communities was to facilitate access to the Krachi Dente. Although Dente-Kofie represents the Dente deity, major cases (illnesses) may be referred to Dente itself to mitigate. The Dente-Kofie deity may also be consulted to overturn impending calamity in the community. The *adikromfo* (owners of land) and the *akyeame* (assistants of priests) of Dente-Kofie take part in rituals involving the Dente deity. There are no extensive festivals devoted to the Dente-Kofie deity as these are conducted in the Dente shrine. Every three years or so, however, a thanks-giving ritual is conducted in the Krachi divisions to acknowledge the functions of the Dente-Kofie deity.⁵²

As illustrated in Figure 4.1, there is a link between the Dente and the indigenised shrines, resulting in referral cases from the latter to the former shrine. Such a link is, however, not found between Dente and the settler/spiritual shrines in the Kete-Krachi area. It is also in

⁵¹ As pointed out earlier in chapter three, the *odikro* is the priest of the Dente-Kofie shrine in each Krachi division. In some instances, the *odikro* may be referred to as a ‘chief’.

⁵² Focus Group Discussion with Nana Kpebu II (Retired Public Servant, Ghana Revenue Authority, Somanya), Openi Peter Kwesi Choni, Farmer, and Kwadjo Brese, Farmer. Gyengyen, 27th February, 2021.

view of this that the priests have indicated that there is a weak/no link between shrines termed as ‘Dente-*mma*’ (‘children of Dente’) and the settler/witchcraft ones. During rituals relating to Dente and its subsidiary shrines therefore, priests of the settler shrines are not invited to participate in their activities. Before discussing the affiliate shrines of Dente, however, it is crucial to consider the traditional calendar which is significant in healing.

4.3.1 Dente and the Kaakye (Krachi) traditional calendar

To understand the Dente deity, an overview of the Kaakye traditional calendar is essential. There are specific days that are suitable for healing. Krachi have a six-day week. These are Kumuta, Kinyiŋi, Kukuruwɛ, Kikpae, Kilɛŋɛgya and Kupɔɔ.⁵³ Each day is set aside for a specific purpose. Apart from Kinyiŋi and Kupɔɔ, which are believed to be dangerous days, the rest of the days are used for the worship of the deity. Kukuruwɛ is suitable for delivery of medicines as the deities are believed to reveal hidden therapeutic knowledge to priests on that day. Kikpae is believed to be the most suitable day for the worship of Dente, which explains why the Dente shrine is cleansed on that day. On Kikpae, nobody works on their farm or goes fishing. Kilɛŋɛgya is suitable for the commencement of rituals relating to social activities such as puberty, traditional marriage, and funeral. There are seven weeks in a month, and forty-two days in a month. The ‘bad’ or ‘evil’ days within the 42-day monthly calendar include: Forgyuwor, Dapaa-Benada, Kurudapaakuwo, Fofiye (Fofie),

⁵³ Kaakye traditional calendar, 2011 edition, GILLBT, Kete-Krachi, Oti Region; Donkor, O.M. (2022). Kaakye nke Ifɔri. Kete-Krachi: Krachi Traditional Council; Interview with Nana Kofi Donkor Gyinae, former Non-Formal Education Director of Sene District, Kadantwe, Krachi West District, 28th October, 2020.

Kikpae-Kwabena, Dapaa-Miminida, Akwasidayi (Akwasidae in Akan) and Kabrabi.⁵⁴ Each of these days occurs nine times (or approximately, in some instances) within the calendar year. The days are referred to as *dabɔni* (a ‘bad’ or ‘evil’ day), Akan terms adopted by the Krachi. *Dabɔni* may not necessarily be ‘bad’ as the name suggests, but they are sacred days set aside for the worship of deities (Nrenzah, 2015, p. 141). Information collected from the field shows that people who work on *dabɔni* may be beaten by some monsters or experience poor harvest. Illnesses which attack people who work on these days are attributed to spirits. Treatments of such illnesses therefore assume a more spiritual dimension.

Kupɔɔ and Kinyiɔi are tabooed days for the worship of Dente. On those days, healing and other activities in the shrine are accordingly prohibited. Specifically, on Kinyiɔi, the Dente shrine is ‘closed’ and no libation is performed at the shrine. Kupɔɔ is reserved for conducting rituals relating to the dead. It is believed that a priest who visits the shrine on Kupɔɔ will be punished by the deity. A fortnight after Kupɔɔ is known as *Akwasidayi*. The first Friday after *Akwasidayi* is referred to as the *Kabrabi* (twin) day. It is believed that twins are special humans who possess special spiritual powers. Kabrabi day, as noted in chapter three, is therefore set aside for the worship and performance of sacrifices relating to twins to avert their potential wrath. On that day, twins, together with their tutelary divinities, are served with abundant food.⁵⁵ It is believed that discrimination against twins can bring hardships and illnesses, particularly to their parents. For instance, twins are believed to invite snakes and scorpions to cause harm to their parents when they are

⁵⁴ Kaakye traditional calendar, 2011 edition, GILLBT, Kete-Krachi.

⁵⁵ Goats and fowls (including guinea fowls) are slaughtered for twins.

discriminated against or feel neglected. In the ensuing discussion, I focus on the link between Dente and its subsidiary shrines.

4.4 Shrines under Krachi Dente: The case of Dente-*mma* (“children of Dente”)

Apart from Dente Kofie, many shrines are derived from, or have their roots in, the Dente shrine and are collectively referred to as ‘Dente-*mma*’ or ‘Dente-*ase abosom*’ (‘under the Dente shrines’) (hence, “children of Dente”). In Kete-Krachi, if the *okisi* (shrine/divinity) is a ‘creation’ of Dente, then both the *okisipo* (priest) and his or her assistant, *ogya*, will be subject to the *Dente-okisipo/Bosomfo* (priest of Dente). The *okisi* and *okisipo* are in this case not regarded as assistants to Dente. Dente itself has assistants called the *akyeame* (see more details of the *akyeame* in chapter five). Petitioners or assistants to the priest of Dente do not become possessed in the shrine of Dente. Items such as drums and bracelets, to state a few, are also not used in the Dente shrine (Williams, 1976/1977, p. 23). Possession, trance, and the use of assistants are remarkable features of “children of Dente” shrines. On the contrary, there is no possession and trance in the Dente shrine.

Dente may have ‘produced’ several subsidiary shrines because it is responsible for determining who acquires one. For instance, individuals who come across spiritual objects must submit them to the priest of Dente for identification and naming. Most shrines regarded as “children of Dente” were materials found to contain spiritual powers. Some individuals were also possessed and were directed by Dente to be given specific shrines to operate as priests or priestesses. It should be stated that, apart from their connection with Dente, “children of Dente” shrines are linked with the indigenised shrines, a relationship

which is seen in the reciprocal exchanges during their annual rituals. Priests and priestesses of the subsidiary shrines of Dente do not participate in the rituals of settler or anti-witchcraft shrines. An examination of these shrines – named, “children of Dente” will enhance understanding of the complex nature of the Dente shrine.

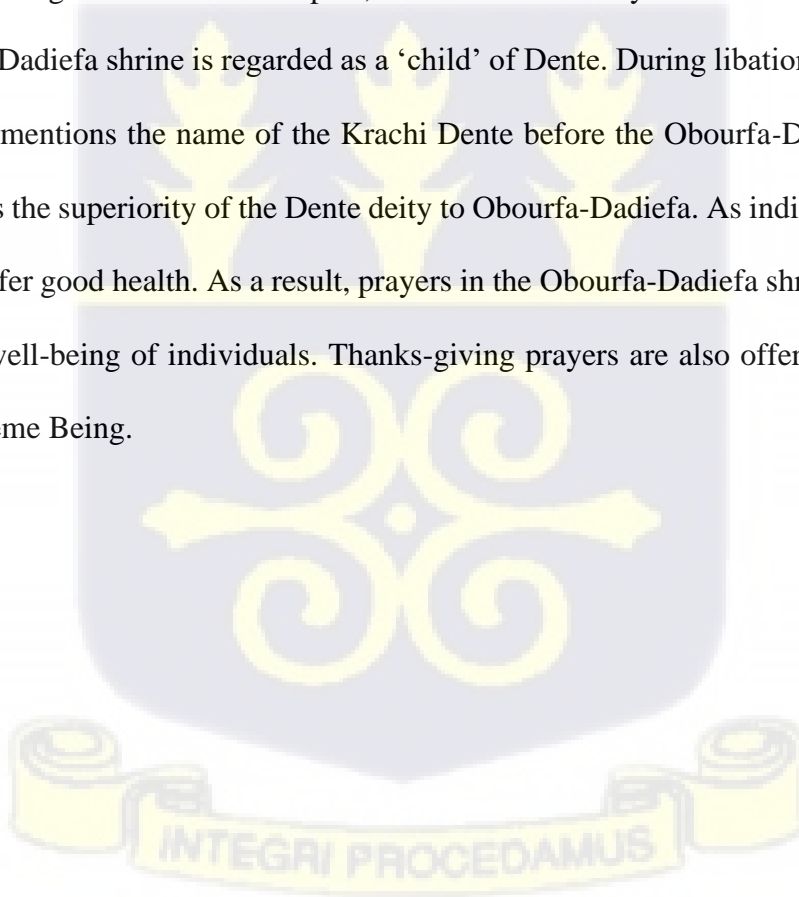
4.4.1 The Obourfa-Dadiefa shrine

Obourfa-Dadiefa refers to the ability of the deity to intercede in difficult challenges, literally as hard as *obour* (stone) or *dadie* (metal), caused by the enemy. The name Obourfa-Dadiefa is believed to have been given by the Dente deity. The shrine, located at Gyankrom, differs from the Obour shrines at Monkra and Osramane-Nnoboja. Obourfa-Dadiefa is believed to be more powerful than the Obour deity. The headship of the Obourfa-Dadiefa shrine is occupied by a priestess, while the Obour shrine is headed by a priest.⁵⁶ There is the general belief that some spiritual objects from the Dente shrine were used to construct the Obourfa-Dadiefa shrine. The spiritual connotations leading to the establishment of the Obourfa-Dadiefa shrine may have led to its high patronage. Besides, the shrine is devoted to healing, as will be seen in chapters five and six. Extensive herbal medicine use, as shall be detailed in chapter six, was found in the Obourfa-Dadiefa shrine. Obourfa-Dadiefa was the most consulted deity at the time of the study. Yaa Donkor Akorsah, the priestess narrated the circumstances leading to the establishment of the Obourfa-Dadiefa shrine as follows:

⁵⁶ This does not, however, mean that men cannot become priests of the Obourfa-Dadiefa shrine. Interview with Emmanuel Akorsah, Priest of the Kipera shrine and husband of the priestess of the Obourfa-Dadiefa shrine, Gyankrom, Kete-Krachi, 28th February, 2021.

I was possessed by a spirit at birth. On some specific days like Kinyigni and Kupɔɔ, believed to be bad, I would not breastfeed. This refusal to suckle the breast continued on bad days. Sometimes, I would be possessed and carried into the bush by spirits. This possession continued even when I was in the primary school at Domaben [in the Oti Region]. Having realised by my parents that I was always possessed by spirits, I was consequently sent for mentorship under the priest of Kikpare, but my spirit did not like the goat that was consumed in the Kikpare shrine. It was there that I fell ill severely, and more consultations had to be made at different shrines. I was then moved to Kadantwe under the Tano shrine. While I was at Kadantwe, further consultations were made at the Dente shrine where it was finally detected that I was possessed by a strange spirit. It was then that Dente instructed that a shrine should be established for me and named as the Obourfa-Dadiefafa, which I have worshipped to-date.⁵⁷

From the above narrative, one mechanism for referring to shrines as “children of Dente” is when Dente gives a name to a spirit, identified as a deity. It is for this reason that the Obourfa-Dadiefafa shrine is regarded as a ‘child’ of Dente. During libation, for instance, the priestess mentions the name of the Krachi Dente before the Obourfa-Dadiefafa deity. This illustrates the superiority of the Dente deity to Obourfa-Dadiefafa. As indicated in the quote, deities offer good health. As a result, prayers in the Obourfa-Dadiefafa shrine emphasise the general well-being of individuals. Thanks-giving prayers are also offered to *Wuruboare*, the Supreme Being.



⁵⁷ Interview with Yaa Donkor Akorsah, Priestess of the Obourfa-Dadiefafa shrine in Gyankrom, Kete-Krachi, 28th February, 2021. Yaa Donkor Akorsah is also the priestess of the Chankpana, Tigare and Sangbe shrines in Gyankrom.



Figure 4.2: A photograph of the priestess of the Obourfa-Dadiefa shrine, reproduced with her permission. Gyankrom, Kete-Krachi. 8th August, 2022.

The annual yam festival is celebrated in the Obourfa-Dadiefa shrine, normally in October, to thank the Supreme Being and the deity for replenishing the society with abundant food. Patients who have received healing also pay homage to the deity. The priestess is prohibited from eating food prepared in the house during the festival. The priestess did not, however, explain this prohibition as she noted that it is a mandatory ritual to observe during the festive season. It is for this reason that a temporary kitchen is constructed outside the house to prepare her meals. Food meant for the priestess is also consumed at a secluded place, under a hut for nine days – a directive from the deity – after which the rituals are said to have ended.

4.4.2 The Fofie shrine

Like the Obourfa-Dadiefa, the Fofie shrine in Abujuro is derived from Dente. Akan appellations characterise the Fofie deity at Abujuro. An example is *agye-nkwa* ('saviour of life'), which implies that one could be saved from illnesses or any form of suffering by consulting the Fofie deity. Fofie may have been a warrior deity, hence the Akan appellation, *agye-man* ('saviour of the state'). It therefore protects the Krachi state. The Fofie deity is believed to liberate those who are in spiritual bondage. In figure 4.1, the researcher has differentiated between Fofie-Kwahu and Fofie-Dente. Fofie-Kwahu refers to the shrine introduced into Kete-Krachi from Kwahu. Though it occupies a central position in the Krachi state, to which a stool is devoted, Fofie-Kwahu is not considered a "child of Dente" but an indigenised shrine. On the other hand, Fofie-Dente is derived from the Dente shrine, giving it the appropriate label, "child of Dente". Fofie-Dente refers to Fofie in Abujuro, which is the subject of attention here. Fofie-Dente is believed to train individuals who are sent to it from Dente, to become good priests and diviners. Those healed by Fofie-Dente are sent back to the Dente shrine, where they are given their own shrines.⁵⁸ This is particularly the case when the Dente deity had earlier identified such individuals as being possessed by certain forces believed to be spirits of shrines.

The Fofie-Dente deity is frequently consulted during illnesses. The spirits of past priests who have healed patients are invoked to determine the causes of illnesses and intercede in the process of healing. The priest of Fofie-Dente pointed out that some illnesses are caused because individuals have come into contact with 'bad wind', or as a result of spells. Some

⁵⁸ Interview with Nana Kofikumah Matenyi, farmer and priest of the Fofie shrine, Abujuro, 1st March, 2021.

illnesses are also believed to be linked to a call to priesthood. Such illnesses are, therefore, not sent to the hospital. Although Fofie-Kwahu (at Kete-Krachi) and Fofie-Dente (at Abujuro) may have started as ‘warrior’ and ‘general well-being’ deities respectively, in contemporary times, the latter deity is believed to cure infertility and mental problems. The notion that individuals can become permanently mad when Fofie-Dente is not consulted early compels people to consult the deity as soon as the symptoms of mental disease are observed in a person.

It has earlier been pointed out in this study that the Fofie day occurs once every seven weeks (every 42 days) on a Friday, and is believed to be a day for the convergence of the spiritual entities. Fofie is believed to be the most sacred, and perhaps the most feared, day reserved for the worship of the Fofie deity. Though treatment of patients is carried out daily, elaborate libation rituals and exorcism are conducted on Kuudapakuo, Fofie and Akwasidae. According to the priest of Fofie, the deity could manifest itself in the form of spirits. Fofie spirits are believed to appear on those days and petitioners interact with them directly. Patients also request healing from the spirits of Fofie. Petitioners who visit or consult Fofie on ordinary days (except ‘taboo days’) are only prayed for by the priests. During libation, attention is paid to *Wuruboare*, Asase (land deity), Krachi Dente and Fofie.

4.4.3 The Akomagy-Lente shrine

Akomagy is an Akan term which means a ‘peaceful heart’. The Akomagy-Lente deity is known to provide fertility. The explanation for the establishment of the shrine in Dadekro is contained in the following narrative:

I was not reproductive after I got married, while my colleagues were giving birth, some of whom had five children. Because I did not have children, I did not have peace at home. I then consulted the Krachi Dente deity to assist me bear a child. It was then that Dente gave the Akomagyo-Lente deity to me to provide children.⁵⁹

It is in view of this that the Akomagyo-Lente deity is regarded as the most powerful and the most consulted deity for fertility. Detailed discussions on the Akomagyo-Lente's health roles are reserved for chapter five.



Figure 4.3: Priestess of Akomagyo-Lente (left) and her shrine (right).
Picture taken by the researcher at Dadekro, 3rd March, 2021.

The Akomagyo-Lente shrine is a stool covered with a white calico material which is placed on a sheep skin. The Akomagyo-Lente shrine resides in the bedroom of the priestess. Besides the stool are calabashes that serve as receptacles for petition.⁶⁰ The calabashes also serve as receptacles for donations such as kola nuts, cowries, and monies. On specific occasions, the priest takes her seat on the Akomagyo-Lente stool.⁶¹ Activities in the shrine relating to infertility are concealed from the public/society believed to be the cause of the infertility. Petitioners sleep by the shrine to become fecund. Sleeping in the room of the

⁵⁹ Interview with Nana Akosua Nkrumah, priestess of the Akomagyo-Lente shrine, Dadekro, 21st March, 2021.

⁶⁰ Sacrifices are also made in the room, except for bigger animals whose blood may be sent into the room and poured on the wall of the room.

⁶¹ Petitioners remove their sandals and bow before the deity in awe and humility.

priestess or by the shrine is believed to protect petitioners from the potential spiritual attacks of people believed to be the cause of the infertility.

4.4.4 The Kikpare shrine

The deification of trees is a well-known phenomenon in Ghana. Trees have a cultural, medicinal, mystical or/and religious value among other uses (Lentz & Sturm, 2001, p. 148).

The Kikpare (*Senna occidentalis*) tree is commonly found on farms. The Kikpare tree in Osramane-Ofoase has been deified because it is believed to be the abode of spirits, especially dwarfs. In Osramane-Ofoase, the Kikpare deity is used to curtail sudden deaths and also boost harvest. Its worship is believed to increase agricultural production. The deity is surrounded by certain mysteries, which render it fearful. For instance, Nana Kwame Kumah, priest of the Kikpare shrine at Osramane-Ofoase, indicated that death associated with the breaking of taboos of the Kikpare deity may account for some difficulty when constructing the graves of such victims. It may also lead to quarrels during the construction process. When the Kikpare deity is believed to be the cause of the death of a person, Dente is consulted before burial. This consultation further bolsters understanding the link between Kikpare and Dente.⁶²

⁶² The Kikpare Festival is celebrated in Osramane-Ofoase in honour of the Kikpare deity. Invitation is extended to all priests operating under the Dente shrine. These encompass priests of “children of Dente”, other indigenous and the indigenised shrines. However, priests of shrines such as Tigare, Konde and others are not invited to the festivities. The Kikpare festival is different from the Yam Festival, which is common to most shrines in the Krachi area. The festival takes place on only Fofie (the sacred Friday). Millet is the staple food in the shrine which is prepared and served to the deity.

Apart from Akomagyo-Lente, the Kikpare deity is believed to provide fertility to people. Besides, the Kikpare tree is believed to be potent in curing epileptic conditions. A decoction is prepared from parts of the tree and used through the enema. When the leaves are ineffective in curing the epileptic condition, the bark, and later the roots, are used. This is contained in the Krachi expression, *susu ndɛfo, kasi kadɛfo*, which means literally, “if the top does not heal one, the down will.” This implies that ‘if the leaves are inefficacious, the bark or the roots will be’. As a result of its efficacy, all the parts of the plant may be used in healing. This points to the efficacy of the *Senna occidentalis* tree. The deity is also believed to cure convulsion, chronic sores, impotence, infertility, and madness.⁶³

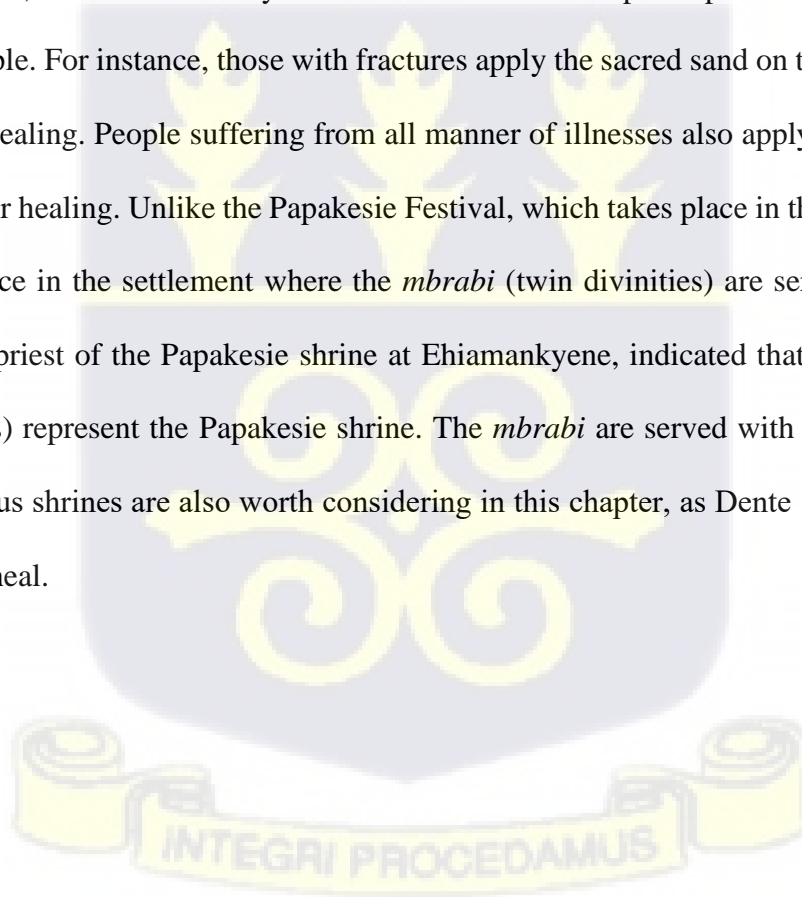
Illnesses are also believed to be caused by deities when individuals break certain taboos. In this case, healing in the Kikpare shrine requires rituals of pacification. Sometimes, albeit rarely, the deity may reject cases when it is found out that the patient has no good character. The deity is believed to assist businessmen/women to retrieve monies from debtors. The Kikpare priest does not charge for services rendered because of the belief that indebtedness to the deity may bring back the suffering of the petitioner. Patients are, therefore, expected to acknowledge the deity voluntarily.

The Kikpare shrine is also found in Ehiamankyene but is referred to in Twi as the Papakasie shrine. Both Kikpare and Papakesie are therefore considered the ‘same’. Other shrines in Ehiamankyene derived from the Dente shrine include Yentumi-Akwasi (see figure 4.1), Borkwei, and Bunchori. In both Osramane-Ofoase and Ehiamankyene, the

⁶³ The *k'tre* (*Lotus edulis* L.) plant is believed to enhance sexual intercourse. The plant is washed, and its vine is chewed. The plant is also believed to heal ear pains. For ear pains, the plant is macerated, and the solution is dropped in the ear. The shrine, apart from its health function, is also believed to provide rainfall which enhances agricultural activities/production.

Kikpare/Papakesie shrine serve as anti-witchcraft shrine. The deity is believed to ward off bad spirits and liberate those traumatised by witches. The Papakesie deity is particularly believed to revamp collapsed businesses associated with witchcraft attacks.⁶⁴ By virtue of its enormous roles in Ehiamankyene, two festivals – the Papakesie and the Igyokigyi Festivals – are celebrated yearly in honour of the Papakesie deity.⁶⁵

The Papakesie and Igyokigyi Festivals take place in the months of April and August, respectively, to thank the Papakesie deity for its numerous roles in the lives of the people, and also to request protection from the deity. The Papakesie Festival, which is conducted in the bush, is characterised by the distribution of sand to participants. The sand is used to heal people. For instance, those with fractures apply the sacred sand on the affected part to receive healing. People suffering from all manner of illnesses also apply the sand on their bodies for healing. Unlike the Papakesie Festival, which takes place in the bush, Igyokigyi takes place in the settlement where the *mbrabi* (twin divinities) are served. Nana Kwesi Angwe, priest of the Papakesie shrine at Ehiamankyene, indicated that the *mbrabi* (twin divinities) represent the Papakesie shrine. The *mbrabi* are served with mashed yam. The indigenous shrines are also worth considering in this chapter, as Dente ‘sends’ patients to them to heal.



⁶⁴ All forms of spiritual misadventures are believed to be combated by the Papakesie deity.

⁶⁵ Interview with Nana Kofi Angwe, Priest of the Papakesie shrine, Ehiamankyene, 23rd March, 2021.

4.5 Other “indigenous” shrines and Dente

It should be indicated that Dente belongs to the broader class of indigenous shrines and therefore has a link with the rest of the shrines under that category, namely: Pɔnyɛ, Chanyiɲi and Frao. Though the rest of the indigenous shrines are not the focus of this study, it is worth stating that those shrines perform complementary roles in the healing of patients sent to them by the Dente priest. Individuals may have also consulted those deities before they were referred to Dente. This complementary role calls for the need to examine indigenous shrines.

Apart from Dente, the two shrines identified as indigenous in Old Osramane were Pɔnyɛ and Kyanyiɲi.⁶⁶ Kyanyiɲi is an anti-witchcraft shrine whose role is found in the etymology of the name. *Kya* means ‘dance’ and *nyɲi* means to ‘remember’. Witches are believed to dance at night after a successful spiritual hunt. The name of the shrine reminds witches that, while they dance and carry out their nocturnal misadventures, it is the duty of Kyanyiɲi to protect the society and expose them. Like most Ghanaian societies, witchcraft was believed to be a common practice in Old Osramane. Kyanyiɲi was, therefore, believed to combat such malevolent spirits. Chanyiɲi and Pɔnyɛ are believed to be ‘security guards’ of the Dente deity. It is worth noting that as a result of the crucial healing roles of Chanyiɲi and Pɔnyɛ, Dente could also ‘send’ patients to their respective priests to heal.

⁶⁶ Pɔnyɛ means a ‘good woman’.

4.6 The indigenised shrines and Dente

Indigenised shrines such as Mprah, Tano and Fofie-Kwahu, as shown in Figure 4.1, constitute a major aspect of the traditional healthcare delivery among the Krachi. The indigenised deities are believed to execute the tasks assigned by the Dente deity. For instance, their priests heal patients sent from the Dente shrine. They also make referrals to Dente anytime they have difficulty with any health conditions. By virtue of that relationship, the priests of the indigenised shrines can participate in the rituals relating to Dente. The priest of Dente is duly informed before annual rituals relating to the indigenised shrines are conducted. Priests/Priestesses of “children of Dente” shrines also participate in the annual rituals of the indigenised shrines. As illustrated in Figure 4.1, like the Dente shrine, it was indicated by the priests that there is weak/no relationship (particularly rituals) between the indigenised shrines and the settler shrines. Although this thesis is not devoted to the indigenised shrines, their link with Dente should be examined, as they paint a broader picture of the Dente deity.

4.6.1 The Mprah shrine

Kadantwe, a suburb of Kete-Krachi, is home to the Mprah deity. Owusu-Ansah and Akyeampong (2019, p. 10 footnote) have pointed out the role of Mprah, the Mampong deity, in the establishment of Mampong as a prominent Asante state.⁶⁷ Nana Mprah, priest of the Mprah shrine in Kete-Krachi, also recalled the origin and migration stories of the deity. He noted that the deity owes its origin to Yonso in Ashanti Region. Over there, it

⁶⁷ [Kora.matrix.msu.edu/files/60/396/3C-18C-F-106-14_Opanin Kwabena Buor Mampong.pdf](http://Kora.matrix.msu.edu/files/60/396/3C-18C-F-106-14_Opanin_Kwabena_Buor_Mampong.pdf)

performed many functions including war and state expansion. In view of its war functions, the Asante engaged the deity in the war against the Denkyira. The Asante, however, failed to pay the deity after they defeated Denkyira, with the help of the Mprah deity. The deity's 'war booty' promised it by the Asante included the decoration of the shrine with several ornaments and other regalia. It is believed that the failure of the Asante to honour the shrine with the promised ornaments angered the deity, leading to its migration from Yonso to Salaga. The deity was believed to be accompanied by Nana Kwadjo Dompseh, the man who was believed to have introduced the deity into Kete-Krachi. The reason Mprah and Dompseh settled at Salaga could not be given by the respondents. It could, however, be inferred that Dompseh settled at Salaga with the deity as a result of the town's economic prospects. As indicated, Salaga became popular for its trade in kola nuts. While the shrine was at Salaga, priests of Dente heard of the Mprah deity and pleaded for its relocation to the Krachi state. Consequently, the Mprah was brought to Kadantwe, a suburb of Kete-Krachi.⁶⁸

Though Mprah is believed to operate under the Krachi Dente, it differs from the latter greatly. For instance, Mprah is contained in a silver panel which resides in the *akentendwa*⁶⁹, a wooden chair, while the Krachi Dente is believed to be a spirit residing in a cave. Besides, the Dente deity has many subsidiary deities that operate under it while Mprah has none. Apart from Kinyiŋi and Kupɔɔ when Mprah is inaccessible to the public,

⁶⁸ Within the Dompseh clan is the Dompseh lineage, which is entitled to the priesthood of Mprah. The oldest surviving male of the Dompseh lineage becomes the priest of Mprah. In addition to seniority in age, a candidate's good character and respect are key in the choice of the priest of the Mprah shrine. The deity has an *ohemaa*, a queen mother who comes from the Dompseh lineage. The rest of the male members of the Dompseh clan can serve as *akyeame* in the Mprah shrine. Currently, three *akyeame* serve the deity. They interpret messages to the priest. Besides, they also help to heal patients who visit the shrine.

⁶⁹ In Akan language.

any day is good for worship and consultation.⁷⁰ A room is reserved in the home of the priest of Mprah to accommodate patients and other petitioners.

During the Igyokigyɪ Festival, the priest performs the *ngyakwɛ*, a ritual meant for the priests and priestesses. Invitation is extended to priests under Dente (Dente-*mma* shrines). The rest of the priests of the indigenised shrines are also invited to the ritual. However, priests of settler shrines (Konde, Tigare, Gurmande etc.) are not invited since they are deemed not to have a link with the Dente shrine. The festival begins on a Tuesday, where several animals are slaughtered. On Wednesday, the gate of the shrine is opened for consultation. It is a taboo to open the shrine for consultation on Thursday, a day for the preparation of the ritual food of the deity. The preparation of the ritual food continues till Sunday. The last day, which falls on a Monday, is devoted exclusively to dance performances. Attendees show appreciation to the deity and request a peaceful year, with divine providence. During healing, the priest of Mprah may refer clients to Dente or any other healing centre under Dente. Health conditions or illnesses that are believed to be physical may be referred to the hospital.

4.6.2 The Fofie shrine at Krachikrom

This study has already highlighted the difference between Fofie-Kwahu (located at Krachikrom) and Fofie-Dente (in other Krachi towns). The study has also pointed out in previous discussions that the Fofie-Kwahu deity is believed to have originated from

⁷⁰ Focus group discussion with Nana Mprah Bosomfo, priest of the Mprah shrine, and Mr. Edward Kwarteng, tailor and farmer, Kadantwe, 22nd March, 2021. Mr. Edward Kwarteng noted that he is an Asante man who is currently residing at Kadantwe.

Kwahu. Although its historical origin is traced to Kwahu, the deity is generally considered as the ‘adopted son’ of Dente. As noted, unlike the Fofie-Kwahu of Krachikrom, the Fofie-Dente shrines at Ehiamankyene, Abujuro and Kpachu were derived from Krachi Dente, and are collectively referred to as “children of Dente”.⁷¹ They are, therefore, not ascribed to the Fofie (Fofie-Kwahu) in Kete-Krachi. Fofie-Kwahu has a stool house in Krachikrom.⁷² The relationship between Dente and Fofie-Kwahu is so close that some respondents consider it as “child of Dente”. According to the narratives, Fofie-Kwahu was the first indigenised shrine to be introduced to Kete-Krachi. Considering its significance, the stool house of Fofie-Kwahu is close to that of Dente.

Fofie shrines also exist among the Ewe people. Venkatachalam (2012) points out that Dente – commonly known as Krachi Dente or Fofie in contemporary Anglo refers to a set of religious practices through which Anglo established a link with their slave ancestors. As a result, rituals that are associated with the worship of Fofie revived and continue to revive the memory of slavery among the Anglo. The worship of Fofie in recent times is to prevent further retribution from slave ancestors. The narrative on the Fofie shrine among Anglo Ewes by Venkatachalam illustrates diffusion and accretion of the shrine beyond the Krachi people.

⁷¹ Most of the contemporary shrines under Dente were established by Nana Kwame Kumah, now priest of the Kikpare shrine. Kwame Kumah served the Dente deity as *okyeame* (assistant) for close to 30 years. He was believed to have established/introduced the Fofie shrines in many Krachi communities, except for Krachikrom and Ehiamankyene. The Fofie-Dente deity at Krachikrom may be sworn to in the traditional and district courts by traditionalists.

⁷² Interview with Nana Kwame Kumah of Osramane-Ofoase, farmer, former *okyeame* of the Dente shrine, and currently the priest of the Kikpare shrine. Kete-Krachi, 2nd March, 2021.

4.6.3 Bruku: A subsidiary shrine at Kwakuae

Bruku is a shrine in Shiare. The efficacy of the Bruku deity is recognised by Africans and Europeans. Commenting on the Bruku shrine, Ferguson, a German officer, noted that the insignia of the great shrine of Bruku at Siade (hence, Shiare) in Adjuti was decorated with cowries and a curved sword with a golden handle representing the Bruku shrine. It was believed by Johnson to be a prototype of the state sword found in Ashanti and also in Dahomey (Johnson, 1965, p. 35). One notable health function believed to be performed by the deity, for which people seek its intervention, is the spiritual assistance to people suffering from illnesses (Adonteng, 2009). Bruku and Dente are so closely associated that, at the field, a few respondents, including the traditional priest of Dente, asked the researcher to visit the Bruku shrine at Shiare to gather data to establish the link between Bruku and Dente.

As a result of the enormous functions performed by Bruku, a prototype of the shrine was introduced into Kwakuae. The Bruku deity in Kwakuae and Shiare are related. The former is considered the 'child' of the latter deity. Derived from the words – *bru* (big stone) and *kung* (protect) – Bruku refers to a deity which provides security to people and keeps the activities of witches in check. Apart from protection from malevolent spirits, which seem to be the preoccupation of the deity, the spiritual help of Bruku is sought in economic activities too. Activities in the Bruku shrine in Kwakuae, like Akoadehye, as would be seen later, are connected with those of Dente. For instance, *ayu kikisi*, a prohibition on the consumption of guinea corn or sorghum over a period of time, is common to both shrines. Just like the *Akwammoo Nanaba* (annual ritual/festival of Dente), there is the clearing of the path leading to the Bruku shrine at Kwakuae. Bruku, like Dente, has no diviner. These

deities are believed to communicate directly to the priest without the need for a medium/intermediary.

Like its 'mother' deity at Shiare, Bruku at Kwakuae is consulted for fertility. When people give birth through intervention of Bruku, they acknowledge the deity by naming such children after the deity or its location (Shiare). Examples of such names are Bruku/Brukum, Sey/Sei, Seinka and Siade/Shiare. The fertility believed to be provided by the deity has compelled many people to consult it for assistance. Children born subsequently are sent to the Bruku shrine for rituals of protection. It is believed that rituals of protection are necessary for the survival of these children. Failure to conduct such rituals in the shrine is believed to lead either to the death of the child or hardships for the delinquent parents.

The priest of Bruku receives visions to either accept or reject a patient. The priest indicated as follows:

If someone is not well, for instance, has a swollen leg, I first pray over it and go to bed. At night, the spirits would inform me about the cause of the illness and also proffer solutions.

Indeed, a major reason some patients consult the Bruku deity at Kwakuae is its spiritual revelations. Priests of Bruku do not, therefore, rely on the services of a diviner. It is also believed to heal spiritual illnesses.

4.6.4 The Akoadehye shrine

Akoadehye is derived from the Akan words, *akoa* (servant) and *odehye* (royal). The deity brings several people (servants) to worship. It is because of the many petitioners and

servants in the Akoadehye shrine that it has been accorded ‘royal’ status. Indeed, Perbi noted that the term *akoa* (‘servant’) could be applied figuratively to describe the people subject to a Stool/Skin and by extension, to a king or chief. It could also be used to describe the relationship between two chiefs – inferior versus superior (Perbi, 2004, p.3). Though in the case of the Krachi Akoadehye does not relate to the relationship between chiefs, Perbi’s opinion of the term offers a deeper meaning into the etymology of the word *akoa*. The Akoadehye deity was believed to have originated from the neighbourhood of Santrokofi in the Volta Region.⁷³ The Akoadehye deity was introduced into Kwakuae to check the proliferation of witchcraft practice. A woman cannot become a priestess of the Akoadehye deity but can assume the role of a seer. Information is disclosed to the seer before it is channeled to the priest. As indicated, Akoadehye is linked to Dente and petitioners in the latter shrine may be redirected to seek further treatment in the Akoadehye shrine.⁷⁴

⁷³ Succession to the priesthoods of Akoadehye and Bruku shrines is the exclusive reserve of males of the Kokroko and Opimisain lineages respectively. Only the males who are close to the priests and have learned the practices and rituals pertaining to those deities are eligible.

⁷⁴ Focus Group Discussion with: Nana Kwadjo Ansrogya II, farmer, retired educationist and the chief of Kwakuae; Kwaku Nana Ekung, farmer and linguist; Nana Kwabena Kunde, priest of Akoadehye shrine; Nana Kwao Gyinyi, farmer; Nana Opimisang, priest of Bruku at Kwakuae; Nana Kofi Nfum, Amankrado of Kwakuae; Paul Yeboah, Kwakuae town secretary. This discussion took place at the Chief Palace at Kwakuae, 2nd March, 2021.



Figure 4.4.: Focus group discussion with some opinion leaders of Kwakuae. First and third (from left) are the priests of the Bruku and Akoadehye shrines, and fifth and sixth (from left) are the researcher and the chief of the town, respectively. Photographed, 28th March, 2021.

Healing in the shrine of Akoadehye involves extensive consultation, including the slaughtering of fowls. The name of the patient is mentioned, and the healing powers of the deity are invoked. The deity is consulted to determine whether it can intercede in healing a patient. Patients may be rejected by the deity based on their bad conduct.⁷⁵ Akoadehye is believed to foretell patients' illnesses and their aetiology.⁷⁶

⁷⁵ This rejection is determined by the way a fowl lies after it has been slaughtered.

⁷⁶ The Yam festival relating to Akoadehye is celebrated immediately after the festival in Kete-Krachi, to thank the deity for divine providence. The priest therefore begins to eat the new yams in October. Fridays, Saturdays and Fofie are reserved for worshipping the Akoadehye deity, except when someone dies. In the case of Bruku at Kwakuae, every day is suitable for its worship, but the most suitable day is *Kikpae*.

4.6.5 The Tano shrine

It must be noted that the worship of the Tano deity is common among Asante. Nevertheless, its worship is not limited to Asante alone; it is, for instance, worshipped in the Western part of Ghana in towns such as Sefwi, Aowin, and Wassa Amenfi that are located along the Tano River. The deity is believed to bestow good health, children, wealth, and defends its integrity.⁷⁷ Indeed, these are the desires of the Krachi and many societies. As pointed out in earlier discussions, deities can migrate – they can be bought and sold. The Tano shrine was introduced in Kete-Krachi by Kwabena Dua.⁷⁸ The historical origin of the Tano deity in Kete-Krachi is traced to Juaben Asukore in Asante.⁷⁹ It was particularly introduced into Kete-Krachi to boost commercial activities at the time, and to heal people. Tano at Kadantwe is contained in a silver bowl⁸⁰ called in Twi as the *yawa*. Dente could assign patients to Tano to heal. On the other hand, the priest of Tano can participate in the rituals of Dente. Like Dente, goats are tabooed by the Tano deity.

⁷⁷ J.C.M. Paton, Assistant District Commissioner, Gold Coast. *The worship of the Tano Fetish*. Government Printing Department, Accra.

⁷⁸ Interview with Nana Kwadjo Nimo, Amankrado of Kadantwe and priest of Tano shrine. Kadantwe, Kete-Krachi. 7th June, 2021.

⁷⁹ Dua fled the town to avoid forceful installation as chief. Kwadjo Nimo, Amankrado of Kadantwe asserted that Dua fled because most of his kinsmen who could have supported him to become a successful chief died, leading to his migration.

⁸⁰ Like the one at Juaben Asukore.



Figure 4.5: A prototype of the silver bowl in which the Tano shrine is found. Photograph taken by the researcher with permission of the Priest of Tano shrine. Kadantwe, Kete-Krachi. 7th June, 2021.

Tano is believed to intercede in the treatment of many diseases. Although the priest claimed to have used some nine plants to cure HIV/AIDs, he did not mention those plants because of the extensive spiritual preparations required to do so. The priest uses the roots of plants such as *krenyu* (*krayio* in Akan) (*Pterocarpus erinaceous*), *kiba* (*Bridelia ferruginea*) and a plant identified as *asagyiriwa* (not found in the area), to cure infertility in women. Infertility is blamed on the woman. It is against this interpretation that men are not required to drink the herbal preparation.

4.7 Conclusion

This chapter has offered insights into the Dente shrine and its interconnections with other shrines in the Kete-Krachi area. Dente is linked to indigenous shrines such as Frao, Chanyiŋi and Pɔnyɛ, which offer healing to people. Although shrines such as Mprah, Fofie at Krachikrom, Tano, Bruku at Kwakuae, and Akoadehye are not indigenous to the Krachi people, they have been incorporated into Krachi traditional practices, and perform complementary roles with the Dente deity. This link between Dente and other shrines is further demonstrated during healing rituals and approaches. Priests of Dente ‘distribute’ or redirect some petitioners to consult other indigenous and the indigenised deities in the Kete-Krachi area. Referrals are also made to the Dente shrine by the priests of the indigenous and indigenised shrines. Besides, priests of those shrines participate in the activities of Dente, unlike the priests of the settler shrines that are not invited to the rituals of Dente. Priests and priestesses who receive petitioners from the Dente shrine consider that a great honour.

Although the shrines may have their specialisation, it is still the prerogative of the Dente deity to identify and (re-)direct petitioners to the appropriate shrines – whether to “children of Dente”, the indigenised, or the rest of the indigenous shrines – for necessary intervention. The discussion on the indigenous, indigenised and settler shrines is significant in understanding power play between shrines, and how this interplay within the structure of shrines could be used to extend the health-seeking roles of Dente. Of particular significance, the chapter highlighted that Dente has “reproduced” many shrines that operate under it, a situation which has bolstered the healing role of the priest(s) of the Dente shrine(s). For instance, referrals are made from Dente shrine to its affiliate shrines where

herbal medicines are used to deal with illnesses. It is clear that most of the shrines considered in this chapter, except the settler ones, have a link with Dente, with whom they interact, and from where they derive their power and authority. The establishment of the affiliate shrines of Dente have promoted healing activities in the Kete-Krachi area. For instance, Obourfa-Dadiefa, an affiliate of Dente was used to deal with urine retention and skin diseases. Critical discussion of healing activities in the affiliate shrines of Dente such as Obourfa-Dadiefa, Kikpare, Fofie, and Akomagyo-Lente and some success narratives are presented in chapter five.

Beyond the health function of the Dente deity is a political function. The Dente-Kofie (a representation of the Dente deity) is found in each Krachi community. It has been asserted previously that the *adikromfo* (owners of land) serve as priests of the Dente-Kofie in Krachi divisions. This brings the *adikromfo* in the Kete-Krachi area under the influence of the Dente priest. Besides, priests of the subsidiary shrines of Dente (termed “children of Dente”), and the indigenised shrines are subject to the Dente priest. In fact, in the past, the sphere of influence of the Dente priest – and by extension the Krachi state – was demonstrated by the presence of the Dente-Kofie/Kachilente shrines in many communities. These areas included parts of Northern and Volta (including the new Oti) Regions, to state a few.



CHAPTER FIVE

HEALING IN THE DENTE SHRINE

5.1 Introduction

This chapter highlights the social and religious interpretations given to illnesses among the Krachi people, which impact their health choices. It sheds insights into the approaches through which social and religious illnesses are dealt with. As indicated in chapter one, this study is guided by the Social Determinants of Health (SDOH) model, which considers the social, cultural, and religious nuances pertaining to health (Lloyd et al., 2019). Healing entails accommodation of patients, ventriloquism, social and religious interpretations of events, application of medicines, among others. It also involves natural and/or physical explanations to illnesses. The chapter further examines the stages of healing in the Dente and its affiliate shrines and at each level, delineates their significance in the healing process.

Healing is carried out with the help of the *akyeame*, assistants to healers. In view of their significance, the chapter discusses the *akyeame* and the roles they perform in healing. The term *akyeame* has two meanings – court *akyeame* and shrine *akyeame*. The latter is the subject of attention. The roles of the *akyeame* differ from shrine to shrine. The chapter highlights the forms of care provided by the *akyeame* and the families of patients in the healing process.

A discussion on healing is incomplete without reference to taboos and prohibitions. Individuals' recovery may be premised on their observation. The previous chapter has provided a nuanced perspective on the Dente shrine. This chapter continues that discussion

by interrogating the healing roles of Dente and its affiliate shrines, namely: Obourfa-Dadiefa, Fofie, Akomagyo-Lente, and Papakesie/Kikpare in respect of healing. It draws a comparative analysis between the findings, the conceptual frameworks, and the literature.

5.2 Healing in the Dente shrine: spiritual and social approaches

The diverse explanations to illnesses have already been pointed out in the previous discussions. This subtheme focuses on the spiritual and social explanations to illnesses and the role of the deities in healthcare. These spiritual and social explanations affect health choices. It further discusses economic issues in the context of Dente and its affiliate shrines.

Table 5.1: Statistics of visits to shrines for 2021-2022

Complaints	Shrines visited					TOTAL
	Dente	Fofie	Obourfa-Dadiefa	Akomagyo-Lente	Papakesie/Kikpare	
Illnesses attributed to spirits	6	7	19	6	20	58
Fertility/Reproduction	9	8	6	12	5	40
Physical illnesses		4	16	2	15	37
Economic ventures	16	6	3	1	2	28
Rain	12	6	9			27
Protection	11	8	3	3		25
Marriage	7	6	2	7		22
Examination success	7	3	4		4	18
Visa acquisition	15					15
Land cases	5		1		2	8
Theft prevention		4				4
Alcoholism	1					1
Other						

Existing studies show that the deities are consulted for reproduction and general well-being (see Turner, 1968, 1975; Devisch, 1993). Fortes (1948) notes among the Asante the idea that ‘normal’ men and women should continue to produce children so long as they are reproductive. This study has indicated in the preceding chapter that a critical trait of women among the Krachi is fertility of the womb (Kumah, 1966). A few female respondents in Kete-Krachi and Dadekro asserted that one cannot speak of well-being or marital/conjugal peace in the absence of childbirth. Among the Krachi, like other societies in Ghana, childlessness is scorned. Families therefore seek fertility in the hospitals, in shrines and the prayer camps.

The data in Table 5.1 shows that many petitioners consulted Dente and its affiliate deities for fertility and reasons of reproduction, with Akomagyo-Lente being the most consulted. Concoctions are prepared in Akomagyo-Lente shrine to enhance fertility, reduce prolonged labour, and ward off malicious spiritual attacks. In the case of prolonged labour, souls (*kra*) are interrogated about the cause. The researcher has already made mention of the concept of the human person among the Krachi, which involves the *kra* and *konokra* (destiny). This is contained in the Krachi expression, *fo kra ha fo, oboti kigyi*, to wit, ‘your soul is troubling you because it needs to be fed’. Barrenness may be associated with negligence of the soul’s needs. It may seldom be associated with *konokra* and is in this case said to be spiritually caused. The concept of infertility among the Krachi is sometimes ambivalent. Unlike Mprah, affiliate deities of Dente are believed to heal naturally caused infertility. Between December 2020 and December 2021, twelve women consulted the Akomagyo-Lente deity for fertility. Indeed, the shrine was established in Dadekro to promote female fertility. A few respondents noted that barrenness is dealt with among the Krachi through fostering.

Other respondents pointed out on the contrary that fostering is incomparable with one's biological children. Nana Akosua Nkrumah, priestess of the Akomagyo-Lente shrine, noted that the services of *kabitegyi* (foster girl) – is no antidote to barrenness. She maintained that such children can only run errands for the barren woman. The services of the foster girl do not completely satiate the psychological challenges of barrenness. For instance, barren women may either be insulted or become the centre of ridicule or discussion in society. Indeed, Adu-Gyamfi (2015) indicates that treatment for a woman who once had a miscarriage is better than that for one who has not carried a fetus in her womb before.

Nana Akosua Nkrumah, priestess of Akomagyo-Lente, therefore consulted the Dente deity to make her fertile. Amegbor (1987) and Akpabli-Honu (2014) have already drawn attention to naming in shrines among the Ewe people. Similarly, children born through intervention of Dente are given names such as Dente (male), Denta (female), Lente-Nwu ('Lente/Dente never dies') and Bakopo⁸¹. It was pointed out in an interview in Kete-Krachi that many patients who recovered from illnesses through the intervention of Dente refused to return to their respective communities because they feared that their illnesses might recur.⁸²

Apart from the Akomagyo-Lente, the Fofie deity at Abujuro (referred to in this study as Fofie-Dente) is believed to provide fertility to women. Parents who consult Fofie for fertility send their children – often named 'Fofie' – to the Dente shrine for presentation and

⁸¹ The name means 'he that comes with a forest.' By implication, Dente brings crowds of people to worship/settle in Kete-Krachi.

⁸² The name 'Semanhyea' ("if I had not met" [Dente]), common in Atebubu, is believed to be associated with the Dente deity.

thanksgiving. The Fofie deity may, through the priest, name the unborn child before birth. Parents may, sometimes, name the child after the deity before the thanks-giving ritual. Children born after the thanks-giving ceremony may be named ‘Daseanya’, which means, ‘receiving another [child]’ after acknowledging the deity. The Fofie deity is believed to protect its children.

The fertility believed to be provided by Dente and its affiliate deities is not completely dissimilar to that of Mprah deity. Though this study is not about indigenised shrines, it is pertinent to note that the most popular function of Mprah in contemporary times is the provision of fertility as is evident in names such as Yaa Mprah and Besumuna Mprah II (Paramount Chief of the Krachi State), to state a few.⁸³ The Mprah deity may have limited power over spiritually caused infertility. It was pointed out, for instance, that the soul or the *konokra* can cause infertility to a woman. In that regard, it is believed that the Supreme Being has instructed the *konokra* to disallow the woman from childbearing. From the perspective of the Krachi, individuals may be born with illnesses. These illnesses are in this case referred to as “natural illnesses” which are, somehow, said to be different from physical illnesses.

Table 5.1 illustrates that the number of people who consulted Dente and its affiliate deities for economic purposes (= 28 petitioners) from 2021 to 2022 is less than those who consulted them for health reasons (illnesses attributed to spirits, physical illnesses and fertility = 135 petitioners). A few of the respondents ascribed the inability of the COVID-19 pandemic to spread in the Kete-Krachi area to the rituals performed at the Dente shrine

⁸³ References were made of a few Europeans who consulted the Mprah deity for diverse reasons.

during the outbreak of the disease. My field assistants (translators) reiterated that Dente can ‘see’ impending disasters and provide the antidote to them or prevent deaths. When disasters are detected, the community is cleansed by priests. The connection between Dente’s intervention and low incidence of the COVID-19 cases was further highlighted in a focus group discussion at Gyankrom. Before the discussion began, Nana Kpebu II, chief of the town, recalled a discussion between a visitor and himself. The visitor questioned why the Gyengyen community, close to Kete-Krachi, had not recorded incidence of the ravaging COVID-19 pandemic, in spite of the over-crowded markets and the general non-adherence to the COVID-19 protocols such as washing of hands and wearing of nose masks. The chief, in his answer, linked the reasons to the Dente deity. This scenario points to the belief in the efficacy of Dente. Good health may be ascribed to deities. It was asserted by the respondents that Dente revealed through the Dente-Kofie that rituals be performed to combat the pandemic. Statistics of COVID-19 cases from the Krachi West Municipal Health Directorate shows, however, that for the year 2020, thirty-seven (37) cases were confirmed in the Municipality while in 2021, sixty-one (61) cases were confirmed. Between January and June 2022, forty-eight (48) cases were confirmed.⁸⁴ No cases of deaths relating to COVID-19 infections have been confirmed in the municipality. Although available data illustrates evidence of COVID-19 infections in the area, a few respondents still believed that the incidence of cases would have been worse had it not been the intervention of Dente.

Dambai, capital of the Krachi East Municipal, recorded lower prevalence of the COVID-19 cases compared to Kete-Krachi. For instance, it recorded two (2) cases in 2020, eleven

⁸⁴ Annual Report, Krachi West Municipal Health Directorate, 2020-2022.

(11) cases in 2021, and three (3) cases in 2022. No incidence of death as a result of COVID-19 infections was recorded in Dambai.⁸⁵ Like the Krachi, a few respondents ascribed the lower incidence of cases in Dambai to Dente. Reports from the Krachi East Municipal Health Directorate shows that the lower incidence of cases in the town is linked with the lack of test-kits, and the general reluctance of people to undergo the COVID-19 test.

The protection believed to be given by Dente was further narrated by Nana Kpebu II as follows:

While I was a revenue officer at Somanya, I insisted that a White man training people how to fly smaller aircrafts should pay tax. He took offence and initiated steps to have me transferred from the District. I saw his actions in a dream when a big bird flew to either attack me or carry me away. I shouted that I was a descendant of Dente and the bird became smaller and fell before me. After the dream, I later gathered information that the White man wanted me to be transferred from my workplace in Somanya but Dente interceded. I had a second dream too. In that dream, someone prepared a poisonous concoction for me to drink. But I drank it while boasting that I was a descendant of Dente. The second dream made me cautious about the food I ate with friends⁸⁶

The first dream reveals the protection that Dente is believed to offer those who solicit its help. The second dream is essential in understanding how revelations of Dente assist people to protect themselves.

As presented in table 5.1, seven patients consulted Fofie for spiritual healing between 2021 and 2022. Individuals rub their bodies with kola or money which is then ‘spoken to’ and deposited in the pot of Fofie. The pot at the top of the shrine serves as receptacle for

⁸⁵ Annual Report, Krachi East Municipal Health Directorate, 2020-2022.

⁸⁶ Focus Group Discussion with Nana Kpebu II (Retired Ghana Revenue Authority Officer, Somanya), 62years old man, Openi Peter Kwesi Choni, farmer, and Kwadjo Brese, farmer, in Gyengyen, 27th February, 2021.

petitions. Spirits are believed to descend at midnight and carry the bad omen in the pot away.⁸⁷

The healing function of the Fofie deity at Abujuro was further illustrated during an interview with Nana Kofi Matenyi, priest of Fofie, when a woman confronted him with the following request:

Anyi has been admitted at the hospital. I need medicines to give to him. I need the medicine to mix in his food. He talks too much now. We need to perform libation too, Nana [priest]. I really need the medicines.⁸⁸

The above illustrates the combined use of traditional and orthodox prophylactics. For the mother of the sick boy, a combination of the two approaches (spiritual and physical) would facilitate healing. A small quantity of the medicine was given to the woman, which was to be ground and mixed in the soup served the boy. The mother of the patient further indicated as follows:

Nana Fofie should intercede. Nana Bruku should also help us. I earlier consulted a different deity when I noticed that the boy had lost his speech. I was given medicines at that shrine and they [the priest] said I should mention the boy's name three times, he will surely respond. I did so and he responded. My observation is that the boy's illness dislikes church. Anytime he attends church service, the illness reappears.⁸⁹

The priest of Fofie noted that the child's illness was associated with wild spirits believed to dislike churches. The Nana Bruku deity (at Shiare) was invoked to intercede because of its link with Dente.

⁸⁷ When fertility is sought from Fofie, the child is named after the deity. There is extensive use of herbs at the Fofie shrine. Water and *adwura* (*Portulaca oacea*) are used to cleanse people who are tormented by bad spirits. *Portulaca oacea* is from the family Portulacaceae. A decoction of the plant is prepared, and libation is poured at the shrine of Fofie.

⁸⁸ Personal observation during an interview session with Nana Kofikumah Matenyi, priest of Fofie at Abujuro, 1st March, 2021.

⁸⁹ *ibid.*

Fofie is believed to heal madness and epileptic (*kikpinkpin*) conditions. As noted earlier, the deity is consulted when signs of mental disorders are observed. The health function of Fofie was further alluded to as follows:

A patient who visited the hospital and the doctors could not cure him finally came here. Upon examination I realised that the boy was suffering from epilepsy, which is not the sphere of the hospital. Most of the conditions that I have handled were those sent to the hospital before they were brought here. I have noticed that most of these conditions that were initially sent to the hospital were supposed to have been brought here immediately because they were spiritual, rather than physical illnesses.⁹⁰

The difference between spiritual and physical illnesses has been highlighted in the quote above. Epilepsy is believed to be spiritual, for which reason the hospitals cannot treat it. It is believed that epileptic patients who have not been burnt by fire can be healed. On the contrary, people suffering from epilepsy and have been burnt by fire are believed to be incurable. The latter belief pertaining to epilepsy implies that the illness is either incurable or difficult to cure.

Like the Fofie deity, madness is believed to be healed by the Obourfa-Dadiefa deity. Husband of the priestess of Obourfa-Dadiefa shrine asserted in an interview as follows:

A man who was suffering from madness was sent to a prayer camp for treatment. His family paid an amount of ₵5, 500 (\$615) to a pastor who claimed had the cure to the condition. When efforts at healing the condition failed, another pastor said he could heal the man. He [the pastor] charged an amount of ₵17, 000 (\$1,903) but the family could not afford it. He was finally brought here [Gyanekrom, in Kete-Krachi] in February 2022. I instructed the family of the patient to buy alcohol and four eggs to plead for healing from the Supreme Being. I subsequently prepared herbs with which the mentally ill man bathed. We noticed some positive changes a few days

⁹⁰ Interview with Nana Kofikumah Matenyi, farmer and priest of the Fofie shrine, Abujuro, 1st March, 2021.

later and eventually, the patient recovered. I did not charge them any amount.⁹¹

Akorsah, a priest noted that madness cannot be healed in orthodox healthcare facilities since such illnesses require extensive use of herbal medicines. It was pointed out by the priest that although herbal medicines are used to heal madness, in instances where the cause of the condition is believed to be spiritual, other metaphysical approaches may be resorted to combat the condition. It should be noted that the priest identified signs of so called 'high fever' for madness. These include the lack of cooperation in the healing process and aggressive behaviour. Nevertheless, deities are further consulted to determine the cause of the condition. Madness is also believed to be inherited from parents or any relative who suffered the condition. Under such circumstances, it is referred to as *kananatɔ kulɔ* (inherited illness).

Insomnia is given spiritual interpretations in the Fofie shrine. According to the priest of Fofie, bad dreams and restlessness cannot be dealt with in orthodox healthcare facilities. They are believed to be spiritually caused, and sometimes said to emanate from the 'home'. Family members may be accused as responsible for such illnesses. Illnesses whose origins are associated with the 'home' are known as *obonsam yarie*, satanic illness. However, not every illness believed to be associated with the 'home' is *obonsam yarie*. Illnesses are, for instance, believed to be caused by the ancestors who feel neglected by society. Individuals who have dreams about certain bad spirits consult the Fofie deity.

⁹¹ Interview with Emmanuel Akorsah, priest of Kipera and husband of the priestess of the Obourfa-Dadiefa shrine, Gyankrom, Kete-Krachi, 8th July, 2021.

In Table 5.1, nineteen supplicants (representing 33% of the population) consulted the Obourfa-Dadiefa deity for spiritual healing. The shrine is easily accessible because it is located in Gyankrom, a suburb of Kete-Krachi. A traditional healthcare facility (serving as ward) has been constructed to accommodate petitioners (see figure 5.6). Mr. Emmanuel Akorsah, a priest, commented on the Obourfa-Dadiefa's healing efficacy as follows:

A woman was insomniac and came here because she was being pursued by evil forces. Besides, she experienced vaginal pains anytime she urinated. Upon enquiry from the deity, I realised that she was the cause of her own illness. The deity revealed to me that the woman refused to marry a man who had spent so much on her. I informed her about the revelation, and she confirmed that it was true. That was the cause of her illness.⁹²

In the light of the scenario above, the insomnia was cured using social, spiritual, and physical approaches. The social approach to healing began with rendering of apology to the man. The spiritual dimension entailed a completely ritualistic approach, where rituals of pacification were conducted. These two steps paved the way for physical healing, which involved the use of herbal medicine. Treatment of illnesses regarded as *yarie kwa* (physical illnesses) assume a physical approach. In other instances, physical illnesses may not require any intervention.

The priestess of the Obourfa-Dadiefa shrine uses herbal medicines and prayers to cure symptoms of urine retention. Interrogating the circumstances leading to his urine retention, Kojo narrated as follows:

I started feeling signs of urine retention in the farm. On arrival in Gyankrom, I visited Dr. Bawuah's hospital [in Kete-Krachi] where I was given medications. Even so, the drugs did not prove to tackle my condition well. ... I proceeded to the Municipal Hospital in Kete-Krachi the next day, but that did not improve my condition either. I then went back to Dr.

⁹² Interview with Emmanuel Akorsah, priest of Kipera and husband of the priestess of the Obourfa-Dadiefa shrine, Gyankrom, Kete-Krachi, 28th February, 2021.

Bawuah's hospital where I was finally referred to the Tamale Teaching Hospital [in Northern Region of Ghana] in December, 2020. However, as a result of the financial constraints, I could not go to the referred hospital. It was on a visit that a brother who is a traditional priest disclosed that my condition was not an ordinary illness. I was admitted at his shrine where I was consequently healed. Had it not been for him [the priest], I would have died because four other people suffered the same condition here in Kete-Krachi and died recently.⁹³

The cause of Kojo's urine retention was given spiritual interpretations by two priests from Tantu in the Kete-Krachi area. They indicated that spiritual medicines were buried in a path leading to Kojo's farm, and the victim was believed to have walked over them. Such spiritual explanations imply that the hospital is deficient in treating urine retention. The priests noted that spiritual illnesses, believed not to be the domain of orthodox healthcare, are perceived to be severe. It was therefore in view of this that the hospitals could not treat the patient. Such explanations confirm the health belief model, as well as the perceived severity of certain illnesses. Interaction with the patient in the shrine at Gyankrom could not take place during my first visit on the 9th January, 2021, as I observed that the patient was unconscious; he could not respond to calls of the daughter and a priest. Upon recovery, Kojo indicated that although he took all the prescribed medications while he was on admission at the two hospitals, he was not cured there. He did not, however, report or complain about any side effects because of the medications. This experience compelled Kojo to accept the spiritual explanations to his condition offered by the priests. The priestess of the Obourfa-Dadiefia shrine at Dadekro confirmed the spiritual underpinnings to Kojo's illness, leading to his admission at the shrine. The priest of the Obourfa-Dadiefia

⁹³ Interview with Francis K. Agyipo, farmer and discharged patient from the Obourfa-Dadiefia shrine, Gyankrom, Kete-Krachi, 27th February, 2021.

shrine, during an interview session, also confirmed that Kojo, his relative, visited hospitals but was not cured.



Figure 5.1: A patient suffering from urine retention seeking treatment in the Obourfa-Dadiefa shrine. Photograph taken with permission of the relatives of the patient and the priestess. The consent of the patient was sought after recovery before use of the photograph. Gyanekrom, Kete-Krachi. 9th January, 2021.



Figure 5.2: A patient (middle) after recovery from urine retention. With him are his children. Photograph taken by the researcher at Gyankekrom, Kete-Krachi. 27th February, 2021.



Figure 5.3: A patient (right) receiving treatment for heart pains in the Obourfa-Dadiefa shrine with the support of her daughter (left). Photograph taken with permission of the patient, her daughter, and the priestess, Gyankrom, Kete-Krachi. 9th January, 2021.



Figure 5.4: A patient suffering from a skin disease undergoing treatment in the Obourfa-Dadiefa shrine. Photograph taken with due permission from the priestess and the patient. Gyankrom, Kete-Krachi, 3rd July, 2021.

Healing in the Obourfa-Dadiefa shrine involves extensive use of herbal medicines. The next chapter discusses in detail the use of herbal medicines in shrines. It is imperative to indicate, however, that plants such as *efri* in Kaakye (*Gossypium arboretum* from the family Malvaceae) (*asaawa* in Twi), lemon and herbs are used for treatment of urine retention in the Obourfa-Dadiefa shrine. In addition, the patient drinks a decoction prepared from charcoal. These treatments are combined with hydrotherapy or hot water therapy; hot water is applied to the abdomen of patients to enhance urine flow. Patients cover themselves over the hot water to detoxify. The hot water, together with herbs, is used to bathe patients, and a quantity of the water is drunk. Indeed, the health effect of hydrotherapy, classified into thermal, mechanical, and chemical, is known. By definition, ‘thermal temperatures’ include heat (35 to 40°C), body temperature (32 to 34°C) and cold (8 to 10°C). High temperature enhances vasodilation and blood flow, while cold therapy reduces pain (An, Lee and Yi, 2019). Hydrotherapy is used as local cold or heat therapy, which is effective in reducing musculoskeletal symptoms and enhances post-traumatic recovery (Garra, Singer, Taira, Gupta, Mathaikuty & Thode, 2010; Malanga, Yan & Stark, 2014). As a result of its efficacy, hot/cold water is used in healing. Figure 5.5 is an enclosure where hot water is used in healing patients in the Obourfa-Dadiefa shrine.

5.3 Stages of healing

Four principal steps are followed in the healing process. The first is accommodation of patients in a detached apartment, serving as a ward. In Gyankrom, the ward was put up by the priestess of the Obourfa-Dadiefa shrine and her husband to accommodate the

increasing number of patients visiting the shrine (see figure 5.6). The facility again serves as the abode of the shrine. Patients are accommodated in the same room (ward) where the shrine is located to facilitate healing. Detached, but close to the wards, are a toilet facility (KVIP) and a bath house.



Figure 5.5. An enclosure where patients heat themselves with hot water. Photograph taken with the knowledge of the priestess of the Obourfa-Dadiefa shrine at Gyanekrom, Kete-Krachi. 8th January, 2021.



Figure 5.6: A two-bedroom uncompleted facility for patients. The Obourfa-Dadiefa shrine is located in the room. Photograph taken by the researcher on 8th August, 2022. Gyankekrom, Kete-Krachi.

The two-bedroom facility accommodates the male and female patients separately.⁹⁴ The facility which is sited close to the house of the priestess grants both the priestess and her husband the opportunity to quickly monitor the condition of patients. The researcher has already drawn attention to Cilliers & Retief's (2013) observation about how patients receive healing by sleeping in shrines. Indeed, the psychological impact of sleeping in shrines among the Krachi is worth stating. When probed whether sleeping in the Obourfa-Dadiefa shrine causes fear, the patients stated that it rather allays the fear for spiritual attacks, particularly at night. The night is believed to be a dangerous transitional/liminal period when malevolent spirits attack and aggravate the illnesses of patients. The deity is believed to offer protection to patients who sleep in the shrine. The belief in the deities can, in this light, offer psychic/psychological healing. This further confirms Twumasi's (1975) assertion that traditional practices allay the fears of the clientele which serves as psychotherapy.

Like the Obourfa-Dadiefa priestess, the priest of the Papakesie shrine constructed a four-bedroom apartment/ward (see figure 5.7) to accommodate petitioners or patients in critical condition and/or those who have come from far places. The rooms are shared according to sex to avoid breaking sexual taboos. It is a taboo for petitioners to have sex in the 'wards' while on admission. Patients live in the facility for several days, sometimes months, depending on the condition of the patient. Patients with mild conditions, may, however, be given traditional medicines to use in their residences. In the Obourfa-Dadiefa and Papakesie shrines, the 'wards' are detached from the residences of the healers because of

⁹⁴ Additional blocks are being moulded to expand the traditional healthcare facility.

certain taboos and the secrecy involving rituals of healing. A few respondents who received treatment in the Papakesie shrine indicated that they resorted to self-medication with orthodox medicines to facilitate healing. These self-medications were largely pain-killers.



Figure 5.7: A four-bedroom infrastructure serving as wards for patients in the Papakesie shrine. Picture taken by the researcher at Ehiamankylene, Krachi West Municipal. 23rd March, 2021.

The second step is the determination of the aetiology of illnesses. Determination of the causes, nature and treatment of illnesses is done through extensive consultation with the Dente deity. It was indicated that patients could contract illnesses through quarrels. This confirms the social framework within which illnesses are perceived. Illnesses may be attributed to negligence of a spirit/deity located in the house. For instance, failure to serve as a diviner or priest to domestic spirits is believed to lead to madness. The deity behind the condition has to be determined before therapy can be proffered. In addition, priests (especially those of the subordinate shrines of Dente) may consult diviners to find out the causes of illnesses or whether patients have come with *agywin boin* ('bad mentality') or *agywin fita* ('good mentality'). Those with *agywin fita* are admitted and healed. It is

believed that the cause of illness may be hidden by malevolent spirits. It is through the performance of libation and divination, among others that the causes and treatments of illnesses can be revealed.

The determination of the aetiology of illnesses ushers in the third step, which involves healing. Herbs are harvested from the bush/forest and prepared into medicines. Though the healer may have profound knowledge about herbal medicines uses, there is extensive consultation with the deities to further disclose useful plants. Roots are either pounded, ground or used in a raw state by the priests or priestesses, *akyeame* and children. Herbal preparations (liniments) may be used as analgesics (see chapter six).

Swellings involving all body parts are considered more spiritual. Whatever the case is, supernatural consultation helps to determine spiritual, physical and/natural, and social illnesses. Health is provided through the joint effort of the priest/priestess, diviner, *okyeame* (assistant), and relatives of the patient. Medicines may be stored in the shrines to make them more potent to heal.

As indicated in chapter three, *tukpoe* (*atukpe* among the Krachi) is crucial in the explanation of health. *Atukpe* is believed to be a gun which is 'fired' by an adversary to cause death or illness. If *atukpe* is suspected to be the cause of an illness, the healer prepares an anti-*atukpe* medicine, which is applied to the affected part. The belief in *atukpe* has led to the preparation of amulets which may be hidden in the room of patients, believed to counteract the 'missiles' of the enemy. A detailed discussion on healing is also offered in chapter six.

The fourth stage of healing involves visiting discharged patients. Priests or priestesses follow their clientele to their residences to monitor the use of medicines or ensure that the illness does not recur. While on visit to the houses of discharged patients, healers claimed to deal with the power of malevolent spirits believed to be the cause of clients' suffering. For instance, the priestess of the Akomagyo-Lente shrine indicated that she visited the house of Kojo and performed rituals to deal with any spiritual attack on the discharged client. Healers may task their *akyeame* to occasionally visit and monitor the health of discharged patient. To know whether or not a "power" has been "neutralised, divination would be resorted to.

5.4 The *akyeame*, shrines and healing

This study has highlighted in previous discussions that the *akyeame* perform many healing roles. The *akyeame* interpret the voices of spirits, conduct healing, and assist priests and priestesses in many capacities. Dente is believed to communicate information to supplicants through the priest and the *akyeame*. It is believed to assign specific illnesses to its *akyeame* to heal. There are four *akyeame* in the Dente shrine, one each from the Krachi towns of Kadantwe, Adankpa, Tworeso, and Gyengyen. It was gleaned from the field that in the past Dente's *akyeame* were many, and one can only conjecture the punitive action of Dente as a major reason the number of the *akyeame* has declined. According to an informant, *akyeame* that could not keep secrets or satisfy Dente in their line of duty were dismissed, and reconciliation with the deity entails expensive and elaborate rituals. The *akyeame* are believed to be chosen by the Dente deity itself. Patients who consult Dente

for healing are further assigned to the *akyeame* and other priests of affiliate shrines of Dente. Healing takes place in the house of the Dente *akyeame*. Efficacious plants are believed to be revealed to the *akyeame* with which they heal their clientele. The *akyeame* do the necessary arrangements before Dente is consulted. They are expected to be available always to assist the priest/priestess.⁹⁵

The *akyeame* may differ from one shrine to another based on the roles that they perform. The *akyeame* of the Dente shrine need to understand and decode the deity's language. In the case of Obourfa-Dadiefa, the priestess becomes possessed during ritual performances and discloses the demands of the deity. The *akyeame* listen to the possessed priestess and communicate the information to her later. Medicines are revealed to the priestess through possession. Like the Obourfa-Dadiefa, the Dente deity is believed to reveal healing efficacies to the priest through 'direct conversation' with the deity. A deity may have an *okyeame*, who serves as an assistant, interpreter, healer, and a messenger.

The priestess of Akomagyo-Lente becomes possessed and spends some time in the bush harvesting medicines, without the *okyeame*. The *okyeame* in the Akomagyo-Lente shrine can take on the roles of the priestess when she is in her menses. Menstrual prohibitions prevent a priestess from conducting certain rituals.

Priests of the affiliate shrines of Dente spend much time in the bush interacting with certain spirits. The bush serves as the dwelling place of different animals and/ as well as monsters such as the *sasabonsam*, an evil fire-breathing creature (Parish, 2003, p. 20). The *okyeame*

⁹⁵ As pointed out by the Dente priest, the role of the *akyeame* is a 'full-time job'.

listens to the names of herbs that are being disclosed through the priest/priestess when the latter is possessed. The training of the *okyeame* involves dripping into his nose and eyes certain concoctions. This ritual enables the *okyeame* to identify and locate herbal medicines. It further enables the *okyeame* to communicate with the spirits. These rituals are similar to those conducted for Gyampo, the founder of Dente, as pointed out in chapter four.

The *okyeame* leads the priest of Fofie when he is traveling or attending a function. Fofie priests must not walk alone, as they are believed to communicate with spirits while walking. The *okyeame* in the Fofie shrine takes cognisance of the conversation between the priest and the deity. Although it is the responsibility of the priest of Fofie to administer medications to patients, the *okyeame* can perform the same task on behalf of the priest. The *okyeame* of Fofie doubles as a herbalist and is allowed to heal patients. The training of the *okyeame*, which takes place in the bush, acquaints them with in-depth knowledge about local pharmacopeia.

5.5 Taboos (*takisi*), prohibitions and healing

Taboos and prohibitions constitute a crucial part of healing. Good health can be enhanced through observation of taboos. During healing, the actors (the priest, the patient and his/her family) must observe taboos. Although pork is considered a delicacy in many societies, its prohibition in the Dente shrine has a scientific implication, as fat can aggravate kidney and other health conditions. Women in their menses (*tégnɛ*) are prohibited from visiting the shrine. This prohibition is associated with the belief that menstrual blood can contaminate

shrines and reduce/neutralise their potency. The taboo on sexual intercourse during healing is associated with the belief that it can defile the deity and destroy the efficacy of the medicines. Patients who violate sexual taboos may be fined in cash or in kind. Fines for breaking taboos may, however, differ from one shrine to another.⁹⁶ A ritual of pacification (*kigywira/gywira*) is conducted when patients break taboos. Patients undergoing treatment are prohibited from the consumption of fresh meat and/or fish in all the shrines.

In the Papakesie shrine at Ehiamankyene, the priest highlighted specific health conditions and their prohibitions. He indicated that patients suffering from distention are prohibited from eating much food. Excessive eating is believed to aggravate certain kidney-related problems. In the Papakesie shrine, ulcer patients are prohibited from eating salt, as it may worsen their condition.⁹⁷

Apart from the taboos and prohibitions relating to healing, there are general taboos in the Dente shrine that deserve attention. Priests of Dente must not eat at night. As a result of this taboo, the wives of priests are expected to prepare supper early enough. This taboo is associated with the belief that bad spirits operate at night and can poison foods. The taboo helps to prevent noxious substances from falling into foods unnoticed. The residences of priests must be quiet. Silence is mandatory in the residences of priests/priestesses because they pay attention to their deities and spirits and interpret their voices.

A wife/wives of a priest of Dente must not pound *fufu* in the compound while it rains. This prohibition prevents rainwater on the bodies of the *fufu* pounders from dripping into the

⁹⁶ In certain instances when taboos are broken, patients may be required to pay a cow for the rituals to be repeated.

⁹⁷ The priest further indicated that there are two types of ulcers – the anus (*kokoo*)- and stomach-related ulcers.

food of the priest to contaminate it. Again, it is a great taboo to kill gorillas and to consume their meat. The taboo on the eating of gorillas is observed by the Dentewia clan. It is believed that illnesses associated with the consumption of gorillas cannot be healed by the Dente deity. Similarly, it is a taboo to eat an elephant because it is the emblem of Dente. The priest of Dente, nevertheless, sits on an elephant stool sculpture. *Pito* brewed from guinea corn, and *akpeteshie* (alcohol), are tabooed in the Dente shrine and its subordinate shrines. Only the *pito* produced from millet can be used to perform Dente rituals. Millet is cultivated by the Krachi people. This study has already indicated that millet is the staple food in the Kikpare shrine, which is prepared and served the deity. The use of millet in rituals is common to many societies. For instance, among the Tallensi, millet constitutes a critical aspect of sacrifices, to thank the ancestors for successful harvest of early millet and also for standing crops of guinea corn, and to avert quarrels or disputes that might arise when people flock to dance (Fortes, 1936). Nortey (2009) asserts that the traditional food for the Ga deities, during the Homowo festival, is *fofoli*, a special food prepared with *nmaa*, millet. The insistence on and continual use of traditional staple crops such as millet, in rituals in some societies in Ghana demonstrates the resilience of traditional societies amidst globalisation. Schnapps is used in libation involving Dente. Its use is also common among other ethnicities of Ghana. For instance, the Ga people use schnappe, water or any imported liquor during the Homowo festival to invoke the spirits of the dead (Nortey, 2009). The use of foreign drinks in the rituals of the Krachi also shows the effects of globalisation on their rituals.

5.6 Referrals

Referrals are made to higher or more powerful deities. As indicated earlier, for downward referrals the Krachi term *ke* ['to distribute'] is used when Dente 'refers'/'sends' patients to its affiliate deities to heal. This emphasises the power relations between Dente and its subordinate deities. Priests of the affiliate shrines of Dente indicated that referrals could be made among themselves or to Dente, but such referrals are usually delayed. All efforts to heal a patient or combat an anomaly are exhausted before a referral is made to a different shrine. When the condition of a patient worsens, priest-healers may invite their colleagues to offer assistance.

Three forms of referrals were identified by the researcher. The first form of referral is intra-shrine referral which takes place between priests of Dente and its affiliate shrines. Intra-shrine referrals may also occur among priests of the affiliate shrines of Dente. The second is inter-shrine referrals between priests of the indigenised shrines and Dente. Inter-shrine referrals can also occur between priests of the Dente, Bruku at Shiare and Akonedi shrine of the Larteh people in Eastern Region. As the study noted earlier, these shrines are linked with Dente. The third form of referral involves recommendations for further treatment in orthodox healthcare facilities. The priestess of the Obourfa-Dadiefa shrine pointed out that referrals may be made to the hospital when patients are not responding to healing. Slow/non-response to healing may be ascribed to physical illnesses requiring blood transfusion or Intravenous (IV) fluids. After visiting the clinic/hospital for blood transfusion or intravenous fluids, patients sometimes return to the Obourfa-Dadiefa shrine for spiritual healing. Patients occasionally visit the clinic/hospital for injections to alleviate pain. The priest of Fofie at Abujuro noted as follows:

When I was healing two patients in my shrine, I observed that they were becoming slim. I then referred them to the Kete-Krachi hospital where they were put on drips and they recovered. It was then that I realised they were lacking water [intravenous fluids] in their body.⁹⁸ For such illnesses the hospital is a better option.

In the Fofie shrine, non-response to treatment is considered as a symptom of physical illness, requiring orthodox treatments. It is based on this observation that illnesses may sometimes be referred to the hospital.

The effect of shrines on orthodox healthcare systems, in the context of referrals, was highlighted by medical staff in Ehiamankyine and in Kete-Krachi. It was pointed out that patients delay in seeking healthcare in the Kete-Krachi hospital because the healers do not refer patients to the hospital quickly. The study interrogated further whether or not medical doctors make referrals to traditional healers. Although responses elicited did not directly confirm this form of referral, it was indicated that a patient could be asked by a physician to “try elsewhere” when orthodox healthcare fails. The expression to “try elsewhere” is often interpreted as “using traditional approaches” to mitigate a health condition. Respondents pointed out that those who had no formal education background or acquired basic education usually visit the shrines for healing. On the contrary, individuals who obtained higher education and are gainfully employed usually prefer the orthodox healthcare system. Nevertheless, when critical, even the highly educated consult the deities for healing.

⁹⁸ Interview with Nana Kofikumah Matenyi, farmer and priest of the Fofie shrine, Abujuro, 1st March, 2021.

5.7 Factors responsible for utilisation of shrines

The study has pointed out earlier in the literature review the factors influencing health choices. This section continues that discussion in the context of shrines, and points out the cardinal factors that account for patronage of shrines as alternative healthcare choice among the Krachi people.

5.7.1 Social/religious factors

The SDOH model emphasises the social and spiritual factors that undergird the concept of health. Indeed, social and religious factors are responsible for the use of shrines in healing in the Kete-Krachi area. A few respondents indicated that Dente priests provide a holistic approach to treatment of illnesses. As this study has noted earlier, illnesses are viewed from physical, social, and spiritual perspectives. The inability of orthodox medical systems to combat the spiritual, and sometimes, social problems, often gives rise to the use of shrines as alternative healthcare. On the contrary, priests offer physical healing (through use of herbal medicines), social healing (by uniting society), and spiritual healing (through invocation of the supernatural) to their clientele. It was indicated on the field that a combination of the physical, social, and spiritual approaches ensures efficient restoration of health. A few of the respondents indicated that it is possible for a patient to restrict himself/herself to one mode of treatment. But in the long run, the sickness will recur, and in some cases, the sickness may aggravate. It is to prevent the recurrence of illnesses that the holistic method of healing offered by priests is sometimes resorted to. In addition, there is the belief that priests provide a comparative advantage of treatment of social and spiritual

illnesses over orthodox healthcare systems. This confirms Amegbor's (2014) view about the health utilisation model that different types of illnesses, based on their aetiologies, may receive different treatments.

The question whether or not social and religious problems could be dealt with in orthodox healthcare facilities was posed by the researcher. A medical officer indicated as follows:

We deal with social illnesses by pretending to give efficacious treatments to patients. Sometimes we detain patients in the hospital to keep them away from the society for a while. Where spiritual issues are involved, we only handle the physical component of the illness but do not discourage them from seeking healthcare with the traditional healers. Sometimes a combination of the spiritual and physical approaches may be effective in healing a condition. We live in societies where belief systems are entrenched. These [beliefs systems] matter in the restoration of health (KOP, anonymous, 9th May, 2022).

Indeed, the hospital in many cases is incapable of dealing with spiritual/social problems. Patients therefore resort to different approaches to deal with the social and religious problems with which they are faced.

5.7.2 Perceived effectiveness

As indicated in table 5.2, the failure of orthodox medicine to cure certain illnesses accounts for the use of shrines in healing. Out of the twenty patients receiving healing in the affiliate shrines of Dente, eleven of them (representing 55%) noted that deities are consulted for healing because they are perceived to be effective as compared to orthodox healthcare. A respondent illustrated this view when he said: "if they [orthodox healthcare systems] were that effective I would not have been seeking treatment here [in the Papakesie shrine]". The percentage of patients who indicated the 'failure of orthodox medicine to heal a disease' is

disproportionately high. These responses are linked to the social and religious explanations pertaining to illnesses. Other respondents indicated that it was not every condition that the orthodox healthcare system could cure. A few of the cases sent to the shrines were chronic. A proportion of the Medical Assistants interviewed confirmed this assertion when they indicated that chronic illnesses relating to the kidney, liver, and sometimes diabetes and hypertension, are usually sent to traditional healers because patients believe that such conditions are spiritually caused. Other sicknesses believed to be spiritually caused are HIV/AIDS and Tuberculosis. It was pointed out that patients with chronic conditions first sent their sicknesses to the hospitals/clinics but did not recover. In such circumstances the deities are perceived to be more effective than orthodox healthcare.

A patient who pleaded anonymity pointed out that he attended multiple hospitals, including the Worawora hospital, over his skin disease (see fig. 5.4), but they could not cure him until he finally heard about the Obourfa-Dadiefa deity in Kete-Krachi. A few patients pointed out that they initially sought healthcare in clinics/hospitals, but they were eventually asked to “try other sources” after their conditions became worse. When traditional mechanisms are resorted to to heal an illness which orthodox healthcare could not treat, the traditional healthcare system is perceived to be more efficient. These interpretations have consequences for health-seeking behaviour/healthcare choices. Many respondents alluded to patients’ use of shrines as ‘last resort’ to heal illnesses. A physician assistant and a few nurses in the Kete-Krachi area argued that they are sometimes incapable of treating certain critical conditions because patients delay in seeking healthcare in the hospitals. The delay in seeking early treatment in orthodox facilities is sometimes blamed on traditional healers. It is when the priests have failed in healing a condition that those

patients visit the hospital. A nurse referred to a woman who sought eye treatment in a shrine at Ehiamankyene before visiting the health centre in the town when all attempts by the priests had failed. This leads to “deterioration of health conditions”, the nurse noted. Patients consult the deities because of the general belief in their efficacy.

5.7.3 Economic constraints

Besides the social and spiritual perspectives, economic factors account for patronage of shrines as alternative sources of healthcare. Five out of the twenty patients interviewed (representing 25%) attributed their choice of shrines to low income. Low income refers to earnings below the daily minimum wage. In 2021, the daily minimum wage in Ghana was ₵14.88 (\$1.03). Out of the five patients, three (15%) of them receiving treatment in the shrines, noted that they did not have enough resources/income to send their illnesses to the hospital. Indeed, economic issues have been captured in the health utilisation model as a major determinant of health behaviours. Two (10%) of the patients however noted that, although they first sent their conditions to the hospitals for treatment, their inadequate income prevented them from seeking further treatment in the hospitals to which they had been referred. Income has been identified as an important determinant of health insurance status, such that most insured persons who have relatively higher incomes could access healthcare, compared to uninsured individuals (Bernard, Banthin, & Encinosa, 2009). Since healthcare comes with a cost, the income of individuals may directly influence health-seeking behaviour such that those who have enough finances can pay for health

services directly, as well as indirectly through the purchase of health insurance coverage (Nuhu, 2018).

The Ghana Statistical Service has indicated that the private informal sector is the largest employer in the Krachi West Municipal.⁹⁹ It engages 94.2 percent of the population. Many of the residents are engaged in agriculture, fishery, craft, and other artisan-related works. A few respondents noted that these occupations hardly provide them with the adequate resources to seek treatment in orthodox healthcare facilities. The 2010 Population and Housing Census and Krachi West Municipal Assembly reports do not contain data on income per household on the municipality. However, reports from the Municipal Assembly show that the Livelihood Empowerment Against Poverty (LEAP) in the Municipality covers 579 (out of 9,491) households made up of extremely poor people above age sixty-five.¹⁰⁰

When probed about average annual income per household, the respondents indicated that many yam farmers sell their annual harvests below ₵2,000 (\$223). It was further indicated that many farmers borrow monies to go into agriculture. After paying back their debts, farmers are left with meagre amounts for the entire year. The result is that many farmers have to borrow monies to go into farming again. These economic constraints are further aggravated by the high cost of public healthcare. With regards to the cost of healthcare in the hospitals, the respondents made references to malaria, which is one of the major health challenges in the Krachi West Municipal. They noted that, on the average, ‘the cost of

⁹⁹ Ghana Statistical Service (2014). 2010 population and housing census (District analytical report), Krachi West District, p.xi.

¹⁰⁰ Component budget for 2019-2022. Krachi West District Assembly; Component budget for 2022-2025. Programme based budget for 2022, Krachi West Municipal Assembly.

treatment for malaria in the hospital is about C200 (\$22.3)'. The analysis confirms Barker's (2014) assertion that socio-economic status of individuals such as education, income and occupation are positively associated with better health (Barker, 2014). Progressive education improves knowledge, health literacy, beliefs, and practices that are associated with better health and health outcomes (Barker, Leon, Greenaway, Collins & Movit, 2011). This further confirms the health utilisation model that low levels of literacy (education) can affect health choices.

In table 5.2, four (20%) of the patients interviewed attributed their inability to access orthodox health facilities to the high cost of medical care. For instance, apart from the social/spiritual interpretations to his condition, Kojo noted that he did not go to the Tamale Teaching Hospital to which he was referred because he would not be able to afford the cost of treatment there, which was why he consulted the Obourfa-Dadiefa deity for healing. Patients who alluded to the high cost of orthodox healthcare further noted that they did not have the National Health Insurance (NHIS) cards to access the clinics, for which they sometimes sought healing from priests. They further explained that the NHIS takes care of basic illnesses which can easily be treated with herbal medicines. Nevertheless, a respondent indicated that she could not afford the cost of NHIS registration. One of the respondents failed to renew the NHIS card because of the delays during registration. This confirms Aryeetey et al's (2014) view that the challenges facing the NHIS impact healthseeking behaviour.

In focus group discussions in the Ehiamankyene Health Centre and in the Kete-Krachi Municipal Hospital, the nurses alluded to patients who left the hospital because they did not have the NHIS cards and could therefore not afford the cost of treatment. Indeed, a

nurse and other patients noted the phenomenon of healer-shopping resulting from economic constraints. It was further pointed out that little or no cost of transportation is involved when seeking healthcare in the shrines. The time needed to travel for treatment increases the cost of treatment on households (Asante, Owusu, and Ahiadeke, 2014, p. 186). On the contrary, priests and priestesses are found in every community in the Kete-Krachi area which reduces the cost of transportation, and consequently the cost of treatment to households.

Table 5.2.: Reasons for failure to utilise biomedical health services

Causes	No. of Respondents	Percentage (%)
High cost of orthodox healthcare	4	20
Inadequate financial income	5	25
Failure of orthodox medicine to heal a disease	11	55
Total	20	100

5.7.4 Availability of traditional healers and medicines

The availability and proximity of traditional healers influences health choices. As shall be discussed in chapter seven, there are about fifty-six priests of the affiliate shrines of Dente in the Kete-Krachi area that have formed a healing association (see p.266 ff.). Apart from availability of healers, the respondents have indicated further that traditional medicines are readily available and accessible. Apart from that, the non-availability of orthodox healthcare amenities influences health choices. A few nurses in the Kete-Krachi Municipal Hospital pointed out that about thirty-six communities across the Oti River (such as Chinikope, Tokpo, Dzilakope, Basare and 1990, to state a few) do not have access to orthodox healthcare and this affects health choices. Nurses in the Kete-Krachi hospital visit

those settlements monthly. It was further pointed out by respondents that a CHPS compound project was started in Dadekro in 2018 but there was no adequate funding by government to complete it. This compels many people to seek alternative healthcare when they are ill.

Many respondents indicated contrarily that the availability of healthcare facilities could not influence the choice of healthcare. They indicated that it is not every condition that can be cured in public healthcare facilities. Indeed, an Acting Director of Health Services in the Krachi West Municipal, in an interview asserted that although the municipality has twenty-four health facilities (including one Public Municipal Hospital, one Private Hospital, three Health Centres and many Community-based Health Planning and Services (CHPS) compounds, individuals still depend on traditional healing. Patients in communities where healthcare facilities were not found indicated that they would have preferred orthodox healthcare, were those facilities to be available. Other respondents asserted that inadequate medical staff, especially in Hospitals and CHPS compounds, influence their use of shrines as alternative healthcare. This implies that some health conditions are sent to the shrines because of the unavailability of healthcare facilities and staff in their communities. The Annual Report of the Krachi West Municipal Health Directorate for 2021 shows that the doctor-to-population ratio in the municipality is 1: 12, 482. This shows that doctors in the municipality are inadequate.

5.8 Comparative analysis and discussion

This theme discusses the findings in the light of conceptual perspectives such as social determinants of health, helplessness belief, health utilisation, and help-seeking models used in this study. These frameworks discuss health within a social context. The findings of the study confirm the Africanised SDOH model by Ichoku, Mooney, and Ataguba (2013). The SDOH model discusses health from social and cultural perspectives. The study observed that individuals assign the causes of their illnesses to society. For instance, signs of urine retention may be assigned spiritual interpretation. The study noted that causes of urine retention may be attributed to sorcery. Dreams are relied on to combat illnesses or potential harm. This emphasises the social and religious context within which illnesses are understood.

The views of the respondents further confirm the helplessness belief model. Individuals encounter challenges in life, and therefore pose questions. Answers to their questions are classified according to underlying causal dimensions (Graham & Weiner, 1996, p. 75). These answers may be found in social and spiritual perspectives. However, the helplessness belief model suggest that human behaviours are not associated with their outcomes. The findings show, on the contrary, that the behaviour of individuals may be said to be responsible for their own affliction. For instance, a woman may suffer from an illness when she refuses to marry a man who spent so much on her. Under such circumstances, rendering of apology and performance of rituals are essential components of the healing process. The findings confirm Twumasi's (1975) assertion that sanctions from the spiritual world pertaining to bad behaviours may include ill-health. The physical state of individuals may

therefore reflect their spiritual-moral state. Individuals' freedom from the suffering thus require confession, performance of rituals and making of amends.

The study findings further confirm aspects of the health belief model used in this study. Illnesses which are believed to have supernatural explanations are viewed as severe and complex than so called 'physical illnesses'. Cues such as pain and incapacitation account for consultation of deities for healing. In the context of perceived susceptibility, it was observed that patients consult the deities to avoid looming death. The findings also correlate with the model's self-efficacy as individuals buy orthodox medications while receiving healing. Patients therefore rely on self-efficacy. The study does not deal with perceived benefits that individuals derive from participation in health promotion behaviours; it does not embrace rationalism as the ultimate basis for health-related behaviours.

The health utilisation model has largely been confirmed in the study. Nevertheless, the study did not delve into genetic considerations as noted by Andersen and Newman (1973), Aday and Anderson (1974) and Dutton (1986). The assertions by respondents greatly correlate with Amegbor's (2014) expanded health utilisation model. In terms of the socio-cultural environment which influences healthcare utilisation, respondents indicated that Dente priests provide a holistic approach to treatment of illnesses. As noted earlier, illnesses are viewed from physical, social, and spiritual perspectives. It was indicated by respondents that a combination of the physical, social, and spiritual approaches ensures efficient restoration of health. This belief gives rise to simultaneous use of orthodox and traditional healthcare approaches.

Amegbor (2014) noted the issue of health policies as a determinant of utilisation of healthcare. His view was confirmed by patients. They indicated that the NHIS takes care of basic illnesses which can easily be treated with herbal medicines. Amegbor further noted that a key factor for healthcare utilisation is health resources and accessibility. The study found that accessibility of health facilities and availability of personnel lead to the use of shrines for healing in the Kete-Krachi area. There is also the general perception that healers are effective over certain chronic diseases. Apart from the models used in this study, the findings also correlate with the literature.

The study noted that the views of the Krachi people regarding the aetiology of illnesses determines their health seeking behaviour and choices. As indicated, illnesses are believed to have spiritual dimensions. This confirms the assertion of De-Graft Aikins (2013) and Cilliers (2019). The findings also confirm Awusabo-Asare & Anarfi's (1997) opinion that perceptions about illnesses have a direct implication on health-seeking behaviour. Finding answers to the causes of diseases raises the supernatural question and the need to consult the deities. Such supernatural explanations to ill-health render it possible to rationalise difficult situations (Castle, 1994). The assertions of Awusabo-Asare & Anarfi (1997), and Castle (1994), have been confirmed by the study findings. Individuals consult the deities for healing when they suspect that their illnesses are caused spiritually. Awedoba (1998) pointed out that, among other considerations, views about illnesses inform help-seeking behaviour. Indeed, patients visited Dente shrines for recovery and protection by sleeping in the shrine. Besides, people sought fertility from the deities, albeit this may have arisen from social pressures.

De-Graft Aikins (2013) and Cilliers (2019) noted that the distinction between acute and chronic illnesses inform healthcare choices. The study observed that epileptic patients and patients who exhibited signs of mental challenges visited Dente shrines for healing. These conditions are considered hopeless, as attempts to treat them in hospitals failed. Under such circumstances, the causes of the conditions may be attributed to supernatural entities. The findings correlate with Cilliers' observation in Roman North Africa that patients sleep in shrines to receive healing. In Obourfa-Dadiefa shrine, for instance, patients sleep in the room with shrines. The study noted that this could enhance psychological and spiritual healing. The study further confirms De-Graft Aikins (2005) opinion that economic constraints of modern healthcare system and inadequacy of healthcare facilities for treating chronic illnesses render traditional medicine a fundamental choice for most populations in Africa. As indicated earlier, patients asserted that they visited the shrines for treatment because of the inadequate income levels that they derived from their farm produce.

Olupona (2004) noted that Western prophylactics are used first and when the illness persists, the diviner may be used as a credible option. The findings show that a few patients visited hospitals prior to their admission in the shrines. These patients were those who felt initially that their illnesses were physical. Nevertheless, in the Kete-Krachi area, many patients consulted the shrines for healing without visiting the hospital first. This assertion was justified by the nurses interviewed. The patients believed that their illnesses were spiritually caused.

5.9 Conclusion

This chapter has discussed the social and religious explanations to health. It also interrogated the various approaches to healing or combating illnesses. The chapter provides an understanding of the SDOH model used in this thesis. Illnesses are assigned different social, cultural, and spiritual explanations, which makes it possible to resort to different approaches of treatment, whether traditional, orthodox or both. Illnesses may, in addition, be given physical and/ natural meanings. Affiliate deities of Dente are believed to combat spiritual, social, and sometimes – in rare cases though – natural illnesses. The chapter further established that the spiritual and social explanations that undergird illnesses in Kete-Krachi do not in any way suggest that priests do not offer physical panacea to illnesses. The nexus between spiritual, social, and physical illnesses is so fluid that the latter illnesses may, sometimes, be assigned social and spiritual explanations. This makes it difficult to settle on a clear distinction between the two spheres of illnesses. Furthermore, the chapter established that deities are consulted in the Kete-Krachi area for several reasons. These encompass economic, political, religious, and social motives.

The perceived efficacy of Dente and its associated deities is linked with the observation of taboos and prohibitions. These taboos and prohibitions relate to shrines/deities, sex, animals and plants, interpersonal/social relations, and food. The ability of patients to recover from illnesses is perceived to depend on observation of taboos.

Healing is carried out by priests with the assistance of the *akyeame*. Care is given by priests and priestesses, *akyeame*, the family of patients, and sometimes the entire community,

described as actors in the healing process.¹⁰¹ In addition, the chapter established that economic activities that are characterised by risks and unpredictable losses account for human dependence on deities. Furthermore, the economic viability of individuals affects health choices. The high cost of orthodox healthcare, coupled with the inadequate income of the Krachi is responsible for the Krachi dependence on deities as alternative healthcare. Linked to the SDOH model is the general belief that orthodox healthcare is unsuitable for certain health conditions. Such explanations or perceptions affect health-seeking behavior/choices.



¹⁰¹ The families of patients and priests/priestesses perform essential roles in the traditional healthcare system. Patients share rooms with their families while on admission in the house of priests/priestesses. Caretakers/family members prepare food for patients because of the taboos which restrict patients from eating food prepared by outsiders or unknown sources. Children of priests and priestesses offer support by fetching water for patients and their families. Besides, children search for medicinal plants and prepare them into medicines. Herbs harvested by children may not require detailed spiritual preparations. Treatment of illnesses is sometimes concealed in secrecy because of the fear of attacks of malevolent spirits. However, there is a general acceptance of the expression, “‘sell’ your illness and receive the cure for it”. Although this may violate the issue of confidentiality, it helps in identifying the cure for diseases, as people voluntarily suggest cures. This accounts for the reason why healers ‘sell’ illnesses of patients. Where illnesses must be disclosed to others, the issue of ‘trust’ is the guiding principle.

CHAPTER SIX

PLANTS AND HEALING IN THE AFFILIATE SHRINES OF DENTE

6.1 Introduction

This chapter offers insights into the profound use of medicinal plants in healing in the affiliate shrines comparative to the main Dente shrine. It highlights specific illnesses and the various modes through which they are treated in the subsidiary shrines of Dente. As a result of its suitability in treating ailments, traditional healthcare system has demonstrated resilience to orthodox healthcare system. This resilience is, however, associated with a number of factors such as the spiritual and social circumstances within which illnesses are understood, the perceived effectiveness of plants and herbal medicines, among others. As noted in earlier discussions, the UNDP reports that about 80% of the population of Ghana relies on herbal preparations for primary healthcare (UNDP Report, 2007). This chapter interrogates the use of medicinal plants in healing, specifically in the Obourfa-Dadiefia, Fofie and Kikpare (Papakesie) shrines.

Different types of medicinal plants are used to heal various illnesses and conditions. In the affiliate shrines of Dente for instance, medicinal plants are used to treat convulsion, infertility, fever, epilepsy, to state a few. Medicinal plants are also used to facilitate conception and delivery of babies. In the Dente shrine itself, the priest does not conduct healing using herbal medicine, except the *akyeame* who possess in-depth knowledge about medicinal plants. Like the *akyeame*, priests of the affiliate shrines of Dente acquaint themselves with the healing properties of herbs, roots, among others, and perform cross-cutting roles as *adunsifo* (herbalists). The *akyeame* have, therefore, gained mastery over

the local pharmacopoeia. The *akyeame* and the priests of the affiliate shrines of Dente use herbal medicines in the course of healing.

In spite of its resilience, traditional healthcare is confronted with many challenges. These challenges encompass the unwillingness of priests and priestesses to disclose useful plants, the slash and burn agricultural practice, and the extinction of plants caused by modern agricultural technology, among others. This chapter shifts the discussion from a predominant social and spiritual healing offered by priests and priestesses to a more physical approach involving the use of herbal medicines. It therefore seeks to highlight how the environment in the Kete-Krachi area matters in the production and utilisation of traditional healthcare.

6.2 Specific health conditions and use of herbal medicines in the affiliate shrines of Dente

The use of herbal medicines in shrines to heal critical health conditions is enormous. This subsection discusses specific health conditions and herbal medicines in the Obourfa-Dadiefa, Fofie, and Kikpare shrines.

6.2.1 Herbal medicines and fertility

As discussed earlier in this study, infertility does not receive approbation by the society; it is a scornful spectacle. The social expectation on individuals to produce children after marriage puts pressure on couples to take necessary steps to seek fertility. Like many

societies in Africa, reproduction is interlinked with pride and prestige among the Krachi. As has been pointed out earlier in the literature review, individuals consult the Ewe *trɔxovi* deities in moments of barrenness and continuous miscarriages, among other conditions (Nukunya & Kwafo, 1998; Nukunya, 2003). In Kete-Krachi and Abujuro, priests and priestesses use herbal medicines extensively to cure infertility. The stem bark of the following plants is used by the priest of Fofie to treat infertility in both men and women: *kprinbeli* (*Maytenus senegalensis*), *kiba* (*Bridelia ferruginea*), *kinkirin* (*Burkea africana*), *potipoti* (*Parinari curatellifolia*), *kuntibura* (*Cussonia barteria*) and *kichawbese* (*Trichilia emetica*). The stem of the *kibutu* plant (*Euphorbia poissonii*, Fig. 6.1) is added to the plants. While it may be difficult to justify the combined efficacies of the plants, their single uses have been found to be curative. *Bridelia ferruginea* (Fig. 6.5) contains anti-microbial properties against gonorrhoea and syphilis infections that are known to be potential causes of infertility in women. Decoction prepared from *Bridelia ferruginea* is therefore used in the treatments of infertility. In Nigeria, the roots of the plant are boiled and administered orally to treat infertility (Macdonald, Oghale & Oyiza, 2016). Similarly, the bark of *Burkea africana* (Fig. 6.4) is used in the treatment of menstrual disorders which may affect conception (Steenkamp, 2003).

The priest of Fofie combine different plants, including *Cussonia barteri*, to treat infertility. Apart from its role in enhancing fertility, *Parinari curatellifolia*, ('hissing' or 'fever tree') (Fig. 6.8) is used in the treatment of malaria in both Fofie and Obourfa-Dadiefafa shrines. *Parinari curatellifolia* serves as anti-analgesic and anti-malarial medicine (Igbe, Edosuyi & Okhwarobo, 2018).

The *Euphorbia poissonii* and its species are used to treat infertility (Burkill, 1985). *Euphorbia poissonii* is characterised by a milky irritant latex, which causes itches. The plant was harvested from a small botanic garden established in the house of the Fofie priest. *Euphorbia poissonii* is difficult to find, which makes the establishment of such gardens crucial. Species of *Euphorbia* are used to enhance conception or fertility (Kemboi, Peter, Langat, & Tembu, 2020). *Euphorbia* spp. are known to cleanse the womb to increase the chances of conception (Kemboi et al., 2020). Apart from their uses in making women fertile, the *Euphorbia* spp. are widely used as medicines to treat respiratory infections, body and skin irritations, digestion complaints and inflammatory infections. They may be used to treat snake bite and scorpion sting. Other species of the plant are used as lactation stimulants and to induce labour. Their success in the traditional healthcare is associated with the various phytochemicals like polycyclic and macrocyclic diterpenes, which are crucial to both chemists and biochemists with reference to the discovery of drugs. In Burundi, the Philippines, China and Nigeria, the decoction of the leaves of *Euphorbia* spp. is said to contain anti-cancer and anti-hepatitis B. agents (Altundag & Öztürk, 2011). Similarly, the *Cussonia barteri* (Fig. 6.7.) is used in the treatment of infertility in women and sexually transmitted diseases (Oladimeji et al., 2017).

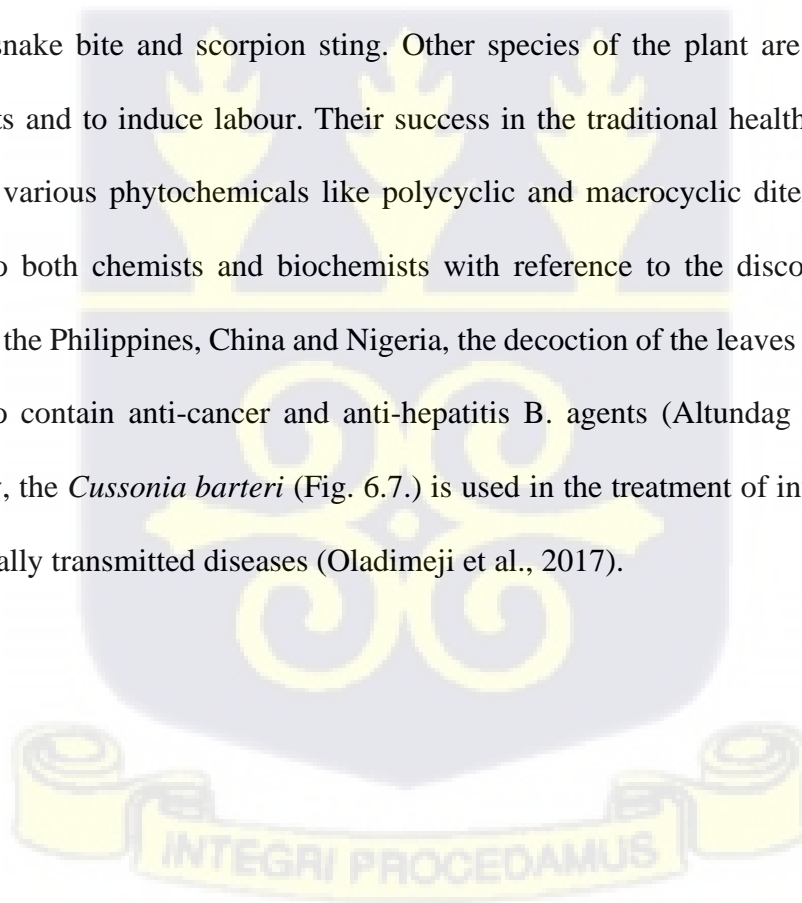




Figure 6.1.: *Kibutu* (*Euphorbia poissonii*). Photograph by the researcher, Abujuro. 4th July, 2021.



Figure 6.2.: *Kichawbese* (*Trichilia emetica*). Photograph by the researcher, Gyankrom, Kete-Krachi. 4th July, 2021.



Figure 6.3.: *Kprinbeli* (*Maytenus senegalensis*). Photograph by the researcher, Gyankrom, Kete-Krachi. 4th July, 2021.

A medicinal plant which is included in the treatment of infertility is *frɔki* (*Salvadora persica* L.), a rare plant in the neighbourhood of Kete-Krachi. Priests travel long distances in search of the plant. The bark of the plant is pounded, and pepper is added to the substance, which is then dried. In the Fofie shrine, women suffering from infertility prepare a quantity of the medicine which is drunk every morning to facilitate conception and ease delivery. The medicine is drunk even after conception. A hen is then sacrificed to the deity. A hen represents fertility of the womb. Furthermore, the priest of Kikpare shrine prepares a decoction from the leaves of *Moringa oleifera* for men to enhance sexual intercourse. There is the general perception among priests and priestesses that it is an arduous task to keep or safeguard pregnancy until delivery. Medicine prepared from *nsanfuri* (*Alternanthera caracasana*) is used to expedite conception and protect the pregnancy.

Apart from facilitating conception, the plant is believed to prevent miscarriages and stillbirths. Pregnancy is a period of transition, which necessitates rituals of healing. Turner (1974) argues that during rituals of transition, individuals in liminal periods are neither 'betwixt' or 'between'. It is for this reason that rituals of healing are essential in safeguarding the pregnant woman.

In the Kikpare shrine, *Trichilia emetica* (Fig. 6.2) is prepared to enhance fertility. This practice of the Krachi is similar to the Fula of Senegal who macerate *Trichilia emetica* spp. for women to cleanse their stomach in preparation to become fecund (Abbiw, 2015). In South Africa, Eastern-Africa and Brazil, *Maytenus senegalensis* (Fig. 6.3), like *Trichilia emetica*, is used to cure infertility, urethra infections and ulcers, respectively. The plant is characterised by thorny branches. Two major explanations were provided for the use of *Maytenus senegalensis* in the treatment of infertility. In the Kikpare shrine at Ofoase-Ndoboja-Motodua, it was indicated that infertility may be caused by *atukpe*, a spell. As has been pointed out earlier in this study, *atukpe* represents a gun, which is believed to cause harm to the human body. To neutralise the bullets equally requires a sharp object which can pierce the body. In the Fofie shrine, it was found that thorny plants are mixed with other medicines to neutralise the 'bullets' of the enemy, believed to be the cause of infertility. The second explanation is that the womb of women – and to a lesser extent the sexual organs of men – may have been 'sealed' by spiritual forces which account for use of *Maytenus senegalensis*, to 'perforate' such 'seals'. The plant, however, has biomedical uses. Harbone and Baxter (1993) have found that the plant is potent in fighting cancer. In South America, *Maytenus* spp. are used to treat gastrointestinal ailments such as ulcers. Moreover, they are used as analgesics (Matu, 2003). *Burkea africana*, which is used to

make a woman reproductive, is common in towns such as Kpandai and Kete-Krachi. Apart from the belief that it boosts pregnancy, the powdered stem of *Burkea africana* is used in Mali in the treatment of stomatitis.¹⁰² It is, therefore, not surprising that the plant is used as a chewing stick among the Krachi people. Its efficacy is associated with the content of tyramine. The stem bark of *Burkea africana* is reported to treat gastrointestinal symptoms and headaches (Malterud, 2017).

The social expectation for reproduction is not limited to the Krachi alone. Pavanello and Schirripa (2011) provide insights into the situation among the Nzema of the Western Region. Among them, treatment of infertility is meant to cool the heat in a woman to enable her conceive and endure it. It is from this perspective that a woman, who has an *anwoma*¹⁰³ (feeling of heat in the stomach) or has witnessed miscarriages with the symptoms of an *anwoma*, requires immediate treatment with identifiable plants such as *baya* (*Mitragyna stipulosa*) and *esia*¹⁰⁴ (*Petersianthus macrocarpus*). *Mitragyna stipulosa* and *Petersianthus macrocarpus* are from the Rubiaceae and Lecythidaceae families, respectively. The barks of the plants are boiled, and the concoction injected into the anus of a woman through an enema to make her fecund (Pavanello & Schirripa, p.147). A major prohibition for people who seek fertility from the Dente deity (or its subsidiaries) is quarrels between sexual partners. This prohibition enables couples to sleep together and reproduce. Medication may be combined with counselling (Adu-Gyamfi, 2015, p. 10). Indeed, among the Krachi,

¹⁰² Stomatitis is a term used for inflamed sore mouth. It can occur around the mouth, in the cheeks, palate, gum, lips and tongue.

¹⁰³ In Nzema language

¹⁰⁴ Also known in Akan as *esia-kokobin* or *asia*.

women suffering from infertility may be advised to desist from visiting people believed or suspected to be the cause of the infertility.



Figure 6.4.: *Kinkirin (Burkea africana)*. Photographed by the researcher, Gyankrom, Kete-Krachi. 4th July, 2021.



Figure 6.5.: *Kiba (Bridelia ferruginea)*. Photograph by the researcher, Gyankrom, Kete-Krachi. 4th July, 2021.



Figure 6.6.: *Nsanfuri* (*Alternanthera caracasana*). Photographed by the researcher in the mini-botanic garden of the priest of Kikpare shrine, Krachikrom. 4th July, 2021.



Figure 6.7.: *Kuntibura* (*Cussonia barteri*). Photographed by the researcher, Gyankrom, Kete-Krachi. 4th July, 2021.



Figure 6.8.: *Potipoti* (*Parinari curatellifolia*). Photograph courtesy: the researcher, Gyankrom, Kete-Krachi. 4th July, 2021.

6.2.2 Herbal plants and childbirth

The factors responsible for prolonged labour include the following: inefficient uterine contraction, contracted pelvis, enlarged fetus and malpresentation of the baby. The psychological factors include abnormally tensed or apprehensive women, fear and exhaustion and the lack of sensation which may inhibit a woman's ability to deliver on time (Bennett & Brown, 1996, pp. 399 & 401). Among the Krachi people, families, however, consult the Dente and its affiliate deities during prolonged labour. Prolonged labour among the Krachi is considered to be more spiritual than physical. Even so, both spiritual and physical approaches – the latter involving the use of herbal medicines – are employed in such cases. Prolonged labour may be associated to marital infidelity. Although social or spiritual explanations may be assigned labour difficulties, the use of herbal

medicine to facilitate childbirth is common. A concoction prepared from *emire*¹⁰⁵ (*Terminalia ivorensis*), *Nunum*¹⁰⁶ (*Ocimum gratissimum*) and a plant identified as *piya*¹⁰⁷ are used as oxytocic agents. *Terminalia ivorensis* and *Ocimum gratissimum* belong to the families *Combretaceae* and *Lamiaceae*, respectively. The leaves of the plants are macerated, and a quantity of water is sprinkled over the medicines. The concoction prepared from *Terminalia ivorensis* and *Ocimum gratissimum* is dripped on the tongue of the woman to facilitate childbirth.¹⁰⁸ Ogbe et al. (2009) point out that the fresh leaves of *Ocimum gratissimum* and dried ground seeds of *Aframomum sceptrum* K. Schum. are applied at the lower abdomen of a woman to treat miscarriages. *Parinari curatellifolia* (Fig. 6.8) is also used to facilitate delivery and improve the health of babies (Sibiya, Kayitesi & Moteetee, 2021).

6.2.3 Medicinal plants and epileptic conditions

Epilepsy (*kikpinkpin*) is believed to be healed in the affiliate shrines of Dente, particularly in the Fofie shrine at Abujuro. Epilepsy is a common neurological disorder which is characterised by frequent seizures. In the Dente shrine itself, prayers are offered for individuals suffering from epilepsy before they are redirected to seek healing in the Fofie shrine. Priests of Fofie, like the Obourfa-Dadiefa priestess, are believed to possess enormous knowledge of medicinal plants. The application of herbal medicines in shrines add to the existing physical approaches to healing. Plants used to treat epilepsy in the Fofie

¹⁰⁵ In Akan language.

¹⁰⁶ Also called *onunum*.

¹⁰⁷ The plant was not found, as a result, the scientific name could not be determined.

¹⁰⁸ It is dripped four times on the tongue of the pregnant woman.

shrine include: *kuntikinimsa* (*Stereospermum kunthianum*), *kichawbese* (*Trichilia emetica*), *kibwe* (*Strophanthus hispidus*), *kidinponansi* (*Pseudocedrella kotschyi*) and *kikyikankya* (*Prosopis africana*).¹⁰⁹ The roots of the plants are pounded and boiled. The concoction is drunk twice a day (in the morning and evening). It is worth noting that *Prosopis africana* (Fig. 6.11.) is pounded separately and sniffed. Besides, the leaves of the plants are boiled and poured into a container or pot, over which epileptic patients cover themselves with a piece of cloth. As stated earlier, hot water is significant in the healing process. Sweat caused through thermal therapy is believed to be signs of recovery of the patient.

Kuntikinimsa (*Stereospermum kunthianum*, Fig. 6.10) in Krachi is derived from the flexible nature of the plant. The plant serves as feed for elephants, and is common in the Savanna regions (Oloche, 2016). *Stereospermum kunthianum* is found in places such as Kpandai and Kete-Krachi in the Northern and Oti regions, respectively. The Nawuri call the plant *kuntikagbiri*, which means the ‘elephant’s trap’. The plant possesses anti-convulsant effects believed to be potent for treatment of seizures (Reid et al., 2009). Like *Stereospermum kunthianum*, *Pseudocedrella kotschyi* (Fig. 6.9.) and *Trichilia emetica* are used to treat epileptic conditions because they possess phytochemicals with pharmacological property (Reid et al, 2009).

The *Kichawbese* plant (*Trichilia emetica*) has enormous medicinal uses. *Kichawbese* translates literally as ‘monkey’s kola’ as the seeds are eaten by monkeys. In terms of its

¹⁰⁹ Other plants in the Krachi language are *kininini* and *kafrɔ*. *kininini* and *kafrɔ* have become scarce in the Kete-Krachi area.

nutritional value, *Trichilia emetica* seeds are found to contain protein, fat, fiber, water, and mineral content. Moreover, the seeds contain fat and carbohydrates, and minerals such as magnesium, iron, potassium, and phosphates (Saka & Msonthi, 1994). Drug treatment for epilepsy is not readily available in orthodox healthcare facilities (Komane, Olivier & Viljoen, 2011). Kipp, Kasoro, and Burnham (1993) and Ovuga, Ogwal-Okeny, & Okello (1992) have indicated a possible association between prevalence of epilepsy and onchocerciasis in Uganda, which was confirmed by Kaiser, C., Kipp, W., Asaba, G. Mugisa, et al. (1996) in a different study. It should, however, be pointed out that the association of onchocerciasis and epilepsy has been suspected by the WHO Expert Committee on Onchocerciasis Third Report (1997). The plant is used as anti-convulsant by traditional healers. Leaf extracts of *Trichilia emetica* demonstrate dichloromethane and methanol properties that are useful in the treatment of convulsion (Bah, Ja'ger, Adsersen, Diallo & Smestad-Paulsen, 2007). As a result of its efficacy, *Trichilia emetica* is used by the priests to cure epilepsy.



Figure 6.9.: *Kidinponansi* (*Pseudocedrella kotschy*). Photographed by the researcher, Gyankrom, Kete-Krachi. 4th July, 2021



Figure 6.10.: *Kuntikinimsa* (*Stereospermum kuntianum*)
Photographed by the researcher, Gyankrom, Kete-Krachi.
4th July, 2021



Figure 6.11.: *Kikyikankya* (*Prosopis africana*) Photographed
by the researcher, Gyankrom, Kete-Krachi. 4th July, 2021

There are other common medicinal uses of *Trichilia emetica*. The plant serves as antidote to the venom of black-necked cobra. It is used to treat syphilis ulcers, guinea-worm sores, and wounds. Besides, the plant serves as an anti-microband, which facilitates wound healing (Agyare, Dwobeng, Agyepong, Boakye, Mensah, Ayande, & Adarkwa-Yiadom, 2013).

Like *Kichawbese* (*Trichilia emetica*), *kibwe* (*Strophanthus hispidus*) is essential in the treatment of epilepsy. *Strophanthus hispidus* is known to be anti-epileptic and anti-psychotic (Ayoka, Akomolafe, Iwalewa, Akanmu, Otas, & Ukponmwan, 2006). The plant, known in Twi as *maatwa*, is common in Ashanti Region of Ghana. Trading activities between the Ashanti and Krachi in the past expanded the latter's knowledge of medicinal plants. The medicinal uses of *maatwa* may have been introduced to the Krachi people in the past through the Mprah and Tano priests in Kete-Krachi. The priests, together with their respective lineages, as previously noted, trace their origin to Ashanti Region.

Other uses of *Strophanthus hispidus* include treatment of leprosy, dysentery, and gonorrhoea. In Ghana and Nigeria, a decoction of the root is ingested to treat rheumatism (Agbaje & Fageyinbo, 2012). As earlier highlighted in this study, epileptic patients who have been burnt by fire are believed to be incurable. Such conditions may, therefore, be said to be punishment from the Supreme Being or associated with the *konokra* (destiny). *Akpetembi* (asthma) is treated in the Obourfa-Dadiefa shrine with the use of herbs and honey. Signs of stroke are treated in the Obourfa-Dadiefa shrine using honey, alcohol and lemon.

6.2.4 Medicinal plants and seizures

The term *susu* or *osusupu* (seizures/convulsion) – literally, ‘sky spirits’ – emanates from the Krachi belief that the illness originates from the spiritual forces. There are several approaches for dealing with seizures among the Krachi people. The *kafrɔ* plant is crucial for the treatment of seizures. A decoction of the plant is prepared from the roots (*alakii*) of *kafrɔ* and a quantity is dripped into the nostrils of the victim, mostly children. A sneeze symbolises recovery. Furthermore, a concoction is prepared from the leaves of *emire*¹¹⁰ (*Terminalia ivorensis*), *piya*, and *nunun* (*Ocimum gratissimum*), which is used to wash the face of the child. Convulsion is commonly cured in Fofie and Obourfa-Dadiefafa shrines. Specifically in the former shrine, three approaches are commonly used. The first approach involves covering up patients over hot concoction/decoction. This method is not only attributed to the Krachi alone. Hippocrates note that high temperatures had a beneficial effect on epilepsy (Jada et al. 2023). Similarly, thermal temperatures of 37°C were reported on mice to fight against seizures. The second method involves sniffing of ground herbal medicines. In the third approach, incisions are made on the cheek of the patient, in which medicines are applied.

Children are believed to suffer from convulsion because they are said to be vulnerable to attacks of bad spirits. Apart from individuals who have treatments to convulsion, children may be sent to the shrine for healing. *Terminalia ivorensis* is used by the Yoruba in incantations to ‘close the paths’ of evil during birth rituals associated with an *abiku* (a reincarnated child) (Abbiw, 2015). Although the Krachi people have their own ways of

¹¹⁰ Also spelt, *emeri*

dealing with spirits haunting children, it was emphasised by a few respondents that knowledge about the use of plants to expel evil spirits from children was obtained from the Yoruba during their trade with Kete-Krachi.

6.2.5 Herbal medicines and stomachache

It was found that herbs such as *kinkirin* (*Burkea africana*), *frɔki* (*Salvadora persica* L), and *kikyamunamoin* (*Flacourtia flavescens*, Fig. 6.12.) may be combined or used separately as treatment for stomachache or upsets in the affiliate shrines of Dente. Patients drink a concoction prepared from the roots of the plants and salt. The significance of *Burkea africana* in the treatment of sore mouths and its ability to boost pregnancy has been indicated earlier in this study. The use of *Burkea africana* for treatment of stomachache was found in the Obourfa-Dadiefa and Fofie shrines. Nonyane and Masupa (2010) have noted the efficacy of the stem bark of *Burkea africana* in the treatment of stomachache, while Augustino et al. (2011) have noted its use as a pain killer and treatment of headache, abdominal pains and diarrhoea. The stem bark of *Burkea africana* is used in traditional medicines as analgesics. Besides, the plant is used for the treatment of venomous stings. *Flacourtia flavescens* is believed to be potent over the treatment of malaria. The plant is categorised into male and female, with the latter bearing fruits. *Burkea Africana* and *Flacourtia flavescens* are used together to treat malaria (Micheline, Karou, Sanon & Fatiou, 2011).



Figure 6.12.: *Kiyamunamoin* (*Flacourtia flavescens*)
Photographed by the researcher, Gyankrom, Kete-Krachi.
4th July, 2021.



Figure 6.13.: *Dundulasi* (*Alternanthera sessilis*)
Photographed by the researcher, Abujuro, Kete-Krachi.
4th July, 2021

6.2.6 Herbal medicines used for preterm (weak) babies

Weakness in babies may be a result of prolonged labour. It may be associated with birth asphyxia, that is the lack of oxygen to the fetus or a child at the time of birth. However, preterm babies may be given spiritual interpretations. It is in view of this that a stump (*kilenteng* in Kaakye) or *ahunabobrim* (literarily, fright in Twi) (Fig. 6.14) is believed to improve the health of such babies. The term *ahunabobrim* shows how the stump frightens people who come into contact with it, especially at dawn. Its use in healing has spiritual connotation. Bad spirits are believed to cause weakness in babies. A baby's inability to develop well after birth may be blamed on traditional birth attendants or anyone who assisted the delivery of the baby. A piece of the *ahunabobrim* is therefore used in the medicine to 'frighten' and deal with the power of the spiritual force behind the baby's condition. A stump is soaked in water and used to bathe the baby. *Ahunabobrim* is believed to be deceptive. It is, for instance, believed to squat and take the shape of humans. For the priest of Fofie and the priestess of the Obourfa-Dadiefafa shrine, the characteristics of *ahunabobrim* makes it suitable in fighting bad spirits, regardless of the form such spirits may assume. *Trichilia emetica* is used by the priest of Fofie to improve the health of babies. Unlike *ahunabobrim*, *Trichilia emetica* offers medicinal uses that are essential in the traditional healthcare. In Tanzania, species of *Trichilia emetica* are ground into powder and rubbed on children to make them grow big and strong (Abbiw, 2015).



Figure 6.14.: *Ahunabobrim* (a stump). Photographed by the researcher, Gyankrom, Kete-Krachi. 4th July, 2021.

6.2.7 Herbs used to enhance sleep

People suffering from insomnia consult the Fofie and the Obourfa-Dadiefa deities to enhance sleep. In the former shrine, the leaves of the *dondulasi* (*Altenanthera sessilis*) plant are soaked in water, with which the victim bathes. The bath is said to ward off evil spirits believed to be the cause of the insomnia. Similarly, in the Obourfa-Dadiefa shrine, a decoction is prepared from *Altenanthera sessilis* which is bathed to boost sleep. *Altenanthera sessilis* is described as the ‘dwarf copperleaf’ and is believed to contain gold. The belief enhances understanding of the spiritual interpretations associated with the plant. Gold is believed to be spiritual among the Krachi and other Ghanaian societies. *Altenanthera sessilis* is therefore believed to drive away evil spirits. Apart from the

Altenanthera sessilis, *kikyikankya* (*Prosopis africana*) is soaked in a bucket of water, with which individuals bathe in both the Obourfa-Dadiefa and Fofie shrines to boost sleep. *Prosopis africana* is believed to expel evil spirits from their hosts. Although the literature points to the spiritual uses of the plant, *Altenanthera sessilis* is used as an anti-malarial (Kumar & Sanjib, 2013) and anti-stress medicine (Shehzad, Qayyum, Rehman, Nadeem, & Shehzad, 2018). Other medicinal uses of *Altenanthera sessilis* include treatment of hernia, hepatitis, asthma, and lung conditions.

6.2.8 Herbs used to heal swellings

In the Obourfa-Dadiefa shrine, swellings are treated using *Calotropis procera* (*yiridi* in Kaakye, *mpatu-asa* in Akan, and *kaboi-ansi* in Nawuri, Fig. 6.15). There are spiritual explanations to the use of *Calotropis procera* which is worth stating. The plant produces big but light fruits, which for the Krachi symbolise swellings. The leaves and fruits of *Calotropis procera* are either ground or pounded and applied on swellings. A study conducted to determine its anti-inflammatory effect has shown that extracts of *Calotropis procera* leaf have demonstrated anti-inflammatory effects by stabilising human red blood cells exposed to heat, among others (Obese, Ameyaw, Biney, Henneh, Edzeamey & Woode, 2018). Apart from its spiritual relevance, the plant offers other nutritional and medicinal uses. *Calotropis procera* is used by the Fulani herdsmen in Kete-Krachi in the preparation of *wagashi* (cheese). The plant converts diary into cheese. Unlike the priest of the Obourfa-Dadiefa shrine, the priest of Kikpare highlighted the use of *okankanse*

(*Dysphania ambrosioides*, Fig. 6.16) in the treatment of swellings. Salt is mixed with ground *Dysphania ambrosioides* and applied on the affected part.



Figure 6.15.: *Yiridi* (*Calotropis procera*). Photographed by the researcher, Kete-Krachi, 5th July, 2021.

In the Kikpare shrine at Osramane-Ofoase, *kabuŋinɛ* (*Sicyos angulatus*, Fig. 6.17., from the family Cucurbitaceae) is prepared together with orange juice to treat fever. The *kiprati* plant (*Portulaca oleracea*, Fig. 6.18, from the family Portulacaceae) is used to treat coughs. A decoction of the plant is dripped into the nostrils to cure the cough. *Portulaca oleracea* is also used to treat joint pains and other skin infections (Ezekwe, Omara, Thomas, & Membrahtu, 1999). Like the Krachi, Dokosi (1998) reports a species of *Portulaca*, *Portulaca quadrifida*, which is used typically in India to treat erysipelas, and to deal with fever in Java. A decoction of *kitire* (*Cleome viscosa*) is dripped into the ear to alleviate pain. Although the plants appear to be used physically, there are spiritual undertones to their usage, which may be known only to the priest. In both Fofie and Obourfa-Dadiefa

shrines, *Akomfem-atikɔ* (*Helitropium indicum*), a corruption of *akomfentikoro* in Akan is macerated and the decoction is dripped in the affected eye to reduce pain or clean the eyeball. The plant is common in many parts of Ghana, with a nice-looking flower like the head of a guinea fowl, given it the Twi name, *akomfentikoro*, the ‘head of a guinea fowl’.



Figure 6.16.: *akankanse* (*Dysphania ambrosioides*). Photographed by the researcher in the mini-botanic garden of the priest of Kikpare shrine, Kete-Krachi.



Figure 6.17.: *Kabuɔɔne* (*Sicyos angulatus*). Photographed by the researcher in the mini-botanic garden of the priest of Kikpare shrine, Kete-Krachi. 4th July, 2021.



Figure 6.18.: *Kiprati* (*Portulaca oleracea*). Photographed by the researcher in the house of the priest of the Kikpare shrine, Kete-Krachi. 4th July, 2021.

6.3 Harvesting and preparation of herbal medicines

Priests and their *akyeame* (assistants) are responsible for searching for plants. A few medicinal plants, as will be noted later, are scarce in the Kete-Krachi area, and healers trek long distances in their search (see pp.237 & 238). Children may be taught medicinal plants and their locations and are occasionally sent to harvest them. Those children are, nevertheless, not sent too far from the settlements because of perceived spiritual attacks that may be associated with harvesting of plants. Such children (particularly those related to priests and priestesses) may be prospective healers and *akyeame* and are therefore taught the practice of healing.

Spiritual preparations and consultations may be made before plants are harvested. In such instances, cowries are deposited under trees to seek the attention and healing efficacy of

the spirit before plants are harvested. As indicated, trees, for instance Kikpare, are believed to be dwelling places of spirits for which they are worshipped. The use of cowries – which in the past served as money – denotes the ‘buying’ of plants from the spiritual entities. Even so, it is expected that parts of the plants be harvested. This practice ensures that the ecology is not arbitrarily destroyed. Passers-by (and this may include strangers) are restricted from harvesting roots of plants in towns. It is believed that strangers with bad intentions may reduce the efficacy of deities, bring catastrophe to society, or even collapse markets when they harvest roots from towns. Due to the Krachi reverence for plants, libation may be poured by healers before harvesting medicinal plants. The following illustrates this: “*Nana* [name of ‘spiritual plant’], *mba kui fɔ kilakii, ya wa adu, yili kɔ ɛwa ilin*, to wit: “*Nana* [name of spiritual plant], I have come to dig your roots, may it be efficacious”.

Apart from their role in harvesting medicinal plants, children assist in the preparation of herbal medicines. For instance, they cook, mould, pound roots and barks of plants, and help to administer treatments to patients. Like children, women in their menopause can participate in the preparation and administration of medicines to patients. Similarly, girls can prepare medicines, but they cannot do so when they are menstruating. Balls of medicines are preserved and are periodically dried, sometimes in the kitchen. The heat in the kitchen helps in the preservation of medicines that may be used at critical times or in future. Medicines can be consumed, smeared, sniffed, or bathed. Charms and amulets (*gyabuni*) are, however, worn around the waist, ankles, and arms. Charms and amulets are used as protective medicines, but they can sometimes be used to expel evil spirits from their hosts.

6.4 Herbal medicines, change and reciprocal exchanges in shrines

Like any traditional practice, healing in the shrines has evolved with time. Anyinam (1987) concurs with Foster and Anderson (1978) that one aspect of the African culture that has considerably altered is the traditional medical systems. These include knowledge in healing, beliefs, values, and practices pertaining to indigenous medical practitioners. In the shrines, herbal medicines may be used together with orthodox medicines. Orthodox medicines may not be recommended by the priests or priestesses, but patients who initially were seeking treatment in orthodox healthcare facilities come along with them to the shrines in the process of healing. Others also purchase orthodox medicines while receiving healing to reduce pain. The priestess of Obourfa-Dadiefa uses bottled herbal preparations believed to treat malaria (see fig. 6.19). Apart from the herbal medicines, priests and priestesses apply liniments to reduce pain.

Herbal medicines may be borrowed from other healers during treatments. Kinship sometimes matters when seeking or receiving medicines from other priests/priestesses. As a result, priests and priestesses seek or accept medicines from their relatives who are equally healers. The Twi expression, *adunsifoɔ nim afe* – meaning ‘herbalists know each other’ – captures it all. Priests and priestesses do not sell their medicines to their colleague healers. This is due to the belief that a priest-/priestess-healer (the giver) may need medicines from the recipient of the medicine in future. There is, therefore, reciprocal exchange of medicines between priests and priestesses of the affiliate shrines of Dente. It was indicated by a few priests that herbal medicines must not be sold as they are considered as gifts from the spirits. The restriction on the sale of medicines may, to some extent, relate to priests whose knowledge in traditional medicines was acquired through spiritual means,

like possession by dwarfs. Exorbitant charges are believed to reduce the efficacy of traditional medicines. Indeed, traditional healthcare is not viewed entirely as a business avenue. A recuperating patient may be given additional herbal medicines to use in the house.



Figure 6.19.: Herbal medicines used in healing in the Obourfa-Dadiefa shrine. Photograph taken by the researcher at Gyankrom, Kete-Krachi. 9th January, 2021.

6.5 Challenges facing herbal knowledge in the Kete-Krachi area

Fabricant and Farnsworth (2001) have asserted that parts of plants that are used in healing are often kept secret by the practitioner. Consequently, little information about medicines has been recorded. Indeed, although four affiliate shrines of Dente were considered for this study, two priests and a priestess of the subsidiary shrines offered to discuss the use of medicinal plants in their respective shrines. Medicinal plants used by the *akyeame* of Akomagyo-Lente were, however, not disclosed to the researcher during the interviews, although the priestess indicated the extensive use of herbal medicines in healing. The priestess of Akomagyo-Lente noted that medicinal plants are revealed through possession. The priest of Fofie noted that disclosing medicinal uses of plants implies revealing the

secrets of the deities. To avoid punishment from the deities, the healers who opted to engage in the discussion conducted prayer and libation before discussing the usefulness of medicinal plants with the researcher. The fear for supernatural sanctions could lead to withholding vital information about medicinal plants, which threatens knowledge transfer and documentation. The fear of some healers to disclose useful medicinal plants has a broader implication for traditional epistemology. The epistemology of the indigenous people is largely premised on spiritual and mental perceptions. This makes it difficult to transmit knowledge and its associated ethics to researchers and other community members, particularly where information relating to practices are guarded away from the public as a result of certain beliefs. Horsthemke (2004) argues that although African Indigenous Knowledge systems are described as being inclusive of all kinds of beliefs, they fall short of making reference to truth or justifications, hence, their status is viewed from the perspective of mere opinions and assumptions, involving superstitious beliefs. That notwithstanding, knowledge on medicinal plants could be taught a few members of the family or apprentices.

Another fear expressed by the priests of Fofie and Kikpare, and the priestess of Obourfa-Dadiefa shrines, was the extinction of medicinal plants. They sometimes cover long distances to harvest plants. The priest of Fofie particularly referred to plants such as *kinijini* and *kafrɔ* as plant species that have become difficult to find in Kete-Krachi. According to the priest, the former plant grew along water bodies while the latter was common in the neighbourhood of Kete-Krachi. The priestess of Obourfa-Dadiefa indicated that *kinijini* is difficult to find of late, except the forest areas, because of environmental depletion. The priest of Tano also indicated the difficulty in finding the *asagyiriwa* plant

which is essential in curing infertility. The scarcity of medicinal plants in the Kete-Krachi area are further linked with the global effect of climate change. The causes of extinction of medicinal plants can be understood by interrogating agricultural activities in the Kete-Krachi area. As noted in chapter three, the Krachi people are largely agrarian. They cultivate yam and other crops in greater quantities with the help of chemicals. The Green Revolution technologies which partly addresses the problems of food insecurity threatens Indigenous Knowledge systems and could lead to soil erosion and loss of plant genetic materials that are resistant to diseases (Kumar, 2010). Indeed, among the Krachi people the use of chemicals like sarosate (a non-selective and systemic herbicide) by farmers destroys weeds and plants, a few days after spraying. This weedicide is applied about twice on farmlands in each farming season. Sarosate is applied first to kill the grasses before farming, and in the second phase it is applied to control the weeds after planting the crop. There is the popular perception that the chemical adds more nutrients to the soil and facilitates plant growth. The use of weedicides has replaced weeding by hoe, which is considered tedious. Another common chemical herbicide used by farmers in the Kete-Krachi area is Paraquat, known commonly by the brand name, Gramoxone. Gramoxone is toxic and can cause fatal poisoning when inhaled or ingested. The chemical is believed to dry herbs immediately after spraying. The slash and burn agricultural practice also affects medicinal plants. Besides, traditional healers serve as a threat to the environment. Healers uproot plants rather than harvesting their parts to conserve them. There are a few cattle herders in the Kete-Krachi area, but this was not cited as a major threat to medicinal plants. The risk of losing vital plants has compelled a few priests and priestesses in the Kete-Krachi area to conserve useful plants in their settlements. For instance, mini-herbal gardens

were established by each of the priests of Fofie, Kikpare and the priestess of the Obourfa-Dadiefafa shrine in their houses, from where medicinal plants are harvested. The fear of extinction of herbal plants accounts for the establishment of such small botanic gardens in the houses of priests and priestesses. Medicinal plants are conserved in the surroundings of priests and priestesses and are harvested for healing.

6.6 Views of healers on collaboration with orthodox health practitioners

Based on their in-depth knowledge about the uses of medicinal plants in healing many illnesses and other conditions, healers noted their readiness for collaboration with orthodox healthcare providers as follows:

We are all doing the same work [providing healthcare]. If they [orthodox healthcare providers] should consult us to heal a patient, we will do so. They know that it is not every illness that they can treat. It is because of this that we have many patients who have left the doctor [hospital] and they are seeking healthcare from us [Interview with Nana Akosua Nkrumah, priestess of Akomagyo-Lente shrine, 20th March, 2021].

Another healer remarked as follows:

We healers don't have a problem if they [orthodox healthcare providers] need our assistance. You [the researcher] have been seeing how we use herbs to heal people suffering from many illnesses. This shows that our herbal medicines are efficacious. So, I am opened for any collaboration with orthodox practitioners [Interview with Yaa Donkor Akorsah, priestess of Obourfa-Dadiefafa shrine, 7th January, 2021].

A third respondent, also a healer, indicated that:

We can always collaborate with them [orthodox practitioners] in the delivery of healthcare to our people. However, they must respect us. We are not considered by doctors as people who do the same work as them. Doctors

can learn from us, and we [healers] can also learn from them [Interview with Nana Kofi Angwe, priest of Kikpare shrine, 23rd March, 2021].

The above quotes illustrate the views of healers with regards to cooperation. Healers are ready to work with orthodox healthcare practitioners. In the first quote, however, healers expect orthodox healthcare providers to initiate steps towards such a cooperation. This proposition may be due to the fact that orthodox healthcare providers are sometimes believed to be resistant to traditional healthcare practices. The third quote emphasises the need for mutual respect between healers and orthodox medical practitioners. Such a collaboration, in the view of healers, would improve the quality of healthcare in the Kete-Krachi area.

6.7 Views of orthodox healthcare practitioners on collaboration with healers

Like healers, questions pertaining to integration of traditional healthcare systems into the orthodox healthcare model received diverse responses from healthcare practitioners in the Kete-Krachi area. A Physician Assistant remarked that “integrating traditional healers into orthodox healthcare facilities will be great”. According to him, both the traditional and orthodox healthcare practitioners can learn from each other. He recounted an incident where the Health Centre at Ehiamankyene could not treat a fracture, and the patient requested referral to a bone-setter. Although the Physician Assistant did not grant the request for referral, on medical ethical grounds, he nonetheless followed due processes and discharged the patient from the Centre. The Physician Assistant remarked that “instead of making a referral case to Korle-Bu, in the case of fractures, it is better to refer to a healer, because of the high-cost implication”. While underscoring the significant successes by

healers, the Physician Assistant indicated a challenge that may hinder the integration effort. Healers have the fear that orthodox medical practitioners may steal their knowledge, particularly about herbal medicines, from them. He indicated that, for healers to fit into the orthodox healthcare infrastructure, government should train them on Anatomy, Physiology, and pain management for them to work effectively with doctors. For him, government should incorporate healers into the hospital infrastructure and the challenges that will ensue will be dealt with. For the Physician Assistant, despite the challenges, incorporation of healers into biomedical healthcare services will improve healthcare in Ghana. The narrative and assertions of the Physician Assistant illustrate his desire for integration.

A few nurses noted that unlike other hospitals in Ghana that have incorporated essential traditional medicines in their facilities, the Krachi West Municipal Hospital is yet to do so. Discussing their views about whether or not to incorporate traditional medicines into biomedical healthcare facilities, a nurse indicated as follows:

Incorporating traditional medicines into the orthodox healthcare system will help improve the health of patients. It is because traditional healers do not know the content of herbal medicines and cannot calculate the right dosages that they [orthodox healthcare practitioners] do not want to work with them. But now that there are professionals [biochemists] who can interrogate and ascertain the chemical compositions of herbal medicines used by healers and their right dosages, it will be easier to incorporate such medicines, and to some extent healers, into the hospitals and clinics. Healers are good at dealing with certain conditions. For instance, my child who had a fracture started recovering after five days when I sent him to a traditional bone-setter. Bone-setters have in-depth knowledge about the efficacy of herbal medicines. Healers need training in order for them to work in orthodox healthcare facilities [Interview with Mensah, a Senior Nurse, Kete-Krachi, 31st October, 2023].

From the above quote, healers assist to deal with certain healthcare challenges such as fractures. Nevertheless, their inability to calculate right dosages pose a limitation to healing. The above assertion was further emphasised by another nurse. He stated that priests and priestesses will require extensive training by mainstream healthcare professionals and government, and employed by the latter in the hospitals. One of the nurses indicated that for traditional healers to be incorporated into the orthodox healthcare facilities, they need to be given certificates, which will be a testimony of their knowledge about healing. “Licenses will also make healers accountable for any harm caused to their clients”, a nurse asserted. Besides, it will make it easier to tell the competence of the healers. As a result of the competence which traditional healers exhibit, some nurses noted that medical doctors have to re-orient their thoughts about traditional healing and accept healers as partners in the efforts to improve the health and general wellbeing of people.

In spite of the perceived benefits incorporation of traditional healers may bring, a respondent expressed some fears. The nurse indicated that incorporating traditional healers into orthodox healthcare infrastructure will lead to a situation where healers will overtake some aspects of care being provided by medical doctors. She explained that the Krachi people are already familiar with healers and also patronise traditional medicines and other services provided by those healers. Added to this fear is the possibility of healers expressing their spirituality during care-giving at the hospitals. They cited examples of a Traditional Birth Attendant at Chantai in the Kete-Krachi area, who is knowledgeable about delivery of babies. However, the woman engages spirituality in her profession. Some of the nurses indicated that, although the traditional birth attendant is occasionally invited to the Chantai clinic to help women deliver their babies, the major challenge with her

service is the use of spirituality. This illustrates the abhorrence on African spirituality in orthodox healthcare facilities, and paints further a perception that, for effective integration to occur, traditional healthcare practitioners must relinquish their spiritual beliefs and practices pertaining to healing, or practice them in areas other than orthodox healthcare facilities.

The prohibition on traditional healing in the hospitals has compelled some family members to smuggle in some traditional modes of therapies into the orthodox healthcare infrastructure. For instance, one of the nurses interviewed indicated that she discovered that a patient in the Kete-Krachi hospital wore beads believed to have spiritual relevance to protect her from evil attacks. For some respondents, however, open expression of one's religiosity in the hospital should not be prohibited, so long as such expression will facilitate recovery of the patient. These assertions have wider implications on questions of integration. In sum, some healthcare professionals interviewed indicated that herbal medicines should be used in the hospital, despite the initial challenges that may be associated with its use. On the contrary, a few are opposed to the use of psychicism in the hospitals, while others are of the view that patients should be allowed to express their traditional beliefs and practices in the hospital so long as such expressions will facilitate recovery of patients.

6.8 Comparative analysis and discussion

The study observed that no patient consulted the Dente shrine for physical healing. However, petitioners may be given ritual water meant to heal many illnesses. This is

contrary to Williams' (1976/77) assertion that priests of Dente do not conduct physical healing. There is, however, extensive use of herbal medicines in the affiliate shrines of Dente. These affiliate shrines heal physical illnesses using herbal medicines, which explains why priests and priestesses are expected to possess in-depth knowledge about medicinal plants.

With regards to herbal medicine use, the findings of the chapter confirm Slikkerveer's (1982) observation in Ethiopia about macro-religious practices and use of medicinal plants that reflect both mystical and pragmatic systems. The findings show that priests and priestesses in the Kete-Krachi area possess in-depth knowledge about both pragmatic and spiritual approaches to healing. A combination of these approaches enhances recovery of patients.

The study further found that a combination of plants is used to heal infertility in shrines. This is contrary to pre-existing studies that have been conducted on the separate uses of plants. For instance, Macdonald, Oghale, & Oyiza (2016) found that the roots of *Bridelia ferruginea* are boiled and administered orally to treat infertility. Steenkamp (2003), on the other hand found that the bark of *Burkea africana* could be used to treat menstrual disorders which may affect conception, while Burkill (1985) found that *Euphorbia poissonii* and its species are used to cure infertility. As indicated, these plants, among others, are used together to enhance fertility in the Fofie shrine. The efficacy of concoctions needs further empirical research.

6.9 Conclusion

This chapter has pointed out the centrality and use of herbal medicines in healing. The chapter has established that priests of the affiliate shrines of Dente (particularly Obourfa-Dadiefa, Fofie and Kikpare) have comprehensive knowledge of the use of medicinal plants. The plants are harvested for the treatment of various illnesses. A documentation on healing in shrines should therefore consider medicinal plants. This makes it possible to consider priests and priestesses in the discourse of integration of traditional healthcare practices. The chapter has further established that the application of the medicinal plants to the treatment of an illness is not done alone; spiritual forces are brought to bear on their application. The uses of herbal medicines and plants in the treatment of illnesses are, in some instances, in tandem with their applications and conceptions of their efficacies in other parts of Ghana and Africa as a whole. Nevertheless, there are pedigrees of variations, such as the social and spiritual interpretations of plants and their usefulness.

Despite the usefulness of medicinal plants in healing, traditional healthcare is threatened by the near-extinction of plants caused by a multiplicity of factors; for instance, modern agricultural practices involving the use of weedicides. Although many medicinal plants can be obtained from the environment in the Kete-Krachi area, others are harvested in places far from the Krachi enclave, which hinders the practice of healing. Climate change, caused largely by human activities, further threatens the activities of traditional healers. Besides climate change, the unwillingness of healers to reveal knowledge of traditional medicine hinders traditional healing. The refusal to disclose medicinal efficacies are linked with fear of the unknown. The refusal to disclose herbal treatments makes it difficult to discuss many healers within the context of integration of traditional medical practices in the orthodox

healthcare system. The chapter complements the discussion on social and spiritual explanations to illnesses. It provides practical approaches to the various illnesses that are often given social and spiritual interpretations. In particular, the chapter broadens the discourse on integration of traditional healthcare services into orthodox healthcare infrastructure.



CHAPTER SEVEN

DENTE AND HEALING ASSOCIATIONS

7.1 Introduction

This chapter focuses on three thematic issues. First, it provides a historical overview of healing associations in Ghana, with references to associations in the Volta Region and Kete-Krachi. Second, it provides insights into healing associations in the Kete-Krachi area. Finally, it discusses the *Lentekuo*, association of priests of the affiliate shrines of Dente. Key questions of this chapter are the following: What kind of social capital promotes the general well-being of priests and priestesses of affiliate shrines of Dente? What activities in the affiliate shrines of Dente bring people together? and how does this union impact welfare?

Two categories of members were identified in the healing associations in the Kete-Krachi area: healers that make use of physical approaches (that is, herbalists) and those that use spiritual mechanisms of healing (example, priests and priestesses). These categories of healers have been highlighted in previous discussions. The psychic healers and herbalists cooperate in the healing associations. It will be difficult to understand healing associations in the Kete-Krachi area without linking the discussion with the history of healing associations in Ghana.

7.2 Historicising healing associations in Ghana: A brief insight

Colonial suppressive policies and discriminations against Africans stimulated African reactions in various ways, including the rediscovery of traditional culture. In Ghana, one form that the cultural renaissance took was the formation of traditional associations. It was these traditional associations that eventually crystalised and metamorphosed into the Ghana Priests and Priestesses Association (GPPA) in the 1960s (Senah et al., 2001). Indeed, the GPPA was said to have a link with Osagyefo Dr. Kwame Nkrumah's espoused "African personality" political ideology, coined by Edward Wilmot Blyden, a believer in building African institutions and cultivating racial pride and unity among West Africans (Biney, 2011).

The Ghana Psychic and Traditional Healing Association (GPTHA), as part of Nkrumah's African personality and self-actualisation agenda was inaugurated on the 7th April, 1962 with the support of Osagyefo Dr. Kwame Nkrumah. Members of the association included traditional priests and priestesses, as well as herbalists who were versatile at healing. The association defined a priest or priestess as "[a] person who has successfully undergone training at a reputable shrine and possesses unquestionable knowledge of Ghanaian herbs." It defined a herbalist as "[a] person who possesses unquestionable knowledge about Ghanaian herbs acquired through a period of training at a reputable shrine or under a competent herbalist" (PRAAD, Ho, VRG/MH/362). These practitioners should be licensed. The definitions underscore the centrality of shrines in the traditional healthcare system.

Nkrumah's Cabinet agreed that in order to give the GPTHA a scientific outlook, it should be linked with the Academy of Sciences and the Ghana Medical Association. All herbalists and traditional priests who administered divine healing were required to register with the association (PRAAD, VRG/MH/362, p.16). One of the main functions of the association (GPTHA) was to preserve the African heritage. It was also to establish a vibrant organisation in Ghana responsible for conducting research into traditional medicine (Warren et al, 1982).¹¹¹ Membership was opened to persons interested or actively involved in psychic healing (such as priests and priestesses of shrines) and herbalism. While the GPTHA was largely opened to spiritual healers, its constitution emphasised that the competence of the practitioners must be unquestionable (PRAAD, VRG/MH/362, p.54).¹¹²

To ensure effective running of the association, various positions were created from the national to the district levels. At the national level, the policies were formulated and supervised by a national committee made up of the national chairman and the national vice-chairman (PRAAD, Ho, VRG/MH/362). These two bureaus' administrative functions were performed by priests and priestesses.¹¹³ Other administrative positions included the national secretary, national treasurer, national organising secretary, regional chairman, and a maximum of two co-opted members. The national committee met at least once every two

¹¹¹ The constitution of the Ghana Psychic and Traditional Healing Association stipulated that the Life Patron of the Association was Osagyefo Dr. Kwame Nkrumah, President of the Republic of Ghana. The aim of the association was to uphold and promote good practices in psychic/traditional healing in Ghana. The association was meant to contribute to national development, PRAAD, Ho, VRG/MH/362.

¹¹² Members were to abide by the aims of the association, refrain from acts that would throw the image of the association into disrepute, and abstain from rituals and ceremonies intended to influence the Head of State. The association was sustained through payment of dues (scheduled by the National Committee) and voluntary contributions.

¹¹³ Issues pertaining to gender balance were critical in the leadership of the GPTHA, particularly at the national level. For instance, if the National Chairman was a priest, then a priestess served as Vice-Chairman, and vice versa. Meetings were convened by the National Chairman in consultation with the National Vice-Chairman and Regional Chairmen.

months. At the regional level, the GPTHA was administered by a chairman, vice-chairman, secretary, treasurer, and the organising secretary. All officers (national and regional) were elected through popular vote.¹¹⁴ Branches of the association were constituted at the district levels. Like the regional level, branches of the association at the district level were made up of priests, priestesses, and herbalists. The Kete-Krachi District established a branch of the GPTHA in 1963. In that year, 147 herbalists registered with the Local Authority in Kete-Krachi, the second highest figure after the Buem Local Authority which registered 151 herbalists (PRAAD, VRG/MH/363, p.94). Delegates of the GPTHA in the Volta Region, where Kete-Krachi was part, attended the Akonedi Yam Festival at Larteh-Kubeasi (PRAAD VRG/MH/363, p.103). The association thus provided a platform for the Krachi people to reconnect with their kinsmen at Larteh-Kubeasi in the Eastern Region.

It is good to point out, however, that the formation of the GPTHA in 1962 coincided with the construction of the Volta Dam by Osagyefo Dr. Kwame Nkrumah. The dam inundated the original Kete-Krachi (Krachikrom) in 1964. This caused disaffection and apathy for the association in subsequent years. The Krachi people blamed the cause of the Volta floods on Nkrumah.

Branches of the GPTHA were widespread in the Volta Region.¹¹⁵ Although priests of Dente coordinated activities of the association in the Kete-Krachi area, they did not personally participate in meetings held in Ho, the regional capital. This was because priests of Dente must not move outside their territory. Priests of Dente would therefore send delegates to

¹¹⁴ Two-third of the members of the national, regional, and district branches constituted a quorum for meetings or deliberations.

¹¹⁵ By 31st October, 1962, the Dzolokpuita branch had been established. On 20th April, 1963, the Kpandu branch of the GPTHA was also established.

represent them at the meetings held in Ho or elsewhere. However, a respondent pointed out that priests of Dente considered themselves supreme and did not want to travel to Ho for meetings.¹¹⁶ The involvement of priests of Dente in such associations had consequences for the establishment of healing associations in the Kete-Krachi area which will be discussed later.

In 1968, the District Administration Office in Kete-Krachi called on the government to designate places for healing activities. Prior to this demand, healers displayed their medicines in the streets and engaged in acrobatic displays aimed at attracting patients. Patients moved from one healing house [shrine] to another “until they drained their resources”. It was in view of this that the District Administration Office in Kete-Krachi wrote to the then government to establish a nationwide Native Doctors Association to study the type of diseases each “native doctor” claimed had competencies in. It was proposed that the chairman of the association in each district would be responsible for directing patients to healers who had in-depth knowledge in the treatment of specific diseases. It was again proposed that, apart from registering the association, the type of diseases that a member could heal should be indicated on the membership card before licenses were issued. The membership cards were to be reviewed by the Local Council Officer (PRAAD, Ho, VRG/LG/FUNC/594).

¹¹⁶Apart from the GPTHA, many associations were formed or introduced in the Volta Region. On 26th July, 1962, the Co-operative Herbalists Society (CHS) was established in Kpedze, with about fifty (50) members. Similarly, a herbalist centre was established at Anfoega Gbogame in 1962, following its establishment in Ho in 1960. It was the responsibility of members to identify medicinal plants. Anfoega served as a good habitat for medicinal plants. Members of the Ve division of the association were said to be knowledgeable in technical and research components of plant medicine. It was in view of this that they pleaded with Nkrumah to support them with finances to research into herbal medicines in the Region. PRAAD, Ho, VRG/MH/363.

7.3 Healing Associations in the Kete-Krachi area

The Kete-Krachi area has seen the upsurge of many healing associations. These include the Ghana Psychic and Traditional Healing Association, the Ghana Psychic and Traditional Healers Association, the Plant Medicine and Traditional Healers Association, and the *Lentekuo*, to mention a few. The ensuing discussion details healing associations in the Kete-Krachi area.

7.3.1 The Ghana Psychic and Traditional Healers Association (GHPTHA) in the Kete-Krachi area

The problem of nomenclature pertaining to the GPTHA led to internal wrangling between members of the association. A small group of the GPTHA argued that healers associate, but not the practice of healing as contained in the name of the GPTHA. As a result, the Ghana Psychic and Traditional Healers Association (GHPTHA) was formed. The breakaway group was led by Nana Oparebea, priest of the Akonedi shrine at Larteh. This study has noted in previous discussions that the Krachi migrated from Larteh to their present location. The relationship between the Krachi and the Larteh people therefore facilitated the establishment of a branch of the GHPTHA in Kete-Krachi. The Ghana Psychic and Traditional Healers Association later became known as the Ghana Psychic and Herbal Practitioners Association (GHPHPA). The new designation implies that, apart from spiritual healing, members of the GHPHPA offer physical healing. Evidence to the establishment of the GHPHPA was not found in the Kete-Krachi area.

The GHPTHA promoted traditional medicine and culture. The preamble of the association is indicated as follows:

We, the Psychic and Traditional Healers, having realized the importance of promoting the [t]raditional [m]edicine and preserving our cultural practices, and customs to foster the peace, [u]nity and [w]elfare [s]ervice among ourselves in the spirit of service to mankind, do hereby promulgate this constitution to guide and regulate our actions and activities.¹¹⁷

The mission of the GHPTHA was to provide healing services. The association was further concerned with the general well-being of members as captured in the terms, “unity”, “welfare” and “services”. The motto of the GHPTHA was “psychic power”, which showed the role of spirituality in healing. In Kete-Krachi, the researcher’s attention was drawn to the symbols of the association, including: the hawk (symbolising strength), a snake (representing wisdom), pouring of libation (implying rituals to Mother Earth), and herbal medicines. There was a proliferation of the GHPTHA in the Kete-Krachi area because it improved the welfare of members. The association offered priests the opportunity to diagnose spiritual diseases. The association attracted many healers when it attempted to foster a close link between orthodox and traditional medical practitioners. Through that collaboration, members of the GHPTHA were trained on preparation of herbal medicine and hygiene. Apart from the healing support by members of the association, priests contributed in kind and in cash to assist needy members.¹¹⁸ Environmental cleanliness was encouraged by members of the association, as captured under article 12 of the GHPTHA membership form. A priest alluded to the periodic visits of the leadership of the GHPTHA to discuss and promote environmental cleanliness in shrines.

¹¹⁷ See membership card, Ghana Psychic and Traditional Healers Association, Registration No. 3377, No. 3484., p.1.

¹¹⁸ *ibid*, p.2.

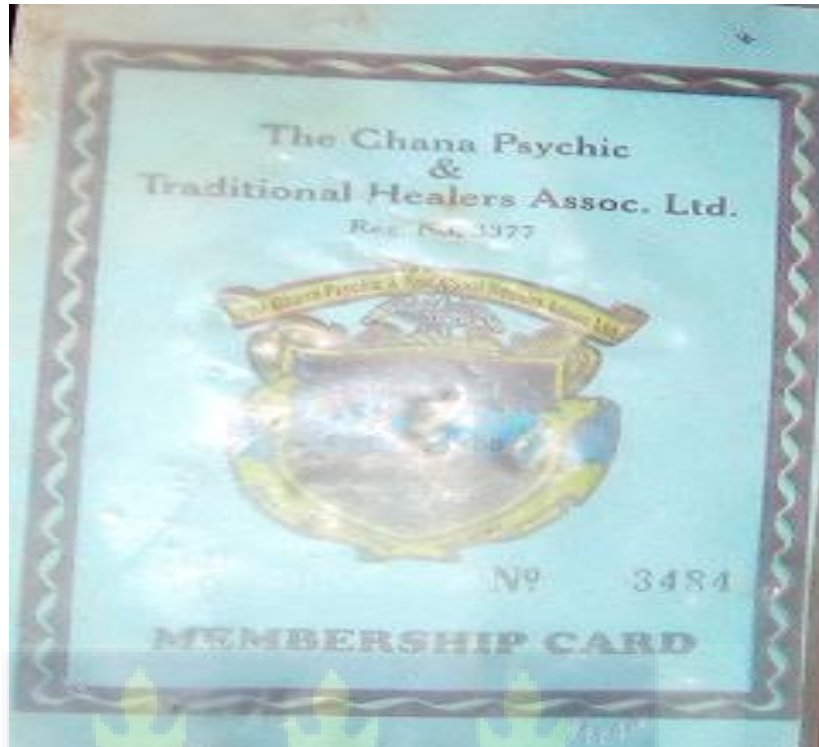


Figure 7.1: The GHPHTA membership card. Photographed by the Researcher, Gyankrom. 27th February, 2021.

7.3.2 The Ghana National Association of Traditional Healers (GNATH)

The GNATH was established in 1987 and consequently introduced in Kete-Krachi in 1995. Members of the GNATH argued that they did not make use of spirituality in healing, as compared to the GPTHA and the GHPHTA. The motto of the GNATH was *Dua ma ayaresa* ('a tree/plant provides healing' in Twi or Akan languages in Ghana). It can be deduced from the motto that the GNATH was interested in herbal medicine. Priests of affiliate shrines of Dente who had in-depth knowledge of herbal medicine and healed specific illnesses/conditions joined the GNATH. Apart from priests of Dente, priests of settler shrines such as Nangoro and Doranya joined the GNATH because of their enormous knowledge in herbal medicines. As indicated earlier, the GNATH did not depend on spirituality in their delivery of healthcare, comparative to psychic healers. Although priests

and priestesses of the affiliate shrines of Dente joined the GNATH, they did so because of their knowledge in medicinal plants. With respect to the gender dynamics, it was indicated that the priestess of the Obourfa-Dadiefa shrine joined the GNATH. The rest of the priestesses of the affiliate shrines of Dente did not consider themselves as *adunsifo* (herbalists) or possessing in-depth knowledge of medicinal plants which was the major focus of the association. In recent times, these priestesses use herbs only when they are revealed by the deities.

The GNATH regulated the use of traditional medicines as captured by its Inspectorate Committee as follows:

Since traditional healing is natural ..., many people who find themselves in financial difficulties and do not know what to do, often find becoming self-styled [t]raditional [h]ealers a way out. They start by imitating existing popular traditional medicines which have already gained ground on the market. As a result, there are now a host of self-styled traditional healers who are producing and marketing various kinds of fake, unapproved and, sometimes, dangerous herbal preparations for the consumption of the unsuspecting general public. These people pay no taxes to the Government and they advertise their medicines with lies and filthy words in public places [GNATH, 1987].

As pointed out already, the executives of the GNATH were to ensure that non-members did not sell unwholesome traditional therapies to the public. It was in view of that the GNATH controlled traditional healing practices in Ghana, with the aim of improving standards.¹¹⁹ Evidence collected from minutes of meetings and membership cards of the GNATH in Gyankrom shows little difference between the GNATH and the GHPTA in the Kete-Krachi area. Priests, priestesses, and herbalists in Gyankrom were members of

¹¹⁹ See appointment card, Ghana National Association of Traditional Healers, 1987.

both the GNATH and the GHPHTA. Members of the GNATH were expected to demonstrate adequate knowledge of use of herbal medicines, unlike the GHPHTA.



Figure 7.2.: Membership card of the GNATH. Photographed by the researcher, Gyankrom. 27th February, 2021.

As part of their responsibilities, the national executives of the GNATH could collect Taxes on behalf of the Commissioner of Internal Revenue under the Income Tax Decree, 1975 (SMCD. 5), section 26 which was an amendment of the Income Tax Law of PNDC L.166 (See figure 7.3). In the then Kete-Krachi District (now split into Krachi West Municipal, Krachi East and Krachi-Nchumuru Districts), members of the GNATH were appointed as inspectors, with the mandate to check bad practices relating to traditional healing. Field

Inspectors of the GNATH were given the mandate to arrest and assist the police in prosecuting income tax defaulters (see figure 7.3). Traditional healers were therefore required to operate within the frameworks of the laws of the Republic of Ghana.

In the Kete-Krachi area, Mr. Abdulai Kwaku Mensah (AKA Mr. Abokyi) who practiced as a herbalist was appointed as the District Inspector. Apart from ensuring that members did not sell unwholesome herbal medicines to the public, Mr. Abokyi ensured that priests and priestesses in the Kete-Krachi area cleaned the precincts of their shrines. He educated priests, priestesses, and herbalists on the need to wash medicinal plants before they were prescribed to clients. Similarly, Field Inspectors were required to stop the operation of healers who had no licenses.

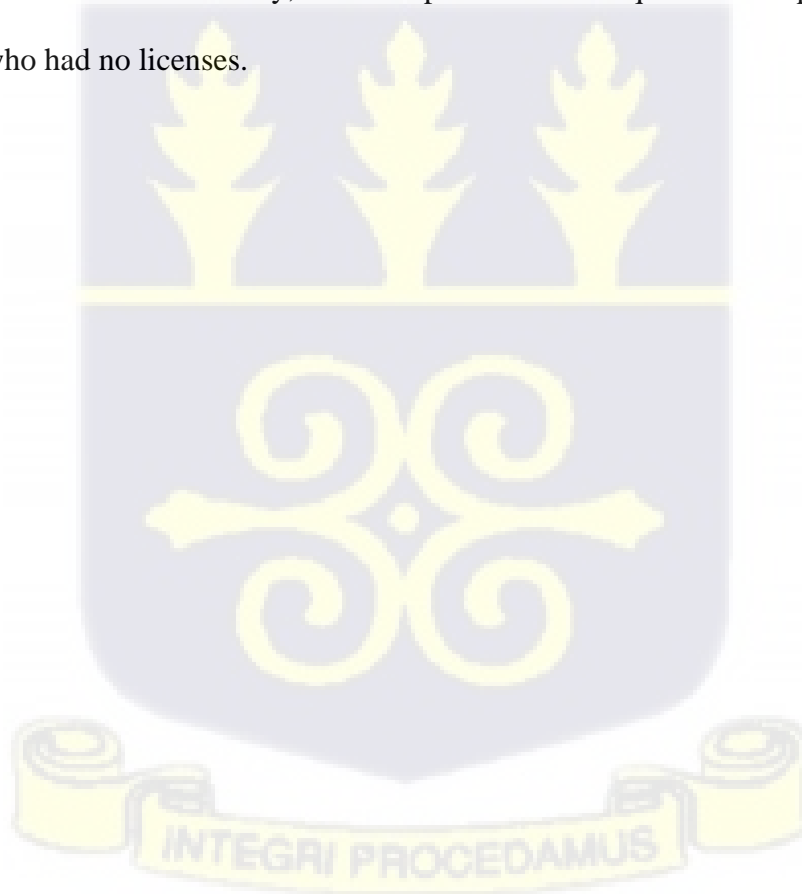




Figure 7.3.: The GNATH leadership card detailing the roles of the Inspectors. Photograph taken by the researcher, Gyankrom. 27th February, 2021.

In 1990, the Plant Medicine and Traditional Healers Association (PMTHA) was introduced into Kete-Krachi. The PMTHA was established in opposition to earlier associations which were greatly dominated by spiritual healers such as priests and priestesses. Like the GNATH, members of the PMTHA in the Kete-Krachi area included those who had knowledge in herbal medicine. Members of the PMTHA who depended on herbal medicines for healing argued that their mode of operation was dissimilar from those of the GHPHTA who engaged in psychic healing. Members of the PMTHA included traditional

birth attendants (TBAs) and the *wazam*. The *wazam*, most of whom were Hausa, had expertise in circumcision. A few priests of the subsidiary shrines of Dente were members of the PMTHA. As noted earlier in chapter six, there were priests of the subsidiary shrines of Dente who had in-depth knowledge in medicinal plants. These included priests of Fofie and Kikpare, and the priestess of Obourfa-Dadiefa. Those whose healing involved extensive use of medicinal plants often joined more than one association. For instance, the priest of Kikpare and the priestess of Obourfa-Dadiefa shrines were members of the GNATH and PMTHA. In much recent times, the priest of Kikpare and priestess of Obourfa-Dadiefa are members of the *Lentekuo*.

Mallams (Islamic healers) in Kete-Krachi indicated the use of ‘physical’ approaches to healing, for which they joined the PMTHA. It should, however, be pointed out that when the PMTHA was introduced in Kete-Krachi, a few traditional priests of the settler shrines such as Tigare, Nangoro, Gurmande and Doranya, joined the association because of their knowledge in herbal medicines. Even so, members of the PMTHA underscored that illnesses have spiritual dimensions, which may better be treated through the combined effort of *ndunsifo* (herbalists) and priests. Prior to the creation of the Oti Region, the executives of the PMTHA in the Kete-Krachi area attended meetings in the Volta Region. The meetings focused on hygiene, preparation of herbal medicines, safety, and welfare issues.



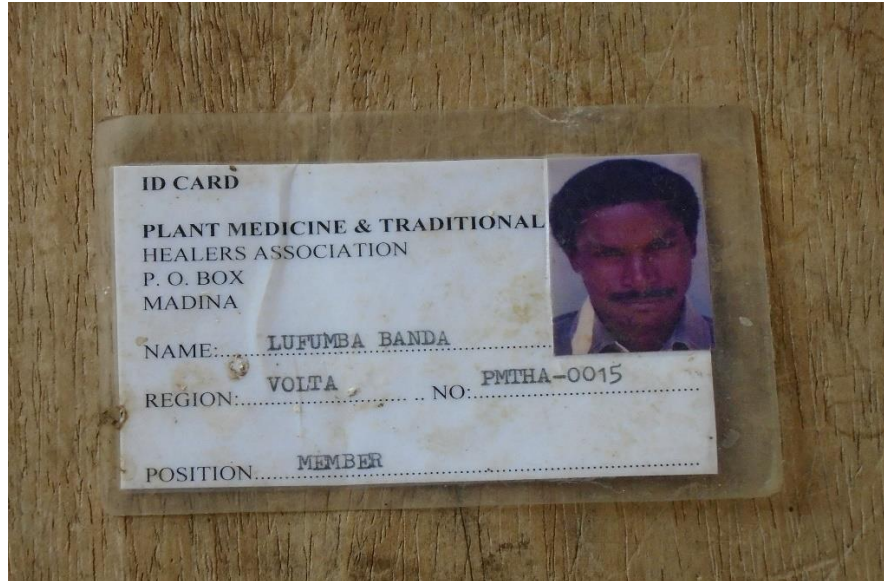
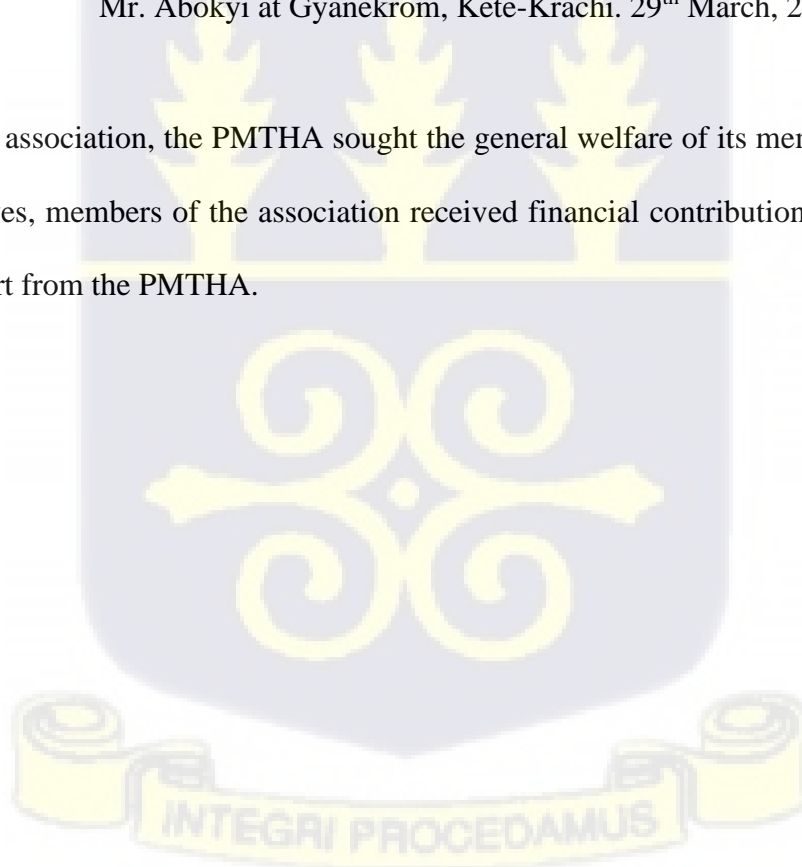


Figure 7.4.: Membership card of the PMTHA. Photograph retrieved from the collections of the secretary of the PMTHA, Mr. Abokyi at Gyankrom, Kete-Krachi. 29th March, 2020.

Like any association, the PMTHA sought the general welfare of its members. At funerals of relatives, members of the association received financial contributions and other forms of support from the PMTHA.



KWASI KUMAH'S FUNERAL (CHAIRMAN)					
1	YAO GARE	Yaborae	✓	45	30
2	DRUNYA YAA	OSRAMANI	✓	45	30
3	Kofi KUMAH	KADENTWEN	✓	45	30
4	KWAME OBOD	KADENTWEN	✓	45	30
5	KWAKU GARE	YABORAE	✓	✓	40
6	FANTIAH BENJAH	KONKROG YA	✓	✓	42
7	KWABENA NYAME	KADENTWEN	✓	✓	42
8	GHACHADEN KWAME	OSRAMANI	✓	✓	44
9	NTE MOSES	KADENTWEN	✓	✓	44
10	ASUMA KABRE	✓	✓	✓	45
11	KWABENA KUNNEY	GYANE KROM	✓	✓	46
12	KEJE YAO	TANTU	✓	✓	47
13	KWABENA KUNNEY	TANTU	✓	✓	48
14	ANNA KUMAH	NTEWUSAE	✓	✓	49
15	KWAME GUNGI	NTEWUSAE	✓	✓	50
16	KWAKU KUMAH	GYANE KROM	✓	✓	51
17	KWASI KECKABE	GYANE KROM	✓	✓	52
18	ABDUAQUESAKE AKOSUA	GYANE KROM	✓	✓	53
19	KOFI DONKOR	TANTU	✓	✓	54
20	KWAKU YESTUMU	TANTU	✓	✓	55
21	KOFI BRAHMA	OSRAMANI	✓	✓	56
22	KWAKU TOAIBUR	OSRAMANI	✓	✓	57
23	YAO BEA ABOKYI	ABOKYI AKUSA	✓	✓	58
24	YAO BAKUKI	GYANE KROM	✓	✓	59
25	AKOSUA DONKOR	OSRAMANI	✓	✓	60
26	KWABENA OBENG	OSRAMANI	✓	✓	61
27	KOFI KEGYINGI	OSRAMANI	✓	✓	62
28	KWAKU BENJAH	ADENKPE	✓	✓	63
29	DARIGABOU	NYENKETE	✓	✓	64
30	YAO KAKYURE	NTEWUSAE	✓	✓	65
31	YAO ALLA	OSRAMANI	✓	✓	66
32	YAO KUNNEY	OSRAMANI	✓	✓	67
33	KWAME NTOOD	OSRAMANI	✓	✓	68
34	YAO AKOSUA	OSRAMANI	✓	✓	69
35	KWABENA MENSANT	GYANE KROM	✓	✓	70
36	MOLIGYA KWABENA	KROCH KROM	✓	✓	71

Figure 7.5.: List of financial contributions towards the funeral of a member of the PMTHA. Photograph taken at GyaneKrom, Kete-Krachi. 27th February, 2021.

Leadership of the PMTHA in the Krachi West District (now Municipal) was made up of the chairman, secretary, treasurer, and the supporter.¹²⁰ Occasional meetings were held to discuss matters of critical concern. As secretary and later inspector of the PMTHA, Mr. Abokyi attended meetings in Ho, Akatsi, and Kpando in the Volta Region, and Nkwanta (now in the Oti Region). In the Kete-Krachi area, meetings were held once every two months. Minutes of meetings regarding the welfare of members of the association and other pressing needs were taken down by the secretary of the PMTHA. For instance, an urgent

¹²⁰ For each position, three candidates were nominated and voted for. The supporter assisted the secretary of the association. Apart from his role as an assistant, the supporter disseminated information to members.

meeting was held at the residence of the Dente Bosomfo (priest) to discuss the need for a herbal centre (See figures 7.6 – 7.8). Dues were paid by members of the PMTHA branch in the Kete-Krachi area only when the need arose.¹²¹



¹²¹ Discussion with Mr. Mensah Kwaku Abubakari (AKA Mr. Abokyi), 72 years, secretary and later Inspector of the PMTHA, and Mr. Baba Ibrahim (70 years old), Farmer, Gyankrom, Kete-Krachi, 23rd November, 2020. Like the secretary of the *Lentekuo* (to be discussed later), the secretary of the PMTHA supervises members in the Kete-Krachi area to ensure that unregistered operators/healers do not sell their products in the markets.

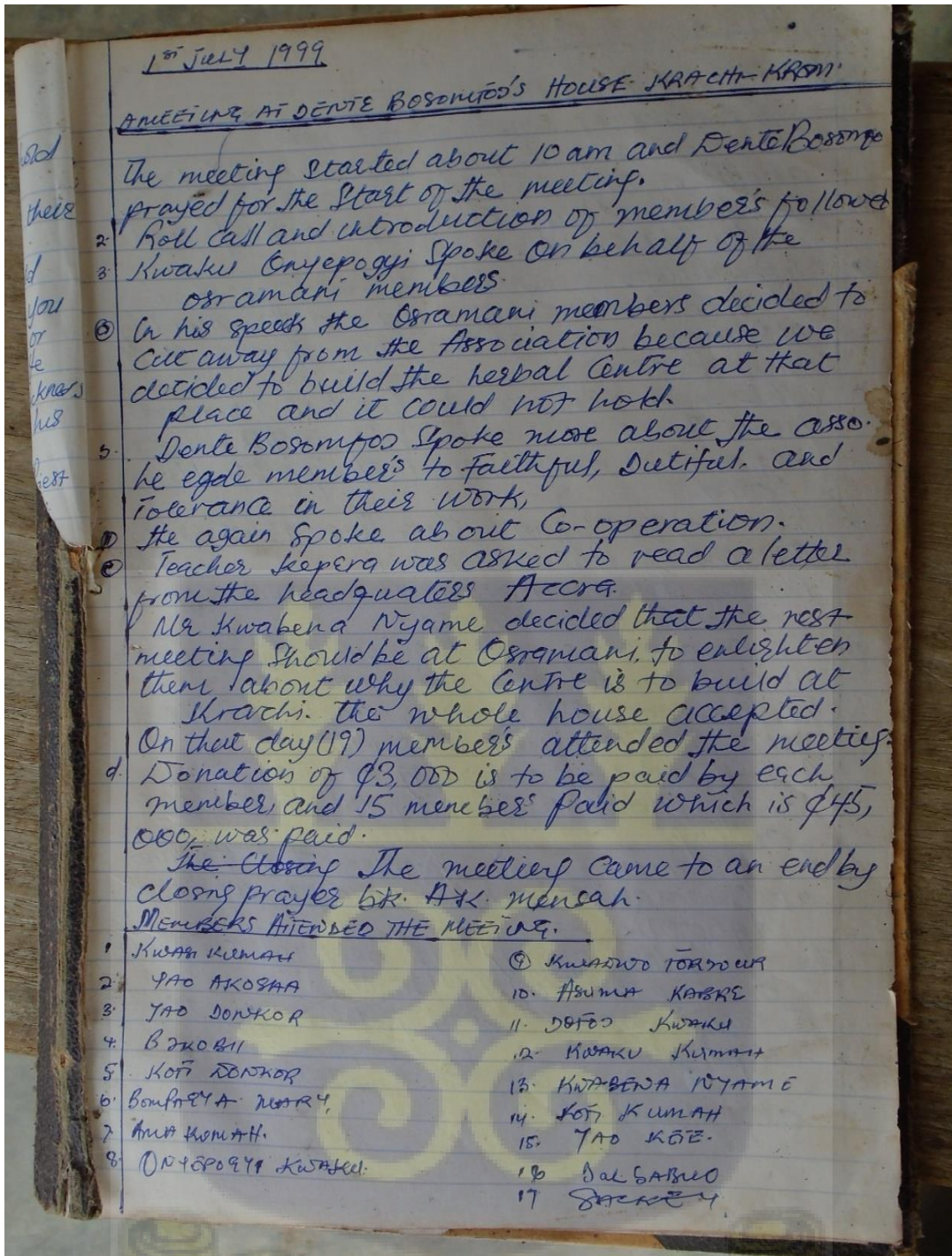


Figure 7.6.: Minutes of meetings of the PMTHA held at Osramane on 1st July, 1999. Retrieved from the collections of Mr. Abokyi, Gyankrom, Kete-Krachi. 27th February, 2021.

17
A MEETING AT OSRAMANI
The meeting started about 11am
① Oosonugos Kofi Kegyingi was asked to bring a bottle of Akpeteshi for liberation.
② Kofi Kegyingi being the vice-president focused the liberation.
③ Introduction of members followed, on that day (25) members attended the meeting.
④ Mr. Bojor read a letter from Accra to the members.
⑤ The members accepted to collect I.D. cards from Accra and each is to pay ₵12 for the registration and transportation for the I.D. card.
⑥ The accepted to pay to their Secretaries at the end of August ending.
Bojor asked questions about our officials and it was answered.
⑦ The Osramanis asked about why the Centre is not build at Osramani
The Secretary A.K. Mensah answered them and they were not satisfied.
A.K. Mensah was quiet on that day and pleaded not to inform them before acting.
The Osramani people suggested that the land at Osramani should be paid for which is ₵40,000.
The site plan should also be paid and all amounted to ₵200,000
Every Zone is to pay ₵39,000 for that dept.
The meeting came to an end at 2pm

Figure 7.7.: Minutes of meetings of the PMTHA held at Osramane, Kete-Krachi. retrieved from the collections of Mr. Abokyi, secretary of the PMTHA. Gyankrom, Kete-Krachi, 27th February, 2021.

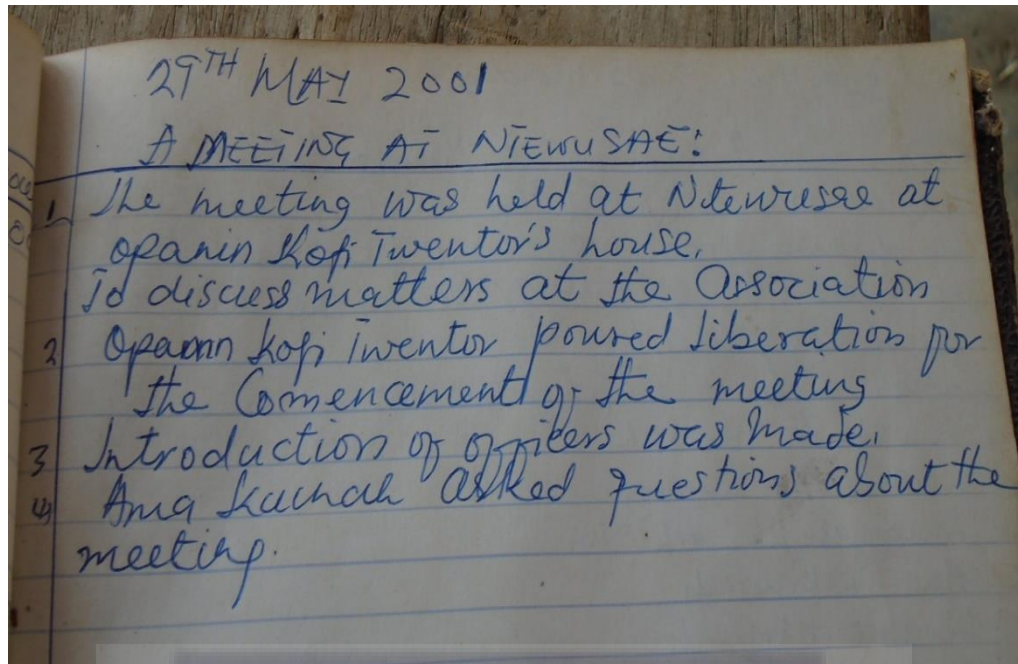


Figure 7.8.: Minutes of meetings of the PMTHA held at Ntewusae, Kete-Krachi
27th February, 2021.

Members of the PMTHA – particularly herbalists – sold medicinal plants in markets in the Kete-Krachi area, except priest-healers who held the belief that medicinal plants must not be sold.¹²² There was the general fear by healers that the sale of medicines might reduce their efficacy. Healers therefore accepted tokens from patients or petitioners. Healers belonging to the PMTHA therefore gifted their herbal medicines and other efficacies to their colleagues in critical circumstances. Besides, they reached out to other members of the association who needed assistance in the course of healing. However, priests or priestesses called for assistance from their colleagues in the association whom they trusted.

It is worth noting that the PMTHA was made up of members from diverse religious backgrounds. The healers included traditional priests, Muslims and Christians who had in-depth knowledge in medicinal plants. In view of this, there were faith-based sub-groups

¹²² In the Kete-Krachi market, there are no unique arrangements/structures for herbalists. Herbalists are therefore dotted across the market.

within the PMTHA. Priests and priestesses in the PMTHA, for instance, invited their colleagues to celebrate yam festival with them. Traditional healers who are Christians, on the other hand, sought the support of their colleagues when healing patients with difficult illnesses.

Members who failed to attend three consecutive meetings of the PMTHA without any reasons were sanctioned. In extreme cases, including persistent failures to pay welfare contributions, a member could be banned from the association.

There was the general belief and fear that members (healers) could acquire bad spirits that could worsen the conditions of patients. It was further believed that a healer could use bad spirits to kill clients. Such healers were not only a threat to patients, but the entire members of the association. These malevolent persons were identified through divination and expelled from the PMTHA. It was in view of this that the leaders of the association consulted diviners to interrogate whether members had bad spirits that could threaten the group.

7.3.3 The *Lentekuo*: Association of priests and priestesses of the affiliate shrines of Dente

As noted, at the district level, the priests of Dente constituted critical members of the Ghana Psychic and Traditional Healing Association (GPTHA) and the Ghana Psychic and Traditional Healers Association (GHPTHA). Priests and priestesses of the affiliate shrines of Dente served as members of the Ghana National Association of Traditional Healers, the Plant Medicine and Traditional Healers Association (PMTHA), among others, and

therefore saw the benefits of healing associations. The experiences gained from such associations were critical in the formation of the *Lentekuo*, association of priests and priestesses of the affiliate shrines of Dente. The association, unlike previous ones, is vibrant in the Kete-Krachi area.

Derived from the name *Lente* (or Dente) and the Akan term *okuo* (an association/union/group), the *Lentekuo* was established on 15th June, 2015, to unify all priests of the affiliate shrines of Dente in the Kete-Krachi area. As pointed out previously, the association, also known as the *Dentekuo*, is made up of about fifty-six (56) priests and priestesses, excluding the Dente priest who is considered as the ‘father’ of the association. Although the priest of Dente is not a member of the association, he is regarded as overall arbiter of cases pertaining to the association. Dente – and by extension its priest – is superior to its subordinate deities.¹²³

Although the study indicated that the *Lentekuo* is made up of priests and priestesses of the subordinate shrines of Dente, the members are ethnically Krachi. The association precludes ethnicities such as Nawuri (Northern Region), Ewe (Volta Region), and Nchumburu (Oti Region) where Dente shrines are found. The Nawuri, Ewe and Nchumburu are unable to

¹²³ Members of the *Lentekuo* include: priests of Boame, Odiako-Boame, Obourfa-Dadiafa, Ma-Lente, Lente Ewiem, Amina-Ano, Dente-Mmobrowa, Ma-Lente-Mmobrowa, Lante-Kusung, Yentumi, Yentumi-Akwasi, Yentumi-Kwame, Yetumi-Ababio, Obour, Ogyeabour-Kibii, Fofie, Oheneba-Fofie, Mframa, Akoadehye, Asuo, Kikpare, Bunchori, Borkwei, Odare, and Ogyeoman among others. These deities, except Mprah, Tano, and Odiako-Boame, are considered as ‘children of Dente’. Odiako-Boame was believed to have settled with Dente but later relocated to its present location. The deity was known for its victories in wars. Presently, Odiako-Boame is feared because it is believed to kill people when petitioned to do so. Odiako-Boame is believed to confirm and guarantee the safety of journeys before members of the association/petitioners embark on them. Statistics of the affiliate shrines of Dente in Krachi divisions include: Gyankrom 3, Tantu 4, Kadantwen 2, Abukonu 1, Krachikrom 1, Abujuro 4, Breweniase 2, Dadekuro 2, Kwakuae 1, Kpachu 2, Yabroae 1, Nyamebekyere 1, Gyaesayor 3, Monkrae 2, Osramane 9, Ntewusuae 2, and Ehamankyene 7, among others.

join the association largely due to the hurdles of traveling long distances for activities in Kete-Krachi.¹²⁴

On the death of a member, leaders of the *Lentekuo* consult the Dente priest before a new one is installed. The bereaved community, together with the leadership of the association, submits three candidates for the vacant position from which a suitable person is chosen. The process is marked by elaborate ritual performances to confirm the validity of the selected candidate before installation. Although the *Lentekuo* is made up of mostly priests, its membership is opened to indigenes who have enormous knowledge in herbal medicines. Presently, two herbalists in Nteususae are members of the association. Priests who do not have adequate knowledge in traditional medicines depend on the services of those herbalists during healing. Herbalists in Nteususae are believed to possess efficacies pertaining to venomous snake bites. Cases relating to snake bite are therefore sent to Nteususae for curing.

Leadership of the *Lentekuo* is made up of the chairman, secretary, and the treasurer.¹²⁵ There are also deputy secretary and deputy treasurer positions in the leadership of the *Lentekuo*, who provide assistance to the secretary and treasurer, respectively. To effectively handle its financial issues, the association opened an account with the Krachi Rural Bank.¹²⁶ Due to the popular belief that ‘money is a spirit’, with a tendency to ‘disappear’, the association is guided by the general principle that finances accrued should

¹²⁴Interview with Mr. Emmanuel Akorsah, priest of Kipera shrine and Revenue Superintendent, Krachi West Municipal. Gyankrom, Kete-Krachi, 23rd November, 2020.

¹²⁵ The priest of the Boame shrine at Breweniase is the current chairman of the association. Breweniase is easily accessible to other Krachi towns such as Kete-Krachi to the south, Nteususae, Monkrae and Osrمانية in the north, and Dadekro to the west.

¹²⁶ Selection of leaders in the association is based on simple vote. Hands are raised to reject or confirm candidates or opinions. Signatories to the account include the secretary, treasurer and any other member of the association other than the chairman.

be deposited in their bank account immediately or not later than 48-hours on receipt of those monies. The activities of the association are sustained through monthly contributions. Each priest/priestess contributes a monthly dues of ten cedis (Gh¢10) to cater for their welfare needs. Curses are invoked on their finances to discourage members from squandering them.

The secretary of the *Lentekuo* takes inventory of their activities and disseminates information relating to the association to members. The position of the secretary is normally reserved for priests or priestesses who can read and write. Regarding the educational statuses of members of the *Lentekuo*, a few members the researcher interacted with had formal education. For instance, the secretary of the association holds a diploma in Basic Education and works with the Krachi West Municipal Assembly as a Revenue Mobilisation Officer. He doubles as a farmer and a priest-healer. The majority of the priests and priestesses, however, are farmers and petty traders. Some of the priestesses are also engaged in pito production. The priests and priestesses possess adequate knowledge in healing a broad spectrum of illnesses. As a result of their critical roles in healing, many healers embark on backyard gardening. This makes it easy for healers to attend to their clients without delay.

Members of the *Lentekuo* meet once every two months to discuss matters such as healing, statuses of accounts, and upcoming festivities. For instance, members of the association are given occasional updates on new cases and the nature of illnesses being treated by members. Meetings may be organised purposely to identify illnesses and their aetiology. Meetings give members opportunity to contribute medicines to remedy a health condition. The researcher observed that members who have medicines relating to a particular illness

assist other healers in their treatment. Members of the *Lentekuo* have jointly healed patients. It must be pointed out that, although healing is done by members of the *Lentekuo*, non-members of the association who have efficacious medicines may be contacted to assist in critical illnesses.

As indicated in chapter five, members of the *Lentekuo* make referrals to orthodox healthcare facilities, sometimes for blood or Intravenous (IV) fluid infusion, after all attempts by other members of the association have failed. Depending on the condition of a patient, members of the association may be sent to the residence of a priest or priestess to administer treatment. It is significant to point out that Dente ‘chooses’ priests who should intercede in healing a particular illness. In this light, the deity determines where patients should send their illnesses. In view of this, members of the *Lentekuo* consult Dente for directives in treatment of difficult illnesses. Urgent attention is paid to patients sent from the Dente to the subsidiary shrines. Although treatments are carried out in the affiliate shrines, Dente is believed to be the ‘source-healer’ of illnesses. It intercedes in treatment of difficult cases.

Members of the *Lentekuo* perform diverse roles during *Akwammoo Nanaba*, the Krachi state annual ritual festival. It is during the *Nanaba* festival that the path leading to the Dente shrine is weeded by the Krachi people. During the festival, priests and priestesses of the *Lentekuo* present monies and other items to the priest of Dente. They assist in clearing the paths leading to the Dente shrine while the priestesses assist in preparing the ritual food. The priestesses further participate in prayers and other crucial rituals during festive occasions.

The ritual roles of the *Lentekuo* transcends the Krachi state. When Nana Afia Kobi Serwaa Ampem II (then Queen mother of the Asante state and mother of Otumfour Osei Tutu II) died on 15th November, 2016, the priest of Dente and members of the *Lentekuo* were, for instance, duly informed and their spiritual assistance was solicited in preparation of the burial ceremony. In response, the priest of Dente selected members (priests and priestesses) of the association to attend the funeral and assist in the burial of the queen. This gesture of members of the *Lentekuo* and the Dente priest was said to have pleased the Asantehene. Besides, members of the association were said to have been invited by the Tafohene (chief of Tafo) to assist in the burial of one of his *okomfo* (priest). Similarly, the secretary of the association indicated that, in the latter part of 2020, another invitation was extended to the members of the association to burry an *okomfo* at Agona Asaman in the Ashanti Region. Priests of the affiliate shrines of Dente are rainmakers in their own right. It is in view of this that they are engaged in funerals and other festive occasions to prevent rain from obstructing such activities.

Members of the association seek protection from the Krachi Dente during the *Nanaba* festival. According to informants, the *Nanaba* festival is historical; the Yam festival, which is celebrated at the state level under the auspices of the paramount chief, is considered a modern invention. For some time now, the *Nanaba* has not been celebrated, a situation that members of the *Lentekuo* described as the ‘marginalisation of culture’. They indicated that the *Nanaba* is being suppressed in favour of the Krachi state Yam Festival. In view of this, members of the *Lentekuo* have boycotted the Krachi state Yam festival, demanding the performance of the *Nanaba* ritual that has halted over a decade now.

Healers in the *Lentekuo* do not charge exorbitantly for their healing services due to the religious proscription that hinders them from doing so. It was asserted that in the training of priests and priestesses, Dente subjected the trainees to critical interrogations. He asked the question through the presiding priest: “these leaves belong to who?” The trainees would answer by saying “the Supreme Being”. A priest further indicated as follows:

“... [P]rovidence of rain by the Supreme Being led to the abundant medicinal plants which we use. Even if one had watered the plants, they would still not have produced as expected, compared to when Wuruboare [the Supreme Being] provides the rain”¹²⁷.

As pointed out by the priest, rainfall which helps in the growth of plants is divine providence. It is in view of this divine providence of water and plants that healing must not be expensive. Besides, healing in the shrines is relatively cheap because it is believed that Dente could make medicines inefficacious when healers charge exorbitantly or exploit their clientele. Healing is therefore construed as a religious or social mandate.

An offense for which a member of the *Lentekuo* may be fined is when a priest commits adultery with someone’s wife. Promiscuity of a priestess is also a scornful act. Apart from the social implications, the act is believed to desecrate sacred abodes and reduces the potency of medicines.

A few members of the *Lentekuo* have joined the Herbalist Association of Ghana (HAG). The certificate of the HAG is a license for healers (see figure 7.9). The activities of the HAG in the Kete-Krachi area are coordinated by the Krachi West Municipal Assembly. Like the PMTHA, priests and priestesses who have adequate knowledge about the use of medicinal plants could join the HAG. On the contrary, priests and priestesses who depend

¹²⁷ Interview with Emmanuel Akorsah at Gyankrom, Kete-Krachi. 23rd November, 2020.

on psychic healing and have not demonstrated adequate knowledge of use of medicinal plants cannot become members of the HAG.

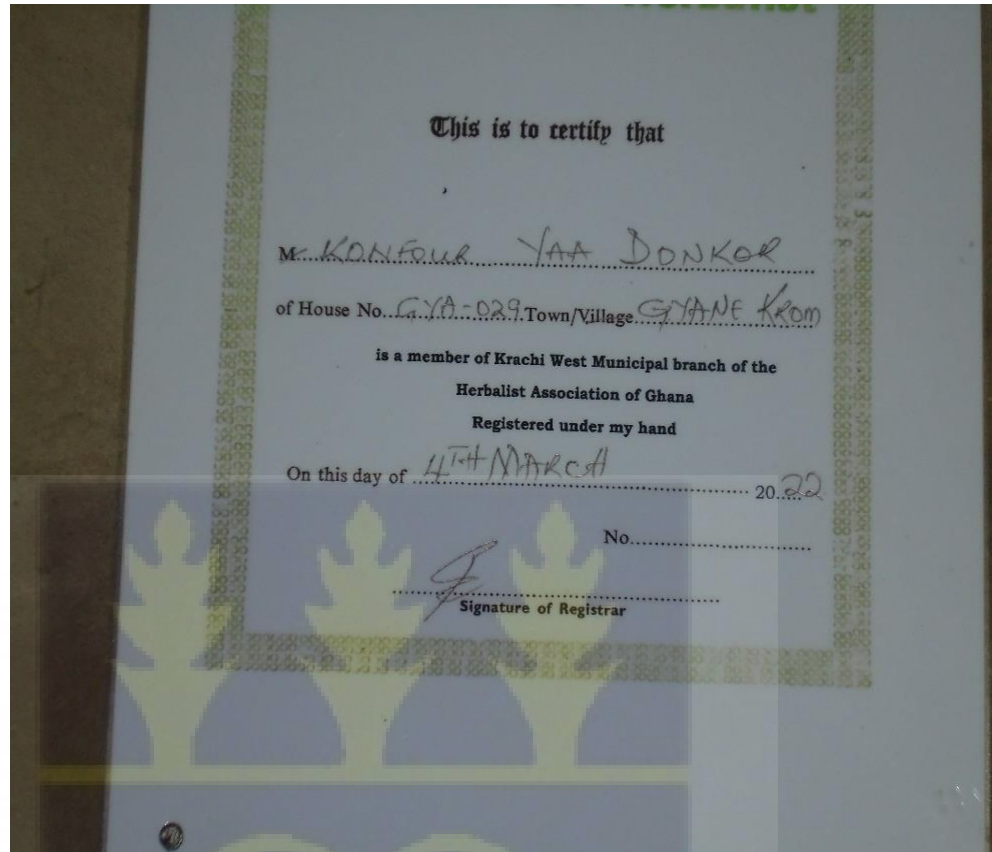


Figure 7.9: Certificate of the priestess of Obourfa-Dadiefia who doubles as a herbalist. Photograph taken at GyaneKrom by the researcher. 8th August 2022.

7.4 The License and traditional healers

Pavanello and Schirripa (2011, p.45) have noted that healers must acquire an operational license which guarantees them to practice traditional therapy or sell traditional medicines/products. The Krachi West Municipal Assembly provides licenses to healers. The license is also known as the ‘Decentralisation License’, ‘Working License’ or ‘Operational License’. The license, which is renewable annually, ensures effective coordination of traditional healers by the Municipal Assembly. Besides, the license gives

members the opportunity to operate in other districts. Such healers pay tax to the district(s) in which they operate.

In the past, the licenses of members of the *Lentekuo* were kept by the priest of Dente. A priest or priestess who needed to operate with the license would consult the Dente priest before it was released. This demonstrates the power relations between the priest of Dente and his subordinate priests. The priest of Dente therefore had the power to seize the licenses of members whose roles and conduct were unsatisfactory. The power of revocation of licenses of healers by the priest of Dente has, however, changed; it is the sole prerogative of the Krachi West Municipal Assembly to cease licenses of healers whose conduct may be unsatisfactory. Nevertheless, the Dente priest still wields power over members of the *Lentekuo*.

Apart from those who are licensed members of the *Lentekuo*, there are healers who may be licensed but are not members of the association.¹²⁸ In Kete-Krachi, the secretary of the association has the power to either stop, report to the police, or seize the products of non-licensed healers who operate in the markets. The license gives members the opportunity to operate without intimidation. As pointed out by Pavanello and Schirripa (2011, p.45), the license and monthly payments records on the association card guarantee recognition of a healer's knowledge and specialisation in healing. It also reduces the legal fees in the event of a complaint filed by the families of a deceased patient in the course of administering therapy. However, none of the members of the *Lentekuo* attested to claims of legal suits in the event of death of clients. The respondents indicated that the nature of illnesses brought

¹²⁸ In the unlikely event that a patient died in the hands of a non-licensed healers/operators, he/she may be sanctioned by the state.

to the shrines make it impossible for litigations, as such patients may have previously visited hospital(s) but had no treatment to their conditions. A chronic illness or condition regarded as 'hopeless' from which a patient dies therefore requires no litigations/summons.

7.5 Conclusion

Religious associations serve as avenues for social capital. In Kete-Krachi, the priests of the Krachi Dente have found various associations of traditional healers as important avenues for social capital. This form of capital among the Krachi cannot be understood without recourse to the events at the time. Traditional healers in the Kete-Krachi area appropriated the avenues provided by the various association of traditional healers to advance their profession. Traditional associations that received membership from the traditional healers in the Kete-Krachi area included the GHPTHA, the GNATH and the PMTHA, to state a few. Apart from joining associations of traditional healers that had a national character, the priests of Dente have also banded themselves together in the *Lentekuo*. The *Lentekuo* provides a platform for collaborations among the priests and priestesses of the affiliate shrines of Dente. It also gives them the recognition and license to practice healing. The association provides a unique social identity for the priests and priestesses, an identity that is unparalleled. The significance of the *Lentekuo* goes beyond the local social spectrum as its members are duly recognised by the local government authority and other state agencies in the Krachi West Municipal.

CHAPTER EIGHT

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

8.1 Introduction

This study examined shrines in the traditional healthcare system in the Kete-Krachi area. It evaluated the significance of Dente in the religious institution among the Krachi. African healthcare systems are pluralistic, including the public healthcare sector, the private healthcare sector, and the informal healthcare sector. Much scholarly attention has been paid to the formal and the private healthcare sectors. The informal healthcare sector was therefore the subject of attention of this study, using the Dente shrine as a special case. Using the social determinants of health (SDOH) model, the thesis argued that among the Krachi, health is socially constructed. Focusing on the social interpretations to health, the thesis further argued that religion matters in the production and utilisation of healthcare.

The complex nature of health leads to the use of social and religious approaches to healthcare. This study contributes to shaping the future of global healthcare. Presently, global health initiatives have been characterised by a commitment to disease-specific programmes. These programmes therefore target diseases such as malaria, tuberculosis, HIV, measles, whooping cough, tetanus, polio, smallpox and indicators of other health status namely: maternal mortality, malnutrition, and access to clean water (Giles-Vernick & Webb, 2013). The future of global healthcare should achieve a mix of clinical, mental, social, emotional, physical and spiritual health, which is shaped not only by healthcare, but through a convoluted interplay of the social, economic and environmental factors that influence health. At present, however, the healthcare inequity leaves a greater proportion

of populations from achieving ‘well-being’. This is when the concept of health assumes a predominantly clinical dimension. The social and religious interpretations make it possible to argue for a shift from the ‘health care economics’ paradigm that pays attention to individual perspectives within the healthcare system to the ‘health economics’ that underscores health as a social good. This thesis therefore agrees with Edwards (2001), Navarro (2002) and Mooney (2009) who argued for a new model of health that examines health within the social context. These socio-economic determinants of health include level of education, worldviews and thoughts, social relations and associational life, and the economy, among other factors. This concluding chapter presents a summary of the research findings and their broader implications on health and topical health discourses. Further, it draws conclusions to the study and provides recommendations based on the research findings.

8.2 Summary of the study findings

The study has made insightful discoveries that are significant to the discussion of health and healthcare. A key objective of the study was to examine conceptualisations of health and illness in the context of the Krachi people and its effect on health seeking behaviours or choices. Among the Krachi, health is conceived as having mundane, spiritual and social dimensions. This view is contrary to the biomedical understanding of health which views health from a clinical perspective. Good health is therefore conceptualised as “well-being” which is synonymous with the Krachi term, *kialin* – the generic concept of good health – which can be obtained through prayers, respect, the consumption of medicines, to state a

few. The conceptualisation of health among the Krachi is, therefore, contrary to the popular germ theory held by Western societies. This thought about health among the Krachi has wider implications for indigenous epistemologies. Knowledge of the Krachi people about health is complex, compared to the narrow Euro-centric view. Understanding about health as a physiological entity may therefore be inadequate and inaccurate. When health is conceptualised from physical, spiritual and social perspectives, it has potential implications for health-seeking options. Spiritual and social explanations to health may lead to the use of traditional health approaches such as shrines, to combat illnesses. On the contrary, when health is assigned “physical” explanations, patients are more likely to use orthodox or herbal medicines.

The study found that the Krachi perspective of illnesses determines their health-seeking choices. The Krachi classifies illnesses into the following: *afu kulɔ* (spiritual illness), *kulɔ gyiga* (normal or physical illness), *kra kulɔ* (soul illness), and *kananatɔ kulɔ* (inherited illnesses). The Krachi also believe in natural illnesses and conditions. This classification of illnesses is significant in understanding health-seeking behaviours. Although the Krachi solicit the intervention of orthodox healthcare providers and herbalists in natural and biological (inherited) illnesses, they are at times believed to require no intervention. Such cases may, occasionally, be sent to the indigenous shrines (Dente, Kyanyiɲi and Pɔnyɛ) for intervention. Such a classification of illnesses firmly takes up the Social Determinants of Health Model, within which to understand the social interpretations ascribed to illnesses. The classification of illnesses among the Krachi requires the following approaches to healthcare: physical/natural (requiring the intervention of the herbalists or orthodox healthcare providers, or no intervention), spiritual (combating illnesses whose aetiology is

attributed to supernatural entities) and social (uniting individuals whose illnesses may be associated with disputes). These approaches are, however, not discrete, as a combination of them may be resorted to during healing.

The study has broader implications for global health. It found that the COVID-19 pandemic was assigned spiritual interpretations. The isolated cases of non-compliance to public health measures also stemmed from social and spiritual interpretations to the disease. Respondents noted that they wore the nose mask to avoid sanctions from government. Individuals who were reluctant to wear the nose mask felt that the COVID-19 pandemic had been 'closed' in the Dente shrine and could therefore not infect them. These were those who believed that deities were powerful to combat the pandemic or prevent it from spreading in Krachi towns. Public health education should, therefore, take into cognisance traditional notions about diseases and approaches that may affect peoples' responses to healthcare.

Perceptions about illnesses have a direct implication on health-seeking behavior. People who embrace the germ theory of causation of illnesses show a differing attitude to the search for the cure to a disease, contrary to those who attribute the disease to a supernatural cause. Such supernatural explanations of ill-health render it possible to rationalise difficult situations. The study found that individuals consult deities and other spiritual entities for healing when they suspect that their illnesses are spiritually caused. Illnesses that orthodox healthcare could treat are considered to be physical. On the contrary, illnesses that orthodox healthcare could not offer treatments to are considered as spiritual. Individuals seek traditional healing when orthodox healthcare proves incapable of curing their illnesses.

The study observed that patients who exhibited signs of *kikpinkpin* (epilepsy) and *akpetembi* (asthma) visited shrines. These health conditions are considered as ‘hopeless’, requiring spiritual intervention. This implies that such notions pertaining to illness chronicity affect health-seeking behaviours among people. Although treatments for epilepsy, a form of seizures, and asthma are readily available in orthodox healthcare facilities, traditional mechanisms for their treatments open another lense for further research into traditional knowledge systems. Sometimes, patients seek treatment in orthodox health facilities before visiting the shrines. When orthodox healthcare system is found to be deficient in treatment of illnesses and other health conditions, then interpretations to aetiology of illnesses assume a social and religious dimension. The perceived failure of orthodox healthcare to treat chronic illnesses accounts for the use of shrines in healing.

Another objective of the study was to examine the extent to which traditional healthcare has altered over time. The study found that affiliate shrines of Dente have altered from ‘mere’ abodes of the supernatural to traditional healthcare centres. Buildings have been constructed to accommodate patients and, in some cases, serve as stores for traditional medicines. The study found that the priestess of the Obourfa-Dadiefa and the priests of the Kikpare/Papakesie shrines constructed ‘wards’ to accommodate patients who visit those shrines. Although the priestess of Akomagyo-Lente and the priest of Fofie shrines do not have ‘wards’, patients are accommodated in rooms of the healers and other family members.

But in which way does the combined use of herbal and orthodox medicines illustrate a change in the traditional healthcare system? The study found that patients use orthodox

medicines while on admission in the shrines. A priest/priestess may recommend herbal medicines to a client to buy. Both the healer and the patient determine which orthodox medicines to use. In some cases, patients continued to use orthodox medicines brought from the hospitals where they had earlier sought treatment. Traditional healing is receptive to orthodox medicines which points to the dynamic nature of the practice. This study found that some orthodox healthcare practitioners are willing to collaborate with traditional healers, although the former foresee emerging challenges which must be dealt with by government. This has wider implications for debates on integration of traditional healthcare into orthodox healthcare system. For instance, the idealist school of thought argue that cooperation between biomedical healthcare providers and indigenous healers will lead to mutual benefits.

Another objective of the study was to interrogate the use of herbal medicines and associational life among healers and how they enhance healing. The study found extensive use of medicinal plants in the affiliate shrines of Dente such as Fofie, Obourfa-Dadiefa, and Kikpare that could help combat many illnesses. The study found, for instance, that the stem bark of *kprinbeli* (*Maytenus senegalensis*), *kiba* (*Bridelia ferruginea*), *kinkirin* (*Burkea africana*), *potipoti* (*Parinari curatellifolia*), *kuntibura* (*Cussonia barteria*), *kichawbese* (*Trichilia emetica*) and *kibutu* (*Euphorbia poissonii*) is used by the priest of Fofie to cure infertility in both men and women. This is contrary to many pre-existing studies that have been conducted on the separate uses of the plants to cure infertility.

Nevertheless, there are a few instances where individual plants (decoction) may be used to heal a condition. For instance, unlike the priest of Fofie that uses a combination of herbal medicines to enhance fertility, the priest of the Kikpare shrine uses only *Alternanthera*

caracasana to expedite conception. The plant is used by the priest of the Kikpare shrine to prevent miscarriages and stillbirths. Unlike the Fofie shrine where *Trichilia emetica* is used together with other plants to treat infertility, in the Kikpare shrine the plant is used separately to improve fertility. Plants such as *emire*¹²⁹ (*Terminalia ivorensis*), *Nunum/Onunum* (*Ocimum gratissimum*) and *piya* are used as oxytocic agents. A concoction prepared from *Terminalia ivorensis* and *Ocimum gratissimum* is drunk to facilitate childbirth. Similarly, herbs such as *kinkirin* (*Burkea africana*), *frɔki* (*Salvadora persica* L), and *kikyamunamoin* (*Flacourtia flavescens*) are mixed and used as treatment for stomachache in the affiliate shrines of Dente.

Among the affiliate deities, Fofie is responsible for epileptic patients. Reasons why symptoms of epilepsy could be cured in the Fofie shrine were ascribed to the deity's healing efficacy. There is the general perception that orthodox medicine is incapable of treating epilepsy. The study found that plants such as *kuntikinimsa* (*Stereospermum kunthianum*), *kichawbese* (*Trichilia emetica*), *kibwe* (*Strophanthus hispidus*), *kidinɔnansi* (*Pseudocedrella kotschyi*) and *kikyikankya* (*Prosopis africana*) are used to treat epilepsy in the Fofie shrine. Like epilepsy, a concoction prepared from the leaves of *Terminalia ivorensis*, *piya* (in Kaakye), *Ocimum gratissimum* and *kafrɔ* (in Kaakye) is believed to treat seizures.

Uses of medicinal plants with respect to healing vary from shrine to shrine, although similarities may be found. For instance, a decoction of *Altenanthera sessilis* is bathed to boost sleep in the Fofie shrine whereas in the Obourfa-Dadiefa shrine, *Prosopis africana*

¹²⁹ In Akan language.

is used to enhance sleep. In the Obourfa-Dadiefa shrine, swellings are treated using *Calotropis procera*. In the Kikpare shrine, however, the priest uses *Dysphania ambrosioides* in the treatment of swellings. In both Fofie and Obourfa-Dadiefa shrines, a drip prepared from *Helitropium indicum* is used to treat eye problems. The extensive use of herbal medicines by some priests and priestesses in the Kete-Krachi area challenges the popular notions that people resort to shrines mainly for spiritual purposes. Besides, the use of herbal medicines in shrines make it possible to consider priests and priestesses in the discourse of integration. Like biomedical healthcare providers, healers such as priests and priestesses rely extensively on plants to deliver healthcare. This corresponds with the idealist view that cooperation between the biomedical healthcare providers and healers will lead to mutual benefit.

The views expressed by healers and orthodox healthcare professionals, as indicated, have broader implication for the integration question in Ghana and Africa at large. Kpobi and Swartz (2018) have indicated that the Pentecostal Christian healers were desirous of collaboration with biomedical practitioners while Muslim healers and shrine priests were less interested in collaboration. Although the priests in the Krachi area noted their interest in collaboration, they wanted the biomedical practitioners to initiate the collaboration. Orthodox care givers in the Kete-Krachi area indicated the benefit to learn from healers, and vice-versa. Appiah, Amponsah, Poudyal, & Mensah (2018) have observed that one of the strengths of the integration of traditional and orthodox healthcare systems is its potential impact on job opportunities for medical herbalists, including those who studied herbal medicine and have graduated from higher institutions of learning. Although integration of traditional and orthodox healthcare systems is significant, its achievement is

fraught with many challenges. For instance, the National Health Insurance Scheme in Ghana is unable to cover the essential herbal medicines that have been introduced into the Orthodox healthcare facilities. Besides the insurance excludes other healing services rendered by traditional healers. For a more comprehensive and accessible healthcare, the Health Insurance Scheme should cover healers who demonstrate adequate knowledge in healing. There are other challenges that need to be dealt with for effective healthcare. For instance, Nyame, et al. (2021) point to the disrespect from the Primary Healthcare giver which may hinder effective collaboration, as healers may be reluctant to disclose their knowledge in herbal medicines. Both the orthodox healthcare provider and the traditional healer should, therefore, consider each other as mutual partners in the healthcare delivery system in Ghana.

There seem to be specialisation of priests of the affiliate shrines of Dente with respect to healing. The Akomagyo-Lente deity is consulted by women to provide fertility. On the other hand, people consult the Fofie deity when they observe signs of mental illnesses. Unlike the Fofie and Akomagyo-Lente, the Obourfa-Dadiefa deity is believed to heal a broad spectrum of illnesses. The efficacy of the Obourfa-Dadiefa deity may be linked to the enormous use of herbal medicines. Although deities may be said to heal specific diseases or conditions, different illnesses may be sent to them for healing. The priest of Dente remains significant in determining which deity to consult for healing, regardless of the illness.

The study found three forms of referrals in shrines: intra-shrine referral, inter-shrine referral, and referral to the hospital. A healer may exhaust every means when healing a patient before a referral is made. A priest- or priestess-healer makes referral to a shrine

believed to have been driven from Dente. It is when the intra- and inter-shrine referrals are, sometimes, exhausted that further referrals may be made to the hospital. These forms of referrals lead to delays in seeking orthodox healthcare. These delays, as noted in previous discussions, are often associated with the use of traditional mechanisms of treatment by patients before seeking orthodox healthcare. While seeking treatment in the shrine, a patient may not suggest to the healer an alternative healthcare to be referred to when they discover that their illnesses are not improving. This could be due to the feeling that a decision for referral might undermine the reputation and prowess of a healer. Patients also fear to request for referral as it is believed that a healer who is displeased about the request may worsen their conditions. This makes healers powerful in the traditional healthcare system.

The study further set out to interrogate factors responsible for the utilisation of shrines in the traditional healthcare system. The findings of the study show that social expectation for reproduction account for patronage of shrines. Reproductivity is a social requirement that determines statuses and privileges of individuals in the society. The social expectations with regards to childbearing puts pressure on women to bear children. Failure to produce children leads to disappointments and disputes in marriages. The practice of fostering lessens the matrimonial pressures regarding infertility. Even so, this practice is not a remedy to barrenness. It is this dissatisfaction associated with the practice of fostering that the deities may be consulted to provide children. The study has found that, among the affiliate deities, the Akomagyo-Lente was the most consulted for fertility. Children believed to have been born through intervention of the deities are named after them. Apart from fertility, Fofie is consulted for economic, religious, and social reasons, unlike the

Akomagyo-Lente whose specific role is to offer fertility to women. The study has indicated that deities such as the Mprah, Dente, and Fofie are known for the provision of fertility. It has also established that the affiliate deity responsible for fertility is the Akomagyo-Lente. In Ghana, In Vitro Fertilisation which helps deal with infertility conditions, is quite expensive. Fertility clinics are being established for that purpose. Research into such fertility shrines could reduce expenditure on In Vitro Fertilisation for partners who need to reproduce.

Besides the social and spiritual reasons, the findings of the study show that the economy affects healthcare choices. Low levels of income, particularly in the rural areas account for the use of shrines for healing. It was noted that agricultural activities constitute the mainstay economic activity in the Kete-Krachi area. However, farmers complain about declining returns from their farms and low levels of income. Inadequate income affects healthcare choices.

Levels of education also affect access to healthcare. For instance, it was observed that many of those who had no formal education background or acquired only basic education usually visited the shrines for healing. It was only in extreme cases when the hospitals were unable to treat the highly educated that they visited shrines for healing. In addition to the social and economic explanation is the general perception that traditional healing is effective as compared to orthodox healthcare. Finally, availability of traditional healers, unlike orthodox healthcare providers in the Kete-Krachi area compel patients to opt for traditional healthcare. The study further observed that the Volta River is a limitation to inhabitants of settlements such as Chinikope, Tokpo, Dzilakope, Basare and 1990. As a result, they hardly

seek healthcare in Kete-Krachi and other communities where orthodox facilities are located.

Economic constraints, unavailability of orthodox healthcare facilities, and long distances to healthcare facilities, among other factors account for the reasons why some Krachi shrines have transformed into traditional healthcare centres. Shrines have also become focal points of healing due to the inability of orthodox health practitioners to treat sicknesses. The Krachi believe that it is not every illness that is the domain of orthodox healthcare practitioners. In this light, illnesses whose aetiology are clouded in mystery are sent to the deities for intervention.

With regards to gender, the study found that females could become priestesses of the affiliate shrines of Dente. Similarly, a woman can initiate the establishment of a subsidiary shrine of Dente. This is usually the case when a woman seeks the intervention of Dente to assist her bear a child. Affiliate shrines such as Obourfa-Dadiefa and Akomagyo-Lente are headed by women while the Fofie and Kikpare shrines are headed by the men. There are several affiliate shrines that are headed by women. The ability of Krachi women to establish and operate their own affiliate shrines have inherent gender and economic connotations. Priestesses obtain their wealth from petitioners who consult the deities for many reasons. The consultation fees paid by petitioners assist priestesses to engage in economic activities such as agriculture and trading activities, making them economically independent on their husbands. Nevertheless, the taboos associated with menstrual blood often pose a challenge to the activities of priestesses. This explains why priestesses in the Kete-Krachi area are expected to, at all times, be assisted by the *akyeame* – shrine assistants.

In spite of the healing conducted by priests and priestesses, the practice is saddled with many challenges. These challenges have broader implication for the future of African Indigenous Knowledge systems. Bad agricultural practices affect traditional healing systems. Apart from the slash and burn agricultural practice, the Green Revolution which seeks to improve food production also threatens knowledge in indigenous medicines. Modern farming methods including the use of sarosate and gramoxone kill medicinal plants. The effect of these new agricultural technologies is the extinction of plants in the Kete-Krachi area. Plants such as *kinijiniji*, *kafrɔ* and *asagyiriwa* were not found in the area. The extinction of plants in the Kete-Krachi area are further aggravated by the effects of climate change.

The priestly institution in Kete-Krachi is an incentive for social capital. Indeed, the study showed that there were several associations in the Kete-Krachi area. These included the GPTHA, GHPTHA, GNATH, and the PMTHA. In contemporary times, priests and priestesses in the area belong to the *Lentekuo* and Herbalist Association of Ghana. Healers may join both associations. This gives them the opportunity to derive support from both associations in difficult times. Bereaved members of associations receive donations and care. Couples receive gifts from members of the association after marriage. Apart from social support, members receive economic assistance. The study found that members of the *Lentekuo* hold a bank account into which their financial contributions are deposited. While the priests borrow money mainly for agricultural purposes, priestesses borrow monies from the association to brew *pito* (local gin) and engage in other trading ventures.

8.3 Conclusions

Traditional healthcare has contributed significantly to alleviating health challenges that confront society. As a result of the social interpretations pertaining to health, the discourse on health should consider health as multi-cultural, rather than universal. It is when health is viewed from a broader perspective that the salience of the shrine in alleviating Ghana's healthcare burden will be uncovered. Similarly, the discourse on traditional knowledge production should also take into consideration the significance of shrines and healing. This work has provided insights into shrines and healing in the Kete-Krachi area, with special focus on Dente. It examined the use of shrines in the framework of health in contemporary Krachi society. The healthcare system in Ghana is pluralistic and complex, composing of traditional and modern healthcare systems. Traditional healing constitutes an essential aspect of Ghana's healthcare system. Unfortunately, not much attention has been paid to the subject of shrines and healing as a significant component of healthcare systems in Ghana. It is therefore crucial for a new model of health to incorporate social, religious, and cultural perspectives.

Traditional worldviews are essential in understanding theories of illnesses and diseases. Orthodox healthcare providers lack adequate knowledge of the cultural beliefs and practices of patients (Hill et al., 2014) that are critical in the theory of illness. From the discussions, it is clear that religion and health are interlinked. Pragmatic solutions to illnesses therefore require different approaches such as: physical, spiritual, social, and moral. The complex view about health is in line with the African concept of health. Besides, the link between spiritual and physical health among the Krachi cannot be farfetched. This is because ordinary human powers and intervention are inadequate to satisfy human needs.

The fear for the unknown, including starvation, diseases, illnesses, and disaster compel people to consult the deities for healing. It is through consultation with the deities that traditional practitioners understand the spiritual explanations of illnesses, their causation and treatment.

The Krachi concept of the human person has wider implication on global health. It has consequences for the treatment of people living with disabilities. Healing entails identification of souls and destinies of individuals. Humans are expected to keep an unbreakable union with the Supreme Being in order to continue to enjoy good health, wealth, and protection from misfortunes. Deities are consulted, and in some instances, believed to be 'sent' to the Supreme Being to maintain that relationship. It is argued in this work, therefore, that although the concept of the human person may be used to promote health, it may not always be the case. Children whose disabilities are clouded in mystery are killed silently to avert impending calamity from befalling the rest of the family members and/or the community at large. A common notion is that spirit-children can harm society. Their existence is believed to drain family resources. Besides, they are believed to retard good harvest. It is to curtail this threat to livelihoods that families may commit infanticide.

A conversation on traditional knowledge production triggers the debate on integration of traditional and orthodox healthcare systems. The debate involves four schools of thought – antagonists, pragmatists, idealists, and skeptics. Antagonists argue that cooperation or integration with indigenous healers as carried in the Alma-Ata Declaration is unachievable. They further argue that such a cooperation will discredit biomedical practitioners. This school is anchored on a positivist viewpoint that traditional medicine is irrational,

unscientific and unobjective. Pragmatists argue that healers are numerous, available at communities and already offering great health support, hence the need to cooperate with them (Harrison, 1979). Idealist, on the other hand, argue for interdependence of both biomedical practitioners and traditional healers as both can learn from each other. Skeptics doubt the effects of cooperation between indigenous healers and orthodox practitioners. They fear that indigenous healers might lose their autonomy. Indeed, Chavunduka (1987) argues that the one-sided interest in herbal remedies by scientists might lead to ignoring the social and spiritual aspects of healers' work. There is therefore the phobia that biomedical scientists will be biased towards herbal medicine which may rob traditional healers of their knowledge. For instance, the Chinese barefoot doctors who are predominantly herbalists have been integrated into the orthodox healthcare system to the neglect of spiritual healers (Pillsbury, 1982).

In the view of skeptics, the superiority of orthodox healthcare might be used to suppress and discriminate against other traditional healthcare practitioners such as priests and priestesses. The study confirms the views of the idealists about collaboration between orthodox and traditional healthcare providers. It, therefore, underscores the need to collaborate with indigenous healers. By interrogating the herbal medicines used by priests for instance, the thesis has demonstrated that cooperation between biomedical scientists and traditional healers would help to deal with the health challenges confronting society. There must therefore be maximum cooperation between orthodox healthcare providers and traditional healers in order to achieve holistic healthcare. The study bridges the gap between humanistic studies on the one hand, and biomedical sciences on the other hand.

8.4 Recommendations

Based on the findings and observations of this research, the following recommendations are made to government, academic and research institutions, civil society organisations, and healers.

8.4.1 Government

This study has discovered that priests, priestesses, and other healers possess enormous knowledge in herbal medicines beyond their spiritual functions. The study therefore recommends that government should establish research institutes in every district/municipal in Ghana to conduct research into medicinal plants used in healing. These institutes will complement the Centre for Plant Medicine Research at Mampong. Such research institutes can identify potential medicinal properties of plants that will benefit the health sciences.

The Ghana Health Service and the Municipal Health Directorate (MHD) should educate priests and priestesses on good personal hygiene practices. It was noticed, for instance, that priests use common towels and other health aids such as gauze and bandage on different patients. Besides, waste disposal remains a major challenge in shrines. The MHD should monitor healing practices of priest- and priestess-healers and supply them with basic healing aids. Public health professionals responsible for sanitation could monitor healing practices to ensure that the environment in which healers operate is convenient. There must be continued dialogue between orthodox and traditional healers. Via this, healers could be trained on prescription and dangers of herbal medicines without appropriate dosage form.

This form of education will be effective when mainstream healthcare providers understand and appreciate the evolving nature of the traditional healthcare system. For instance, priests and priestesses may instruct their clients to use herbal or orthodox medicines such as pain killers, or both.

The cost of operational license should be made affordable to acquire from the Municipal and District Assemblies. This will facilitate registration with the Assemblies. Registration of healers could assist government to keep record of the efficacies of traditional healing in the Kete-Krachi area.

8.4.2 Research institutions and institutes

Research institutions and institutes such as the Centre for Scientific Research into Plant Medicine (CSRPM) (now the Centre for Plant Medicine Research (CPMR)), the Institute of Traditional and Alternative Medicine at the University of Health and Allied Sciences (UHAS) in Ho, and the Department of Pharmacognosy at Kwame Nkrumah University of Science and Technology (KNUST), should conduct research into medicinal plants used by priests and priestesses in healing. The result of the findings could have wider implications for global healthcare. Research into plants in the Kete-Krachi area could, for instance, help deal with urine retention and mental health, among other conditions.

There are several affiliate shrines of Dente that constitute the *Lentekuo*. This study has however focused on a few of them, namely: Obourfa-Dadiefia, Fofie, Akomgyo-Lente and Kikpare shrines. The study recommends that further research should be conducted into affiliate shrines of Dente namely: Ma-Lente, Lente-Kusung, Ogye-Abour-Kibii, to state a

few, from the perspective of traditional healthcare and the peculiar illnesses they are said to cure.

The study observed that patients abandon orthodox healthcare for healing in the shrines. The integration question then arises. The study recommends that healers and orthodox practitioners should collaborate with each other. A collaboration is necessary as the study found that healers could combat symptoms of urine retention and skin conditions, among other diseases. This collaboration should be mutual.

Ghanaian or African universities should demystify the negative perceptions created by European imperial forces about traditional medicine as devilish and sinful. This will increase patronage for traditional healthcare with an attendant improvement in the practice. A decolonial frame should necessarily consider traditional medicine and argue for its incorporation in orthodox healthcare.

8.4.3 Civil Society Organisations

Civil society organisations such as the Centre for Indigenous Knowledge and Organisational Development (CIKOD), Organisation for Indigenous Initiatives and Sustainability (ORGIIS Ghana), and the Centre for Indigenous Knowledge Systems (CEFIKS), among others interested in developing traditional knowledge systems and institutions should identify traditional priests and priestesses whose knowledge could help improve the quality of health. These healers could be trained to improve the quality of healthcare delivery. This would enhance involvement of rural communities in the process of development.

8.4.4 Traditional Healers

Traditional healers should cooperate with researchers who are interested in documenting traditional medicines. Such a cooperation can assist researchers make discoveries that can aid drug discovery.

Healers depend on nature's flora and fauna for healing. The study has shown, however, that bad agricultural practices and modern scientific innovations such as the use of chemicals for farming endangers plant life. The study, therefore, recommends that healers should extract (rather than uproot) parts of plants for healing. Healers could, on the other hand, be trained on sustainable uses of plants. Such training would help to avoid extinction of medicinal plants.



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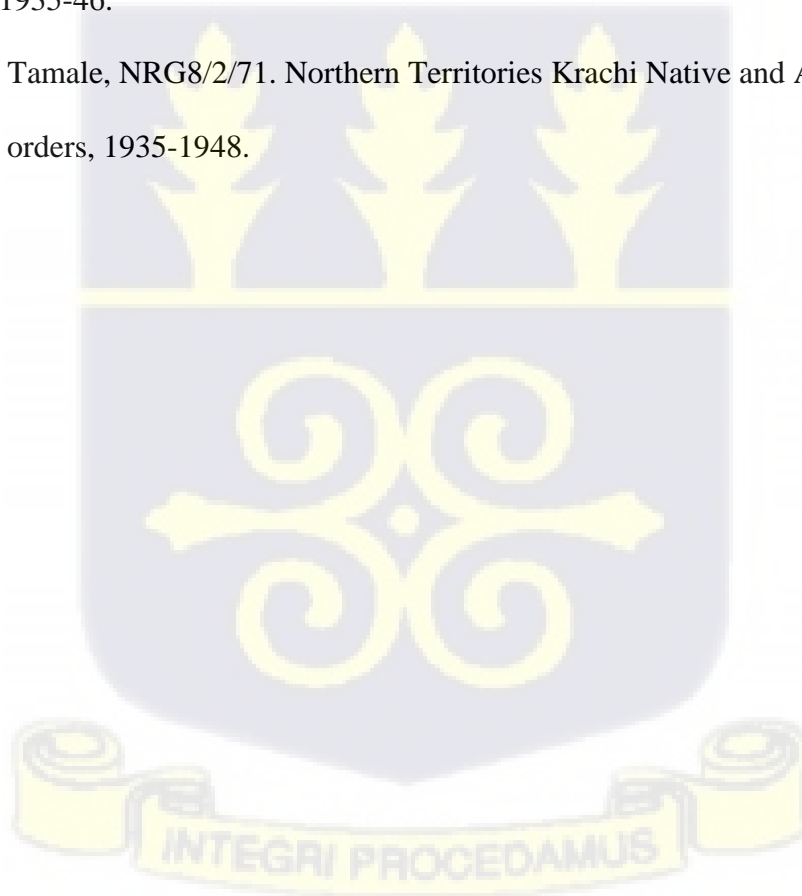
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APPENDICES

Appendix A.: Notice of ethical clearance



UNIVERSITY OF GHANA

ETHICS COMMITTEE FOR THE HUMANITIES (ECH)

P. O. Box LG 74, Legon, Accra, Ghana

My Ref. No...ECH 270/ 21-22 ...

February 11, 2022.

Mr. Richard Awubomu
Institute of African Studies
University of Ghana
Legon

ETHICAL CLEARANCE
(ECH 270/ 21-22)

The protocol title below has been reviewed and approved by the ECH Committee.

TITLE OF PROTOCOL: SHRINES AND HEALING IN KETE-KRACHI: THE CASE OF DENTE

PRINCIPAL INVESTIGATOR: RICHARD AWUBOMU

Please note that the final review report must be submitted to the Committee at the completion of the study. Your research records may be audited at any time during or after the implementation. Any modification of this research project must be submitted to ECH for review and approval prior to implementation.

Please report all serious adverse events related to this study to ECH within seven (7) days verbally and in writing within fourteen (14) days.

This certificate is valid till February 10, 2023. You are to submit annual reports for continuing review.

Please accept my congratulations.

Yours Sincerely,

Professor C. Charles Mate-Kole
ECH Chair

Cc: Professor Albert K. Awedoba, Institute of African Studies, UG

Tel: +233-303933866

Email: ech@ug.edu.gh



Appendix B.: Interview guide

SHRINES AND HEALING IN THE KETE-KRACHI AREA: THE CASE OF DENTE

BIO-DATA

1. Name of respondent
2. Sex of respondent
3. Place of respondent
4. Religion of respondent
5. Occupation of respondent

SHRINES

1. What is the origin of the Dente shrine?
2. What encounters did the colonial administration have with the shrine?
3. What are the forms of traditional healing institutions in the Kete-Krachi area?
4. What is the link between the traditional religious institutions in the Kete-Krachi area and traditional healing?
5. Identify the indigenous and the non-indigenous shrines in the Kete-Krachi area.
6. How widespread is the Dente shrine?
7. When is the Dente deity worshipped?
8. What activities take place during worship?
9. What taboos are associated with the deity?
10. Why do petitioners seek the Dente and its affiliate deities?
11. What general roles do the indigenous deities perform in the Kete-Krachi area?

SHRINES AND HEALING

12. How is 'health' and 'ill-health' conceptualised among the Krachi people?
13. How is 'well-being' conceptualised among the Krachi people?
14. In which way are the deities in the Kete-Krachi area involved in healthcare?
15. Which days are suitable for healing in the shrines?

16. How relevant is the Dente and its affiliate shrines in the healing practices in the Kete-Krachi area?
17. What are the taboos associated with the deities during healing?
18. How are spiritual illnesses determined?
19. How different are spiritual causes of illnesses from those that are naturally caused?
20. Under what circumstances are patients not allowed to send their illnesses to the hospital?
21. In situations where a patient is admitted in the shrine, how is healing conducted?
22. How are patients cared for in the shrines and do priests/priestesses have accommodation for such patients? Probe.
23. What happens when a patient flouts the religious order by going to the hospital rather than seeking healthcare in the shrines.
24. Are there any rituals conducted before individuals can visit the hospital? If yes, explain.

HERBS AND HEALING

25. Whose responsibility is it to search for herbs? Probe.
26. Can roots be searched for from shrines? Give reasons.
27. What preparations (including spiritual) are done before medicines are searched?
28. What ritual preparations are done before, during, and after harvesting of plants?
29. Explain whose responsibility it is to prepare herbal medicines?
30. Can women take part in their preparation? If yes, which category of women?
31. How are medicines stored (and where)?

USE OF TRADITIONAL MEDICINES

32. How are medicines applied to patients?
33. Are traditional medicines used in conjunction with orthodox medicines? Give reasons.
34. Under what circumstances are herbal medicines applied without spiritual interpretations?

35. Under what circumstances are herbs or medicines accepted from other healers during healing?
36. Are patients given herbs or medicines to use at home? Give reasons to your response.
37. What reasons could possibly account for patients combined use of both orthodox and traditional medicines while seeking healing in the shrines?
38. Identify plants and show how they are used to heal specific illnesses.
39. Apart from orthodox medicines use, please explain any remarkable changes in the practice of healing in the shrines.
40. Are there healing associations along the lines of herbal/plant medicines and spiritual 'medicines? If 'yes' kindly explain these associations and give their differences and similarities?



Appendix C.: Interview guide for orthodox healthcare practitioners

**HOSPITAL/CLINIC
(INTERVIEW GUIDE)**

BIO-DATA

1. Name of respondent
2. Sex of respondent
3. Place of respondent
4. Religion of respondent
5. Occupation of respondent

SHRINES AND ORTHODOX HEALTHCARE

6. Kindly identify the health facilities in or around Kete-Krachi (e.g., Hospital, clinic, CHPS compound etc).
7. How does the presence of shrines affect access to allopathic healthcare in the Kete-Krachi area?
8. Under what circumstances are patients referred from the shrines to orthodox healthcare facility?
9. What forms of illnesses are usually referred to the hospitals/clinics?
10. What spiritual/social explanations do patients give concerning the causes of their illnesses/disease conditions?
11. While seeking treatment in orthodox healthcare facilities, are there any reports of use of traditional healing methods by patients? Explain.
12. Under what circumstances are referrals made from hospitals/clinics to traditional healers? Explain.
13. What economic constraints do patients give when they fail to seek early treatment in orthodox healthcare facilities?
14. What other factors, other than economic, do patients give as responsible for the use of shrines for healing?
15. In what ways do availability/the lack of health facilities and staff affect health choices and behaviours?

Appendix D.: Interview guide for Krachi West Municipal Assembly

**THE MUNICIPAL ASSEMBLY
(INTERVIEW GUIDE)**

BIO-DATA

1. Name of respondent
2. Sex of respondent
3. Place of respondent
4. Religion of respondent
5. Occupation of respondent

6. Kindly identify the health systems in Kete-Krachi.
7. What measures have been put in place by the Government/Municipal Assembly to promote access to healthcare?
8. What is the role of the Municipal Assembly in educating people on culture and health seeking behaviour?
9. What interventions have been put in place to protect the lives of children living with disabilities?
10. What support systems are there for people living or born with disability in general?
11. When a patient dies in a shrine what are the intervention of the Municipal Assembly?
12. Are such deaths cases reported to the police? If yes, what sanctions are applied to healers? Probe.
13. What are the statistics on COVID-19 cases in the Krachi West Municipality?
14. What reports does the Municipal Health Directorate receive with reference to the socio-religious causes of COVID-19? Probe.

Appendix E.: Interview guide on association of traditional healers

ASSOCIATION OF TRADITIONAL HEALERS IN THE KETE-KRACHI AREA

- 1) Kindly identify the healing associations in the Kete-Krachi area.
- 2) What reasons led to the formation of healing associations in the area?
- 3) Which category of healers are part of the Association?
- 4) Have the association in the Kete-Krachi area any link with those in the Volta Region? Probe.
- 5) Who qualifies to be a member of the association of healers?
- 6) Are members of the Association licensed?
- 7) If yes, what are the entitlements when members are licensed?
- 8) Which institution authorises the license?
- 9) What is the implication for those who are not members of the Association?
- 10) What activities take place in the association that bind practitioners together?
- 11) What are the leadership positions in the associations?
- 12) How are leaders selected?
- 13) In case a leader dies, how is replacement done?
- 14) What are the roles of leaders in the associations?
- 15) How are dues mobilised and how are they used?
- 16) What benefits do members derive from the associations?
- 17) What constitutes wrongdoing in the association?
- 18) What is the nature of punishment?
- 19) Under what circumstances is membership revoked?
- 20) Are members incorporated into orthodox medical facilities?
- 21) Are their medicines used in the hospitals? Probe.
- 22) Under what circumstances are referrals made within members of the association?
- 23) When are referrals made to orthodox healthcare facilities.
- 24) Do members of the association receive patients from the hospitals? If yes, what kind of cases do you receive?

Appendix F.: Krachi West Municipal Hospital



Photographed by the researcher. Kete-Krachi.
17th August, 2022.

Appendix G.: Compression and identification of medicinal plants



Photographed at the Herbarium Unit of Botany Department,
University of Ghana, Legon. July, 2021.

Appendix H: Dr. Bawuah Memorial Hospital, Kete-Krachi



Photograph taken by the researcher, Kete-Krachi. 3rd July, 2021

Appendix I.: Ehiamankyene Health Centre



Photograph taken by the researcher, Ehiamankyene.
23rd March, 2021.

Appendix J.: Letter soliciting data on COVID-19 cases in Krachi West Municipal

Institute of African Studies
P.O. Box LG73
University of Ghana
Legon, Accra.
7th July, 2022.

The Municipal Director of Health Services,
Krachi West Municipality
P.O. Box 29
Kete-Krachi.

Dear Sir,

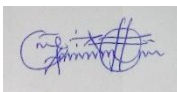
**REQUEST FOR DATA ON COVID-19 CASES IN THE KRACHI WEST
MUNICIPALITY**

I write to request for data on COVID-19 cases in the Krachi West Municipality. I am a final year PhD candidate at the Institute of African Studies, University of Ghana, Legon and I am currently conducting research on the thesis title, *Shrines and healing in the Kete-Krachi area: The case of Dente*. Aspects of the study discuss the link between orthodox healthcare and Dente shrine(s). Data on COVID-19 cases will therefore be essential to this study.

Please find attached ethical clearance for this research.

I hope my request will receive a kind consideration.

Thank you.



(Richard Awubomu)

Final Year PhD Candidate
Institute of African Studies
University of Ghana
Legon, Accra.

Appendix K.: Letter soliciting data on COVID-19 cases in Krachi East Municipal

Institute of African Studies
P.O. Box LG73
University of Ghana
Legon, Accra.
8th December, 2022.

The Municipal Director of Health Services,
Krachi East Municipality
Dambai, Oti Region.

Dear Sir/Madam,

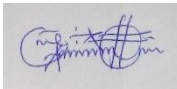
**REQUEST FOR DATA ON COVID-19 CASES IN THE KRACHI EAST
MUNICIPALITY**

I write to request for data on COVID-19 cases in the Krachi East Municipality. I am a final year PhD candidate at the Institute of African Studies, University of Ghana, Legon and I am currently conducting research on the thesis title, *Shrines and healing in the Kete-Krachi area: The case of Dente*. Aspects of the study discuss the connection between orthodox healthcare and Dente shrine(s) in the Oti Region. Data on COVID-19 cases in the Municipality will therefore be essential to this study.

Please find attached ethical clearance for this research.

I hope my request will receive a kind consideration.

Thank you.



(Richard Awubomu)

Final Year PhD Candidate
Institute of African Studies
University of Ghana
Legon, Accra.

