Asram: A superdiverse illness concept

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Introduction

Medical pluralism – the simultaneous presence of different healing traditions or systems in the same setting – became popular among anthropologists in the 1970s and early 1980s because conceptualising medical systems in this way challenged the hegemony of biomedicine and raised the status of other approaches to healing. Biomedicine thus became an object of study: scholars emphasized its *culture* and it became just another ethnomedicine (Hahn & Kleinman 1983). Models of health seeking behaviour, mainly developed from a biomedical perspective, began to incorporate previously excluded expert practices (Perdiguero 2006; Leslie 1980).

It soon became clear, however, that these plural medical systems were not so systematic; key concepts of medical pluralism, such as Kleinman's (1980) *health care system*, began to receive criticism for their formalism and ostensible certainty. Subsequent critical studies of medical practices in Africa stressed that medical systems were often more like *non-systems* (Last 1981; Pool 1994a, 1994b). The assumption of consensus underlying the pluralistic medical systems model had overlooked the conflict, hegemony and subaltern relations that configure the medical arena in practice (Kahn 2006; Menéndez 2005; Schirripa, 2005). Even Kleinman (1995) later acknowledged that the emphasis on systematic connections had neglected the "differences, absences, gaps, contradictions, and uncertainties" that characterise medical systems in practice (*ivi*: 8).

It also became clear that the different medical sub-systems were not so discrete. In practice, people seeking treatment shopped around pragmatically and mixed treatments from different medical

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traditions. Healers did the same, often prescribing herbs and antibiotics simultaneously. Anthropologists termed this medical syncretism. Medical syncretism, however, was however underpinned by a relatively static understanding of discrete medical traditions. Studies of syncretism were often limited to particular locations and neglected the mobility of people and healing practices.

In this article, we move beyond pluralism and syncretism to address the dynamic and multi-faceted nature of illness. In ethnographic detail, we examine an illness concept and the ways in which it is negotiated, transformed and reconstructed as it is passed between people, practitioners, medical traditions, and geographical settings. First, we focus on the variability and heterogeneity of local practices. We then analyze the fluidity and operational transformations of an Asante illness concept in a context of mobile patients and healers. We discuss the transactions, influences and silences that characterize the relationship between local forms of biomedicine and other therapeutic alternatives.

Our ethnographic data are drawn from a larger multi-sited programme of anthropological research on the social and cultural context of malaria in pregnancy, undertaken under the auspices of the Malaria in Pregnancy Consortium[1]. Fieldwork was carried out over a period of two years in Ghana's Upper East and Ashanti Regions. Data were collected through in-depth interviews, case studies, group discussions, and participant observation with pregnant women and their families, community leaders, local healers, traditional birth attendants (TBA), and health providers in the public and private sector[2].

Pregnancy care in two contexts

In Ghana, our two research sites were characterised by important cultural, historical, religious and geographical differences. The centrally located Ashanti Region experiences a tropical climate and is home to one of the richest and most urban populations in the country. Kumasi, Ashanti's regional capital, is Ghana's second city and comprises a large proportion of the region's population. Nevertheless, a notable percentage of the population is rural and agriculture is the main economic activity. Crops, both for commerce and subsistence, include cocoa, palm tree, citrus, plantain, cassava, cocoyam, maize and vegetables. Most residents are born locally, and their ethnic affiliation is Asante (Akan, matrilineal). Internal migrants, mainly from the north and the east of the country comprise around 10% of the population (11.1% in the 2000 census, GSS 2002). More than two-thirds of the region's population are Christian, followed by Muslims (13.2% in GSS 2002). We collected data in two mainly rural

districts: Ejisu Juaben and Ahafo Ano South. Ejisu Juaben is more densely populated and closer to Kumasi (where part of its population works).

Upper East Region is located in northern Ghana, bordering Burkina Faso and Togo. As part of the Sahel, its climate is dry: there is one rainy and farming season (May to October), when people grow millet, maize, and vegetables for subsistence. During the rest of the year, part of the population migrates temporarily to the south, including to Ashanti Region (Adongo *et al.* 1997). With only 15.7% of the population living in urban areas (GSS 2002), it is Ghana's least urbanized region. Upper East is ethnically diverse and groups tend to be concentrated in specific districts. In the Kassena-Nankana Districts, the Kassena (Grussi) and the Nankani (Mole-Dagbon) – both patrilineal – make up almost 90% of the population. In 2000, traditional religion was dominant in the district, followed by Christianity, mainly Catholicism, and Islam (GSS 2002). However, our data suggest that the number of followers of traditional religion may be decreasing, especially in urban centres.

In terms of biomedical services, there are district hospitals in Juaben and Mankranso (Ahafo Ano South) and in Navrongo (Kassena Nankana), two to three health centres in each district, and a greater number of smaller clinics. In Kassena Nankana, community-based health planning and services (CHPS) are more widely implemented than in the Ashanti because, during the nineties, this project was designed and piloted locally (Nyonator *et al.* 2005). Antenatal care (ANC) is well established in Ghana: according to the Ghana Demographic Health Survey (GSS *et al.* 2009), more than 95% of the women receive antenatal care from a skilled provider, and the number of women who make four or more visits is over 78%. However, deliveries in a health facility are not so common, or so evenly distributed among the different regions: in Ashanti, around 70% of births are delivered in a health facility, compared to 46.1% of births in Upper East. A TBA attends less than half the deliveries that are not attended by biomedical providers in Upper East. Instead, the majority of births are attended by a relative, neighbour or another actor from the *popular sector*. Both ANC and delivery care can be accessed free of charge at public health facilities and at some private facilities that are affiliated with the national health insurance scheme.

Compared to the relative homogeneity of biomedical ANC, non-biomedical practices varied widely across the two regions[3]. In Ashanti, the majority of pregnant women interviewed used herbal medicine care for their pregnancies. The herbs, bought from folk healers[4] or collected by the women or their relatives and used to prepare soup (*abedro*), enemas or concoctions, were said to support the health of the baby and the pregnant woman and to ease delivery. In this sense, they were considered similar

to the drugs supplied at health facilities. Nevertheless, many women explained that their main purpose is to protect the child from *asram*, a locally defined disease that they claim biomedicine cannot cure or prevent.

The ambiguous relationship between herbal preparations and the medicines provided during ANC health facilities, which respondents considered both complementary and antagonistic, was epitomized by their use. During pregnancy, women take herbal remedies and medicines provided at ANC, but do not take them simultaneously: most do not use them on the same days or they take them at different times of day.

I: Assuming you go to the hospital and you're given drugs and at the same time you have to take the herbs what do you do?
R: Well, they don't give us too many drugs so you have to finish with them and then shift to the herbs after about ten days. This is the only way to have some strength. You don't combine the two or you can become dizzy and weak. [...]
I: What do you think about the herbal medication?
R: Well, the foreign medication can't heal everything. Sometimes you need the herbs to make up the difference. It gives strength to the child and makes the woman strong for child birth. It takes away any sickness and allows a smooth delivery. [...]
I: Do you know of the sickness called asram*?*
R: Yes, it's a sickness in children. It makes a child weak and lean. The main reason for taking herbs is to prevent such a disease.

(Pregnant woman, 40 years old, 5 children)

Although *asram* was considered to be the main *spiritual*[5] disease in the area, some women and community members acknowledged the existence of other *spiritual* or witchcraft-related risks during pregnancy that can lead to miscarriage or delayed delivery. To gain protection from these risks, women mainly sought help from Christian pastors. However, in contrast to the ease with which they talk about *asram*, respondents preferred not to talk of these other *spiritual* risks.

Biomedical providers had a different view of these practices. Enemas were unanimously condemned for causing dirty green amniotic fluid in the uterus during delivery (a symptom of foetal suffering), and other uterine problems, such as ruptures. Most pregnant women were aware of this strong opposition, and some, especially women who lived in an urban context and who had previously experienced pregnancy-related complications that required biomedical intervention, no longer resort to them.

While the health talk is going on, the (female) midwife comes and commands the women to re-arrange the seats properly so that they can hear the talk. The pregnant women murmur. The midwife begins the talk and complains about enemas. She narrates a case of a pregnant woman who used an enema and of the baby dying a

few moments after delivery. She says that because of the enema, the baby was tired of turning in her womb, so when he was delivered he was very weak and died. She cautioned: if a woman doesn't use enemas, her amniotic liquid is very clear, like coconut drink; but if she does use enemas, the liquid becomes very green and the baby suffocates. She ends her by saying "It is worrisome, so now that times have changed, let's also change and not follow our grandmothers again".

(Ashanti Region, notes from participant observation in a health centre)

In Kassena-Nankana, non-biomedical practices during pregnancy were different. Here, there was no herbal medicine to help with pregnancy and women only resorted to herbal medicine when faced with a problem: if they are unable to conceive or experience vaginal bleeding during pregnancy and therefore suspect a miscarriage. Moreover, some very common herbal self-care treatments, such as the remedy for malaria, were not taken during pregnancy: their bitterness considered a sign that they can damage a pregnancy.

Among those practicing traditional religion, two main pregnancy-related rituals were practiced. The *pebelo* ritual, performed during a woman's first pregnancy, before the community is aware of the pregnancy, was said to protect her from "being always sick if people from outside talk about the pregnancy". This ritual seemed to be losing relevance and it was very unusual to find it performed for younger women.

I: Are there traditional practices/rites that should be performed for safe delivery?
R: In the past what our grandfathers and fathers used to do was that if a woman was pregnant they had to blow her with ash (pebelo) *and she had to wear a* valenga *(a strip made from leather).*
I: Has your daughter done that?
R: No.
I: Why hasn't she done it?
R: They have stopped doing that and they now go to church.

(Mother of a pregnant woman, 36 years old)

In families that follow traditional religious practice, men can consult a diviner to discover the taboos that must be taken into account to protect the pregnancy, whether there will be problems during pregnancy and delivery, the reasons why the ancestors may cause problems, the ways to solve or avoid these problems, and the nature of the *creature* the woman will deliver (it might not be a human being). Women were not involved in these consultations and only find out about their results if they have to respect a taboo. During fieldwork, families made use of such consultations in combination with ANC at health facilities.

I: Do you know whether your husband or father-in-law has gone to consult about your pregnancy?
R: I don't know if they have done it.
I: And would you like them to do it?
R: I have no problem if they will do it… but I am sure they will do it.
I: When do you think it to be done?
R: I don't know the time precisely but I know that they will do it, now that I am not well [she had malaria and had sought biomedical care that same morning].

(Pregnant woman, around 20 years old, first pregnancy)

Finally, in Kassena-Nankana, pregnant women and their families were worried about witchcraft. Witchcraft was one reason why they did not to want other community members to find out about their pregnancy during the first few months. Like the ancestors and taboo-breaking, people saw witchcraft as an explanation for infertility, miscarriage, and problems during delivery. As in Ashanti Region, people preferred not to talk about such situations, and they will not generally admit that they have suspected witchcraft or sought traditional advice when a family member has experienced reproductive problems.

Biomedical professionals in Kassena-Nankana considered the use of herbal preparations and self-medication[6] as *risk* practices. They associated such practices with unsafe abortion and miscarriage, and, in a more rigid fashion than their colleagues in Ashanti, advised against the use of all kinds of herbal medicines during pregnancy. Nevertheless, none of the professionals talked about non-biomedical remedies for suspected pregnancy loss, infertility or malaria during fieldwork. In some cases, they explained that the *belief* in *spiritual* harm was one of the reasons why women delayed attending clinic and, in exceptional circumstances, they admitted sharing these *beliefs*.

In our setting, there is the belief that a woman should not let people know that she is pregnant shortly after conceiving. Like me, I am a midwife. With my first born, I was at my first stationing, and when I started wearing maternity clothes my in-charge, who was a medical assistant, said I should not let people know that I am pregnant, I should wear jeans and other things, and to the best of my knowledge she knew what she meant by that. There are times you don't question elder ones like that.

(Midwife, female, small health centre)

In both study sites, there were also other folk healers whose practices and interpretations of illness differed. These healers had migrated from other regions: Asante healers in Kassena-Nankana, and northern healers in Ahafo Ano South District; and others who had been schooled in "traditional medicine training centres" (Bonsi 1980).

Asram[7]: a fluid illness category

From the first interviews with opinion leaders in Ejisu Juaben District, *asram* emerged as one of the main worries in the communities which influences pregnant women's self-care practices.

I: What are some of the foods that are not good for a pregnant woman to eat?
R1: Roasted plantain is not good for a pregnant woman.
I: How?
R1: It gives the baby a disease. It is not good also to buy food from outside to eat. Even if you buy food, make sure you don't eat it outside; bring it home to eat.
I: Why?
R1: Now there is a medicine (a leaf), when somebody plucks it and puts it in fire and then the smoke gets to the pregnant woman who is eating outside, the baby will be born sick.
R2: Even if the pregnant woman is in the room and the person puts the leaf behind the window and the smoke gets into the room her baby will be born with a disease, asram.
R1: Do you know what it is called in English?
I: I don't know, I'll ask.
R2: So, she'll give birth to a small baby with a very big head. So, when it happens like that, you take the baby to the person who caused the disease for him to cure the baby.
I: Which person?
Rs: The one who caused the disease.
I: So, how do you know?
Rs: Because he's the one who cures the disease. So, he causes them, he would have more cases.
I: Why would someone cause a disease only to cure it?
R1: For money (laughing).
N: Ohhh, so what you do to such a person?
Rs: How can you know? Ohhh.

(Male political (1) and traditional (2) leaders in a rural community)

This fieldwork excerpt illustrates the main characteristics of *asram*: it only affects babies and small children; its symptoms are related to the growth of the baby; it is transmitted during pregnancy, when it can be prevented; it is intentionally caused by someone; and there is a cure, but only the person who causes the disease can cure it. However, during fieldwork in Ejisu Juaben District, we found multiple variations on and exceptions to this definition. *Asram* appeared as a live entity, and conversations during focus groups became animated as people explained their multiple, related ideas and experiences. The variations reflect a process through which women adjust the use of a shared illness category to their practical experiences of the disease, interpreting the

specificities of their experiences and responding to the new questions that their experiences pose.

The symptoms vary from one child to another because, we were told, and there are different kinds of *asram*. Some are more prevalent than others: *bodewo*, for example, leads to stunting and to protruding veins on the child's stomach or hands. Some varieties are more dangerous and can kill faster, such as the *asram* "that affects the jaw" and does not allow the baby to breastfeed, or the *asram* "that infects inside the body". Some others are known by their name, but nowadays they have to be treated with biomedical remedies: *asram ntoes*, for example, which refers to a dermatological condition.

Although the children of some women never experience *asram*, all the children of a neighbour may contract it. Also, people explained that the herbal medicine taken during pregnancy can help to prevent *asram*. However, there was a lack of consensus regarding whether the herbal medicine helps in all cases; whether *asram* can be given directly to a child; whether there are strategies to prevent the person who you suspect of causing *asram* giving the disease to your children; and whether, for some women, the disease is already present in the womb, so they have to be more cautious and increase their prevention practices if they want their next babies not to be affected.

There was also disagreement and uncertainty regarding the *spiritual* nature of *asram*. Some healers who offer a remedy for *asram* are not considered to cause the disease, and it is not clear whether it is only medicine from the person who has caused the illness that can also cure it. In one neighbourhood, a woman suspected of causing *asram* had moved several weeks before our group discussion, and women were waiting to see whether her absence would also mean the end of *asram* in the area.

Asram was not equally relevant to all sections of society. The educated and migrants from other regions did not engage in such impassioned discussions. We interviewed migrant women from the north and east. Some of them are temporary, seasonal migrants who return home after making some money, and others have settled in Ashanti Region. Like the locals, they mainly work in the fields or in small businesses in urban areas. Some migrant women knew nothing about *asram* whereas others have some knowledge and experience, but their explanations of the disease were less rich and complex than those found among local Asante women. A smaller proportion of migrant women made use of traditional medicine during pregnancy, even among those that have heard of or experienced *asram*. Also, among migrant women, *asram* was also not so clearly differentiated from other *spiritual* or witchcraft-related risks and they were therefore as

reticent to talk of their personal *asram* experience as to talk about *spiritual* or witchcraft-related risks. Moreover, knowledge of this local disease has travelled to the north, to Kassena-Nankana, but the *asram* understanding that has been taken by returnee migrants was a simplified version of the Asante disease. At home, returnee migrants feel safe: they have left behind *asram* and it will not be able to affect their new pregnancies if they are away from Asante.

> We (fieldworkers and informant) continued talking about her time in Kumasi and I asked if she knew *asram*. She replied that she knew it, and that her daughter had had it. She explained that when she was born she was very little, but she had a big belly with veins in it. She resorted to the clinic but the medicines they gave her were not good ones, so she went to one old woman and she gave her some concoctions to give to the child, when the child took them she defecated a lot, and after that she was better. We asked her if after that she had done anything to prevent her children from getting *asram*, and she explained that there was nothing that you could do to prevent *asram*, as it was given to the mother during pregnancy by another person.
>
> (Pregnant woman, 36 years old, 7 children)

> We (fieldworkers) asked if she (informant) had used traditional medicine in any pregnancy. She said yes, she used some during pregnancy in Kumasi. When we asked of the purpose of that traditional medicine she responded that, if a pregnant woman in Kumasi did not take that medicine, people might harm her baby or might even kill her. She added that many people who refused to take that medicine lost their children after delivery. We asked whether that could be *asram*, she responded that there was *asram* and many others. She continued saying that given that there, in Kassena Nankana District, as you didn't find such problems, she was not taking herbal medicine in that pregnancy.
>
> (Pregnant woman, 30 years old, 4 children)

The variability in interpretations of *asram* was also reflected among traditional healers. In Ejisu Juaben District, a diverse group of local healers specialized in treating the disease: some were solely experts in treating *asram*, and therefore suspected of causing the disease; others, in addition to their expertise in *asram*, also attended deliveries, or practiced a wide variety of traditional medicine and people were less certain about whether they can cause the disease.

Other kinds of traditional healers also reinvented their position in the pregnancy and childcare arena through using and transforming the different meanings of *asram*. Asante traditional doctors travel and settle all around the country to sell different kinds of remedies to local populations. Different Asante healers in the Upper East Region commodify *asram*, emphasizing its symptoms and the herbal treatments that cure them and not its *spiritual* origin.

R: We have another medicine for pregnant women to which you can add fellankasa *(a clayish type of cake), water and fish – mash and sieve and boil it. But you don't have to add meat, tomatoes or Maggie, only fish and some small pepper and palm oil and salt. You cook all these and then keep the soup and drink it for about 2 or 3 months. You will be okay. You see the Asante women have been wearing trousers to avoid people seeing their umbilical cord. When they see your umbilical cord during delivery your baby will get* asram.
I: What is asram*?*
R: If you continue to do this until delivery, the baby will not get asram. *You Kassena call* asram kaliya *(monkey). The baby will appear like a monkey's baby. He looks very small and weak and his hair will look pearl [coloured]. That is why we called it* asram. *We still have medicine for* asram. *You can boil that one for him to drink and use a towel to massage the back of your head and forehead because that is where the illness is. We have another medicine that we grind and apply on the head as pomade. In such situations, the babies develop sores on their head and they never get satisfied with food or breast milk – he can breastfeed for about three hours and he will never get satisfied. So if he continues to drink the water and apply it regularly within two to three days he will be fine again.*

(Female Asante herbalist)

Their perspective differs widely from those of migrant women who returned home. It is likely that their audiences are not returnee migrants, but rather middle class urban women becausetheir prices are very high compared to those of local healers. Indeed, these two marginal and partial accounts of *asram* coexist in the Upper East without suspicion or open conflict.

Back in Ashanti, migrant traditional healers and TBAs from the north partially disagree with the local model of *asram*. Influenced by their religion and their contact with biomedicine, they reject the *spiritual* origin of the disease, while claiming to have medicines for it.

I: What causes asram*?*
R: It is a disease, my child. It is a disease.
I: It is a disease that causes asram*?*
R: Yes.
I: What sort of disease?
R: It is the disease that makes him [the child] grow lean. If you get the herbs to bathe him with, that will be the end of it. It is a disease that god has brought. Those who come here have never had their children getting asram *before. When she drinks the medicine, her baby will be strong and she will not have difficulty in giving birth.*
I: The people at Ejisu Juaben District were saying that it is certain people who give the asram *to the mother.*
R: As for that, I cannot tell.
I: The women were saying that some people cause the asram.
R: As for that, I cannot tell.

(Female Muslim herbalist from Northern region)

Migration is not the only the reason underpinning some healers' more sceptical approaches to *asram*. Some Asante Christian pastors and officially trained herbalists, influenced by their religious or scientific beliefs and by their position in society, distance themselves from traditional explanations of *asram*.

I: They say asram *is a spiritual sickness. Do you agree with them?*
R: With the asram*, in a way, I will say yes, but in another way, I will say no. The reason is that, there are a lot of people who have bad eyes… So if a pregnant woman is even walking in her clothes [...] she will be wearing a mini skirt even though she is pregnant… her dress that she used to wear when she was not pregnant [...] is the same dress that she will wear, so you will see her stomach and her chest and all. [...] So if someone sees her and she irritates him, [...] he can infect her with that disease. Those who have its remedy, most of them have spiritual eyes; they are witches so they can infect you. When they infect you, people will tell you that this woman has a remedy for* asram *so go to her. Sometimes, they can even say that they are the ones that infected her. So spiritually, it is like that.*
And sometimes, the person will not go to the hospital. The food she eats will also not be good for her because she is pregnant so that can also make the baby small on delivery. It is not all that is spiritual but sometimes, some are spiritual cases and some are also due to her eating habits and things like that, some constraints that she is in with her husband so it does not help her to get her full strength during her pregnancy so when she delivers, it does not make the baby get strength like that.
I: Do some of the women come to the church to complain that their children have asram*?*
R: As for our church, truthfully, no one has given birth for the baby to get asram*. [...]*
I: In your opinion, do you think you should use both ANC and herbal medicine during pregnancy; a little of this and a little of that for it to help?
R: In my opinion, I feel that… some people do not like enema, so they will not do it. They will only go to the hospital. They will go every time. My wife for instance, she has never used herbal medicine before. By the grace of God, it is just the hospital and the things they teach her she follows. When she comes, and when I back it with prayer and she delivers, she delivers peacefully.

(Male Baptist Pastor)

I: What kind of medicines do you have for asram*?*
R: Whenever I meet with my people, I tell them that there is no asram*. It is the fluids of both the man and woman that mix up when there is copulation that turns into either a good outcome or a bad one. [...]*
I: I have been talking with some women and they insist that the asram *is a spiritual disease [...] What do you have to say about that?*
R: You see, being pregnant is the most difficult work because you, the woman carrying the child, will have pressure on you. What is the pressure? Your heart and mind knows that you are pregnant so the blood that you have is what you are using to form the baby. It is like a builder, building his house. That is why I was saying that we use chemical foods to make nutrients available to the child to make everything work out for the baby so when some women are pregnant, they eat just

one ripe plantain from morning to a time like this. What nutrients are found in half of a ripe plantain? When some women are pregnant and you check the food that they eat from morning till evening, they are not foods that fit the body [...] what nutrients did you get for your baby? So that is what they don't take notice of and it beats them and when they deliver unhealthy children, they say that someone has given a disease to their babies.

(Male school-trained herbalist)

All these different healers' conceptualizations of *asram* depended on their positions and interests in the medical arena. Their motivations are different: some have economic interests, others religious or scientific claims. Their conclusions diverge as well: some accepted the illness category, whereas others disregarded it, giving alternative explanations for the symptoms generally associated with *asram.* But, in every case, the *spiritual* dimension of *asram* was dismissed, and the approach bio-medicalized.

Finally, biomedical professionals' position on *asram* and the associated use of herbal preparations diverged greatly[8]. Some condemned it as superstition and looked for multiple biomedical explanations for the symptoms, such as the trained traditional doctor discussed earlier. Others who had treated or delivered babies with *asram,* described a more flexible position, accepting the *spiritual* nature of the disease and recognizing the relevance of traditional healers' expertise. Generally, those who were unfamiliar with, or opposed to *asram*, were not locals, and had less contact with the pregnant women (laboratory technicians or specialists), were younger or were from higher social position. The following conversation with two midwives shows these different positions: one tr to find out the biomedical explanation, whereas the other recalled her experience and acknowledged its *spiritual* nature.

I: Have you heard of the disease called asram*?*
R1: Yes.
I: What disease is that?
R1: It is measles. (Elderly midwife comes in now. She shakes her head in disagreement) Maa, is that not what they call asram*?*
R2: No.
R1: So what is asram*?*
R2: With asram*, they believe that someone infects the baby upon delivery and the baby becomes small and his weight keeps reducing. Sometimes, they say that if someone is passing by and if someone comes to see the baby and he has some on him, he will infect him. Or if there is someone passing by your backyard and he hears the baby crying, he can infect him. So you will see that the baby will be very small. No matter how much he suckles, he will be as if he has marasmus.*
R1: Then it is marasmus that has attacked the baby.
R2: No, the baby will suckle a lot but he will grow lean. [...]
I: Maa, do you believe that asram *exists?*

R2: That is what they say. You see, there are certain things that I don't believe in but when they go to someone who makes medicines for it, the baby recovers [...]
R1: It could be that there is a condition …we have not had people conducting investigations to see it. It could be due to a condition that is there.
R2: It could be due to a condition or it is spiritual.
R1: You would find that there is something really worrying the children. So far, the herbal medicine has been a good remedy for them
I: So far, it is spiritual according to what they (other informants) say.
R2: It is spiritual. (She explains the experience of one of her church members).
(Two female midwives)

Revisiting medical pluralism

In the complex arena of pregnancy and delivery care in Ghana, *asram is* characterised by different layers of meaning and purpose. In Ashante, *asram* is a meaningful category that condenses worries, self-care norms and practices, and social sanctions relating to pregnant women and their children. It is actively used and reshaped by communities to think about and act during pregnancy and the first months of motherhood. In the performance of *asram*, healers, pregnant women, relatives, neighbours, and biomedical practitioners interact to explain and improve the health status of fragile women and their babies. From the perspective of the different actors engaged in this arena, *asram* is not just an Asante traditional medical category, but rather a concept that condenses multiple meanings, patterns of practice, and moral/power interactions.

It could be termed a *superdiverse* illness concept: it has a clear enough core of meaning to enable people to communicate about it meaningfully and use it practically, but also an ambiguous wider aura of meaning that is open to interpretation in different settings and on different levels. In this way, illness categories can themselves be plural in the sense that they vary within settings and move between geographical areas and traditions (both cultural and medical), thus enabling a variety of interpretations within local population, among local healers, between different geographical areas, between people with different levels of education and between different biomedical practitioners. On the one hand, it is clearly a naturalistic illness category, but witchcraft and the supernatural is ever-present. These variations reflect a process through which women adjust the use of a shared illness category to their practical experiences of physical symptoms, interpreting the specificities of their experiences and responding to the new questions that their experiences pose.

Asram is a mobile category. Migrants from other parts of the country embody *asram* and carry it with them and Asante healers, repackage, reconfigure and market it in other regions. However, these fluxes

involve transformations and simplifications of the disease category. Even when local experiences and interpretations of *asram* permeate migrant populations, they generally do so in a vaguer form, simply as an additional *spiritual* risk. At the same time, migrants give more consideration to biomedical professionals' recommendations, when they are opposed to the traditional practices, such enemas. In a context where biomedicine remains relatively similar to their experiences at home, yet traditional practices differ deeply, and where they lack the social networks to guide their use of local resources, their trust in biomedicine and, thus, its hegemony in medical practice, is reinforced.

Migration also influences migrant TBAs' and traditional healers' relationships with biomedicine with regard to the negotiation of their skills and position within the new local settings. The acceptance of some restrictions imposed by biomedicine, and the use of more symptomatic models, seems to be practical for the immigrant healers. Finally, Asante healers also reproduce the physiological neutrality of biomedical categories, to make *asram* fit for travelling and commerce. The three examples follow the tendency, described in various studies of international migration and transnational exchanges, of movement to reinforce the hegemony of biomedicine, making biomedical institutions and drugs more available and trustworthy than the local ones (Meñaca 2010; Mendiguren 2010).

Another source of variability is the different biomedical professionals' perspectives on and relationships with other local therapeutic traditions. Some practices are clearly condemned, and the population is strongly encouraged to discontinue them – or to deny them in the presence of biomedical professionals. Nonetheless, biomedical professionals' views on other local practices, like *asram*, are strongly mediated by their personal experience and social position. In a context where mobility of health professionals is important, local nurses and midwives seem to occupy more flexible positions regarding local traditional knowledge, and thus can better fulfil the role of mediators between the populations and the policies, opening new possibilities for intercultural medicine approaches[9] (Flores Martos 2004). Indeed, their practical engagement in these dynamics of medical pluralism, and the tensions and contradictions that they find in their everyday work deserve more research attention.

Concluding remarks

We have presented an ethnographic account of concerns and practices during pregnancy and delivery care, and of how they relate to a specific illness category in Ashanti Region. This account also sheds light on the transactions between the healing traditions of two different regions in

Ghana. Given the diversity in local and regional therapeutic traditions, and the specificities of the biomedical constellations – public facilities, research programmes, private services – at different sites, we consider that the meanings and practical implications of such medical complexity must be understood as grounded in particular contexts.

Migration and mobility of different actors has also proved to be important in the transformations of medical categories and transactions between different sectors. Medical anthropology has taken an interest in the international, global fluxes of certain non-biomedical healing traditions: African migrants bringing their medicines to Europe, Chinese medicine moving to Africa and Latin America, but other national, regional and local level fluxes are less prominent. In the case of *asram*, fluxes occurring at a local, regional and national level appear to be more relevant to these communities' everyday experiences.

The idea of a complex field – with a multitude of actors in different power positions, interacting, following their own interests and transforming the meanings and practices of pregnancy, child health, and illness concepts across mobile and dynamic landscapes – enables us to better understand the intricacies of health-related behaviour in practice. Using the ethnographic detail of a single illness concept, tracing the ways in which it is negotiated, transformed and reconstructed as it relates to maternal and child health and as it moves between different people, practitioners, medical traditions, and geographical settings, we have attempted to illustrate the value of this approach.

Notes

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1. <http://www.mip-consortium.org>.

2. The research project was undertaken by a central team based at the time in Barcelona in collaboration with local teams of coordinators and research assistants in Papua New Guinea, Kenya, Malawi and Ghana (Ashanti and Upper East Region). As part of the Malaria in Pregnancy (MiP) Consortium, we worked in coordination with groups conducting clinical trials of interventions for the treatment and prevention of MiP at the different sites. In order to understand the social context of malaria in pregnancy, the main part of the data collection was conducted before the trials started. A second phase was undertaken during the trials in order to assess the acceptability of the different treatment and prevention strategies that the trials involved. NAA and AM conducted fieldwork in Twi

(the Asante local language) in two districts of the Ashanti Region between April 2009 and December 2010. Fieldwork in the Upper East Region was conducted between June 2009 and March 2011. In this setting, four research assistants: Charity Siayire, Louis Alatinga, Dominic Anaseba and Gertrude Nyaaba, collected data both in Kassem and Nankam (the two local languages of the Kassena Nankana districts) coordinated by SC and AM. In both settings, local fieldworkers lived near the research area but not in the communities where fieldwork was conducted. AM visited the field sites for data collection, training, supervision and discussion several weeks every three months. Further details on methods can be consulted in Pell *et al.* (2013).

3. This is an expected finding taking into account the different historical and cultural background of the regions and the extreme diversity in theories and practices included in the hotchpotch concept of "African traditional medicine" (van der Geest 2003).

4. In this article, the terms "traditional", "folk" and "local healer" are considered synonymous to designate the complete range of African non-biomedical healing experts. More specific designations: "TBA", "herbalist", "soothsayer", "pastor" are used when the differences were clearly made by our informants.

5. During fieldwork the term "*spiritual*" was used by health professionals and other English speaking informants to refer to those problems that include *supernatural* causes. This use is acknowledged in Ghanian literature on traditional medicine (Fosu 1981; Gyapong *et al.* 1996), but there is a second use that only partially overlaps: it can also be used to distinguish between traditional healers whose trade is "spiritually based" and believe "that you cannot treat the illness without adequately dealing with the "spiritual" factors which ultimately account for all illnesses and other human misfortunes" (Tsey 1997: 1068) and healers who tend "to look upon their healing plants for what they are, increasingly like the biomedical approach" (*ivi*). Even when we do not use this classification the reader would see that both kinds of traditional healers are represented in this article.

6. Following the theoretical framework laid out by Eduardo Menéndez, self-medication is defined as the "decision to use biomedical drugs to treat different illnesses without the direct and/or immediate intervention of doctors or other health personnel allowed to prescribe them" (Menéndez 2005: 55). Self-care is used as a translation of his term of "autoatención" to talk of the different practices used by (lay) subjects and social groups in a relative autonomous way (from health experts).

7. In the literature, *asram* is a local disease concept from Akan tradition that is found at least in Ashanti (Lefeber & Voorhoeve 1998; Marah 2011; Koffuor *et al.* 2011; Adusi-Poku *et al.* 2012) and Brong-Ahafo (Anang 1980; Hill *et al.* 2003; Bazzano *et al.* 2008; Hill *et al.* 2008; Okyere *et al.* 2010; Howe *et al.* 2011) Provinces of Ghana. In both regions, the broad notion of *asram* includes multiple types (Lefeber & Voorhoeve 1998; Okyere *et al.* 2010) and some authors consider that it can be used to "designate all pediatric diseases in the first year" (Lefeber & Voorhoeve 1998: 72). Some articles consider part of the different *asram* types as specific diseases, such as in the case of *puni*, which is classified as a different disease from *asram* (Hill *et al.* 2003; Bazzano *et al.* 2008), whereas in others the word *asram* is mainly used to talk of one of its types, *asram bodewo*, and it is only associated with malnutrition and, especially, marasmus (Anang 1980). From the medical perspective of the team (HT) the best biomedical equivalence to most (not all) of the *asram* types is "failure to thrive", which can be provoked by many different causes.

8. A variety of health professionals' views and messages given to pregnant women in relation to *asram* was also reported in Brong-Ahafo Region (Howe *et al.* 2011) where in a new strategy for home-based community neonatal care formal referrals to the health centre are considered a relevant strategy to overcome late arrivals to health centres associated with *asram* diagnosis (Hill *et al.* 2008).

9. The concept of intercultural medicine is widely used in Latin America to designate the different projects that have tried to integrate indigenous and biomedical healing systems. Myriad anthropologists have highlighted the limits of this rhetoric (many examples can be found in Fernández Juárez 2004), as have others with regard to African cases, though without referring specifically to intercultural medicine.

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Abstract

In this article, we move beyond pluralism and syncretism and address the dynamic and multi-faceted nature of illness by offering a detailed ethnography of an illness concept and the ways in which it is negotiated, transformed and reconstructed as it is passed between different people, practitioners, medical traditions, and geographical settings. In Ashante, asram *condenses worries, self-care norms, practices, and social sanctions relating to pregnant women and their children. It is used to think about and act during pregnancy and the first months of motherhood. In the local performance of* asram*, local healers, pregnant women, relatives, neighbours, and biomedical practitioners interact trying to explain and improve the health status of fragile women and their babies.* Asram *is a superdiverse concept, with a clear enough core of meaning to enable people to communicate about it meaningfully and use it practically, but has an ambiguous wider meaning. It varies within settings and moves, enabling a variety of interpretations within local population, among local healers, between different geographical areas, between people with different levels of education, and between different biomedical practitioners. It is a naturalistic illness category, but witchcraft and the supernatural are ever-present. Women adjust it to their practical experiences of physical symptoms, interpreting the specificities of their experiences and responding to new questions that their experiences pose.* Asram *is also a mobile category: migrants embody* asram *and carry it with them, and Asante healers repackage, reconfigure and market it in other regions. However, these fluxes involve transformations and simplifications of the disease category, and in contexts where biomedicine remains relatively uniform while traditional practices vary and where the social networks that guide their use are absent, trust in biomedicine and, therefore its hegemony, is reinforced.*

Key words: Ghana, *asram*, complexity, pregnancy, delivery care, ethnography, mobility, pluralism.

Riassunto

In questo contributo gli autori intendono andare oltre i concetti di pluralismo medico e sincretismo per affrontare la dinamica e la natura pluriforme della malattia attraverso una etnografia dettagliata di un concetto di malattia e dei modi in cui esso è negoziato, trasformato e ricostruito viaggiando tra popolazioni, operatori, tradizioni mediche e contesti geografici differenti. Nell'Ashanti, l'asram *condensa preoccupazioni, norme di autoattenzione, pratiche e sanzioni sociali relative alle donne incinte e ai loro figli. Esso è usato per pensare e agire durante la gravidanza e i primi mesi di maternità. Nelle performance locali dell'*asram*, operatori tradizionali, donne incinte, parenti, vicini e operatori biomedici interagiscono tentando di interpretare e migliorare la salute di donne deboli e dei loro figli.* Asram *è un concetto superdiverso, con un nucleo abbastanza chiaro di significato che permette agli individui di comunicare su di esso e di usarlo nelle pratiche, ma ha anche un più ampio e ambiguo significato. Esso varia muovendosi attraverso i contesti, consentendo una varietà di interpretazioni nelle popolazioni locali, tra i guaritori, nelle diverse aree geografiche,*

*tra persone con differenti livelli di scolarizzazione, e tra i diversi operatori biomedici. Benché sia una categoria di malattia "naturale", il sovrannaturale e la stregoneria sono sempre presenti. Le donne la adattano a come praticamente esperiscono i sintomi fisici, interpretando le specificità delle loro esperienze e le nuove questioni che esse pongono. L'*asram *è anche una categoria mobile: i migranti lo incorporano e lo portano con loro e i guaritori asante lo riconfezionano, lo riconfigurano e lo commercializzano in altre regioni. Questi flussi comportano risignificazioni e semplificazioni della categoria di* asram*, così, in contesti in cui la biomedicina rimane relativamente uniforme mentre le pratiche tradizionali sono differenti, ed in cui le reti sociali che orientano l'uso di tali pratiche sono assenti, ne risulta che la fiducia nella biomedicina, e comunque la sua egemonia, sia rinforzata*.

Parole chiave: Ghana, *asram*, complessità, gravidanza, cura, etnografia, mobilità, pluralismo.