10 Healing Works

Nana Kofi Donko and the Business of Indigenous Therapeutics

Kwasi Konadu

This chapter focuses on indigenous forms of enterprise and leadership in the allied fields of medicine and health care in twentieth-century Africa. Although on average indigenous healers account for 60 to 70 percent of the health care delivered in African communities, especially rural ones, healers as individual practitioners or a category of analysis have rarely been studied as integral providers of value-added services to their societies. In short, healers have been written out of African economic and social histories, castaways intelligible to us only as “fetish priests,” “cult officials,” and ubiquitous purveyors of “witchcraft.” This caricature, however, stands in stark contrast to the résumé and lifework of most African healers, embodied by prominent healers such as Nana Kofi Donko of Ghana.

Nana Kofi Donko (Sakyi) was an indigenous healer and blacksmith who lived and worked in the Takymian (Techiman) township of the central Gold Coast/Ghana. Born to Bono (Akan) parents around 1912/1913, he was also a marginal peasant farmer whose fortune and misfortune rode the tides of the cocoa boom, and a great person who articulated a profound understanding of disease and medicine to trainees in Ghana and the African diaspora, as well as a notable group of anthropologists and historians. Although patient treatment records are extremely rare among indigenous healers, two recently discovered patient record books kept in the 1980s place his healing work in a broader perspective and form the intellectual source of this chapter.

During the 1980s Ghana’s economy was in an advanced stage of economic cancer: its leading share of the world market in cocoa dropped to one-eighth, its mineral production fell by 50 percent, its inflation rose over 50 percent, production and living standards plummeted dramatically, and a military government seized power and accepted the notoriously detrimental structural adjustments of the International Monetary Fund and the World Bank. The structural adjustment scheme reinstated the colonial economic structure by focusing on the export sector and on gold and cocoa, worsening the socioeconomic woes of most Ghanaians and exacerbating rather than alleviating the widespread droughts and forest fires that destroyed crop production. Against this backdrop of a country ravaged by economic inertia and social anxiety, this chapter frames the work of Nana Donko and provides salient perspectives on how the business of healing helped a largely farming population deal with their social and biological ills in a time of great uncertainty. The story places the reader in the sensory and intellectual world of the healer; charts Nana Donko’s therapeutic itinerary in the latter part of his healing career, where we have the records to do so; and finally closes with an examination of a series of connected transitions in the life, community, and nation of Nana Donko.

Context: A Healer’s World

The Bono are an Akan people clustered principally in the Takymian district of Ghana’s Brong Ahafo region, though they are also found in much smaller numbers dispersed throughout Ghana and the neighboring Ivory Coast (Côte d’Ivoire). Between late November and March, harmattan winds bring dust and chill permeate the early mornings and late nights, while morning mists, green grasses, and light to heavy rains signal a rejuvenation of the land between March and April and again from July to late August. A harvest period follows each rainy season. The Bono of Takymian reside in lands situated between the northern edge of dense tropical rainforests and the southern beginnings of arid savannah terrain punctuated by hills and rivers, the most important of which is the sacred Tano River. Access to these ecologies allowed the Bono to create enduring systems of therapeutic and spirituality, archaeologically extending into the last two millennia.

The Tano River, which originates in Takymian and flows north to south into the Ivory Coast’s Aby Lagoon and eventually into the Atlantic Ocean, has remained the most iconic site of therapy and spiritual culture in Akan life. However, the social use of this river and the healing technologies of Bono spiritual culture historically existed in an interconnected web of human intuition and action, organic compounds, and inorganic or immaterial forces that constituted a sense of the world. This world is not simply the physical world we call planet Earth but rather the “real” world consisting of all sorts and forms of matter, energy, force, and what might be incomprehensible to our “normal” physical senses. In fact, our understanding of the universe and our human selves boils down to the intimate and sometimes-volatile interactions between matter, energies, and forces. Some we pretend to know very well in laboratory conditions; others we know little about and proffer theories in the place of sure knowledge. In either case, the accumulated knowledge from the deep empiricism of nature and the cultural practices bound to it provided the Bono with their own grounded ideas of the world and the human’s place in it.
From the world of cells and life force animating our being to the world of matter and immaterial forces, humans are mobile ecosystems, connected to other kinds of ecologies. There are billions of microorganisms we cannot see that we walk past or around each day; our inability to see them makes them no less real and no less an integral part of our interconnected world. As in much of early human history, the Bono had to first figure out the human body and the constituent parts of its being, while incrementally pushing the bounds of survival in ecologies filled with threats, uncertainty, and potential. Humans have no natural predators except for other human beings. The determination of what foods to eat and in which season, which plants were medicinal or fatal, which animals were competitors, and how to battle disease-carrying insects and microorganisms that invaded the body was therefore decisive in the process of fine-tuning effective therapeutic measures for inescapable human maladies. These measures were shaped by culture, but their recourse was nature. Culture and nature were intimately bound. However, if culture was crafted out of and in response to the natural world, nature placed parameters on human culture. Arguably, when nature was viewed as a partner rather than a nemesis, it provided the conditions for human creativity and cultural nuance. Once the Bono people determined the workings of the human being and the forest-savanna landscape, hunting and farming could then provide surplus that allowed cultural development in the widest sense.

While politicians are more concerned with the dispensation of power than with the public they claim to serve, healers are preoccupied with the public good and its wholeness. A diseased society is merely a collection of traumatized bodies working against rather than with their natural, self-healing capacities—what scientists now call immunotherapy. Healers aptly recognize this disease or trauma because they see human life in the context of community and connectedness, rather than viewing people as individuals to be manipulated for the prize of power. Healers work incessantly against these forces, most often serving their communities and not their self-interest. The fundamental tension of human life is between healers and those who seek power over people. Truth be told, both manipulate, but each works with different kinds of power and toward radically different conclusions. The politician deploys the forces of deception and manipulation in order to accrue temporal power to be used against other humans, with little regard for the ruin of those individuals, while the healer understands what constitutes a human community.

The healer understands the whole human being and therefore marshals the material and immaterial resources located in his or her ecology to restore health, repair relationships, and regenerate the self-healing capacity that doggedly fights for balance within that fundamental tension. Disequilibrium is disease, and those who seek power over people thrive in diseased environments. An equally funda-mental human challenge is that most humans are politicians—with or without electoral aspirations—and very few have the inborn or cultivated temperament to be a healer. It is clear why healing will never be a popular vocation, though it is necessarily an integral one. Nonetheless, the healer fights proactively against the politician in us and in the disease settings in which afflictions thrive, working with forces that form the bookends of the human experience—physical forces and spiritual forces. These forces are no more than variations of the thematic interplay between energy and matter: if we view such forces as water, our physical world would be the solid and our spiritual world the gaseous form that water assumes. Ultimately, human beings—and the world we have inherited and shaped—are composites of these basic root forces, and the healer skillfully calibrates them to cure single individuals but also to make a people whole.

A Life of Indigenous Therapeutics

Ghana's economic and political troubles from the 1970s encroached on the 1980s, and the ubiquitous cancer of corruption—or at least the charge of pervasive corruption—infected each regime. Ghana squandered its dominant position as a global producer of cocoa as production declined precipitously and the country's support for President Hilla Limann quickly faded. The awkward tango between local politics and the forces of the global marketplace meant that each regime paid more attention to the prospects of removal by military coup than to engendering the prosperity of the country. As Jerry Rawlings's recurring calls to terminate corruption generated wide popular support, corruption within the government and the wider society cannibalized the ruling party, opening the doors for yet another Rawlings-led coup in December 1981 against Limann's inept administration. The December 31 "revolution" followed a series of military efforts to take power from Limann, but where those attempts failed, the December 31 attempt reined in the near anarchy and social distress facing the country. Through the "revolution" Rawlings established the Provisional National Defense Council (PNDC), under which the country was managed, with Rawlings as chairperson. Once the PNDC seized power, the constitution was suspended, parliament and the governing councils were dissolved, political parties were banned, and those deemed threats to national security were detained indefinitely without trial—eerily reminiscent of the Kwame Nkrumah regime.

In place of these governing structures, the PNDC installed military committees to pave the way for a promised democracy, while engendering greater public involvement in the fight against the national malady of corruption. Although Rawlings and his PNDC utilized authoritarianism, they were able to halt the country's steep economic slide and stabilize its temperamental politics through a mixture of socialist and liberal policies. The broader benefit to average citizens
under PNDC rule is still being debated. Nana Kwasi Appiah, a former student of Nana Donkor who trained during the PNDC period, noted, “I remember it was [the] PNDC era where there was a redenomination exercise, so it became very difficult for me, even traveling from my hometown (Saase) to Takymian for my akwas training for the first time. Kerosene was also in short supply and people had to queue to buy kerosene for their lamps since electricity was only in the urban centers of Ghana, leaving most of the rural areas dependent on kerosene.” Rawlings’ push to create the conditions for anticorruption and “democracy” was no cure for the ills of the country, and healers who attended to the country’s majority rural population had to engineer their own way out of the thick fog of competing forces.

While Rawlings staged his December 31 coup using the prop of corruption and the rhetoric of revolutionary change, a quiet but no less important revolution was occurring between the dominant ideologies of the enjoined fields of health and culture. The revolution of ideas and practice took place among representatives of indigenous culture and spirituality, drawn from the ranks of prominent healers and biomedical workers of African and European origin who accepted the ideology of white or European superiority in all things that mattered. Most of Ghana’s and Takymian’s population lived in a world touched by politics only in abstract ways; the biomedical workers at mission hospitals, such as the Holy Family Hospital (HFH) in Takymian, were situated in the web of individuals and local institutions that mattered in the lives of the indigenes, as well as strangers and visitors. By summer 1981 Nana Donkor and other healers involved in the Primary Health Training for Indigenous Healers (PRHETIH) program had renamed the project Abibiduro ne Aborofo duo Nkabom Kuo (African Medicine and Western Medicine Integrated Group), marking a significant shift in their understanding of what was at stake and representing an assertion of their right to be equal partners rather than empty receptacles of biomedical knowledge.

An April 1981 report prepared by Mary Ann Tregoning of the HFH, anthropologist Dennis M. Warren, Peace Corp volunteers, and PRHETIH field coordinators G. Steven Bova (1979–1980) and Mark Kliwer (1980–1981) also suggests healers were not passive receptacles. Rather, healers approached the one-way flow of Western medical knowledge with tact and from their own core self-understandings. The PRHETIH sessions that focused on medicinal herbs “were most enthusiastically received,” whereas healers disregarded “those sessions that consisted primarily of advice or description” and about “family planning.” The latter session received “such a low rating... probably because contraception was antithetical to the beliefs and practices of this highly natalistic society. In fact, one priest-healer, Nana Kofi Donkor [Donk], revealed that his giving advice regarding contraception was an anathema to his shrine.” While organizers of the PRHETIH project envisioned a health revolution wherein healers could be used in national health delivery systems and outside Ghana, the healers’ rebellion against their prescribed role and the pejorative view held by the Ghana Ministry of Health toward healers placed project organizers and their backers in a precarious position.

With an estimated healer-to-Takymian-township-population ratio of one to three hundred,

most of the traditional healers interviewed [for the PRHETIH project] practice their skills upon demand. They typically return from a morning of farming to find a friend or neighbor waiting with a patient. The most prominent healer in Techiman Township, Nana Kofi Donkor, is an exception to this, however. He has set aside Friday (the principal Techiman weekly market day), and Tuesday as his special healing days. On a typical Friday, one finds seated lines of 10–20 patients waiting to consult the healer, each patient with a wooden chip with a number painted on it, modeled after a similar practice at the Techiman Holy Family Hospital. Nana Donkor does see patients upon demand on other days of the week if he is not at farm or in the forest collecting herbs.

Nana Donkor led the revolution not only in how healers practiced their evolving craft but also in the ways in which healers and biomedical practitioners worked for the health of the community in which both served, albeit with different epistemologies.

When PRHETIH field officer James Donkor helped prepare a report on the PRHETIH project that optimistically claimed, “The project continued steadily this year,” this optimism was based on some promising results. The final two groups of healers from Takymian had completed the PRHETIH coursework, while healers from the localities of Krobo and Tuobodom were interviewed for two additional cohorts. Guided by Nana Donkor and his exemplary practice, healers who completed the PRHETIH program also had a decisively immediate impact on health outcomes for the Takymian community. The HFH served some 83,000 patients in the Takymian area in 1981, with patients coming from a forty-mile radius. The HFH received about 300 to 350 patients a day. The forty-four healers who received primary health training were an integral part of the 26 percent decrease in the outpatient department and in the more than 80 percent drop in that department’s diagnoses of malaria, gastroenteritis, respiratory tract infection, and skin diseases in 1981. According to HFH reporting, most of the maladies “could [and did] receive first line treatment in the villages and/or be prevented by decent water supply and sanitation facilities,” though malaria remained the most intractable health problem for all.

In 1981 a North American visitor to Nana Donkor’s compound was struck by its apparent “state of perpetual pandemonium.” At sixty-eight or sixty-nine years
of age, Nana Donkɔ and his healing practice showed little sign of slowing down. The visitor continued,

One can arrive any given morning to the sound of wild drumming, and the sight of a half-dozen young priests and priestesses covered in white powder, gyrating wildly across the compound. Occasionally one falls unconscious, eyes rolled back, only to be helped back up to continue dancing. Amidst this clamor, older priests demonstrate how to grind roots, bark, and leaves into medicines, and how to sacrifice and butcher goats, providing food for priests and deities alike. For Kofi Donkor is a teacher, initiating young trainees into the priesthood . . . [and] when we arrived at [Kofi Donkor’s compound, the] . . . initiates were undergoing intensive possession experience and training.9

As this training session for indigenous healers ended, “a more reserved crowd quietly filtered in and took orderly seats on a bench along one wall. They were outpatients, come to Kofi Donkor’s weekly clinic to employ his healing knowledge. Each held a small piece of wood with a number brightly painted on it, an idea Donkor picked up at a modern hospital.”10 Nana Donkor’s ability to adopt an effective technique or procedure without undermining the cultural platform on which his healing practice stood was precisely why he was so effective and why the hospital—and the biomedical practitioner in general—was constrained in understanding and holistically treating patients. Patients were not simply diseased organisms; they had histories, aspirations, deferred dreams, ancestral linkages, and a range of material and psycho-emotional conditions that weighed, in one lived moment or another, heavily on the individual and his or her community. Viewed from this perspective, Nana Donkor argued convincingly, “It is always better for a patient to consult a traditional healer. We are more conversant than Western doctors, and it is our rapport with patients that leads to our success.”11

Healers like Nana Donkor delivered some 70 percent of the health care in the Takymian district. We can assume that the picture in Takymian, with over forty-five thousand villages that accounted for three-fourths of Ghana’s total population, more or less reflected the country as a whole. Doctors at the HFH, such as Dutch husband-and-wife physicians Willem and Magda Boere, had no doubt of the healers’ capacity and what role they should play in Takymian and in the national health care system. As Willem conceded, “The healers have the potential to help us with our overwhelming caseload . . . I already refer patients with psychiatric diseases to Kofi Donkor’s place.” In a remarkable statement that should not be taken lightly, Willem continued, “It is difficult to find convincing evidence that our medicine [that is, biomedicine] is more effective than theirs. Take snakebite, for example. Seventy percent of the snakebites in this area are nontoxic. So if a patient with snakebite consults a traditional healer, he will always cure seventy percent. But we with our antivenom, on the other hand, can cure seventy-five percent. But that is just not convincing statistically.”12

Overall, Willem was right. The number of patients that flowed through Nana Donkor’s compound daily supports Willem’s case. One day in summer 1981, a woman carrying a small child and holding the token marked with a bright number ‘one’ took a seat opposite [Kofi] Donkor. Serene and grandfatherly, he immediately put the mother and child at ease. His popularity was obvious. Nearly 40 patients had come that day, some from more than 30 kilometers away. . . . After receiving medicine, each patient had his or her condition and treatment recorded in a large record book, and a small payment was elicited. This payment was purely a token gesture, to foster a bond of obligation between patient and healer . . . . It is only after a cure has been effective that proper compensation can be offered.13

More statistically convincing are two record books Nana Donkor kept during the 1980s, providing an unprecedented, big-data view of a “modern” healing praxis and the communities served.

In a 1980 interview Nana Donkor asserted, “My work is like that of a medical doctor and so anybody can come to me.”14 This English translation and the statement itself deserve further attention. Nana Donkor was sbenfo—one with a high degree of knowledge and skill within a system of spiritual practice and cultural acumen. Counterparts are rare and cross-cultural comparisons are imprecise, but if we had to pin the term sbenfo down to something familiar, that something would be a doctorate degree for healers since sben is another term for “medicine,” properly called aduro (pl. nnuaro). Though the sbenfo knows the properties and uses for all types of indigenous medicines, he or she employs aduro rather than aduto (adu: medicine; to: to throw), medicine of neutral value but whose outcome is fashioned by the intent of the user. Those healers or individuals supplied by healers target the aduto with their ill intent and “throw” (that is, leave or deliver through spiritual means) the aduto to cause destruction or malice on another person. The target of successful aduto develops a sickness (syare) and becomes a diseased person (syarefo). In some cases, the perpetrators or recipients of aduto, who may retaliate with their own deployment of aduto, can transform an individual into an invalid (syare-susow) or cause an epidemic (syaredebm) in a community. The diseased person or community may seek out the hospital (ayareseba) and a medical doctor (syarendrafo), but they soon realize neither hospital nor doctor can heal, though the latter might offer some relief. Patients need ayare-sa, the holistic act or art of healing. Therefore, in 70 percent of the encounters between a range of illnesses and infected patients, the patients consulted or sought therapeutic intervention from indigenous healers. In these encounters and in cases where doctors referred patients to him, Kofi Donkor was the embodiment of sben (medicines of high spiritual potency) and appropriately known as sbenfo to all who remained “amazed at his endurance when it came to seeing his patients. Nana Donkor would sit in the same spot for hours, talking and diagnosing his patient.”15
The efficacious delivery of health with care was the hallmark of Nana Donkɔ’s healing practice. Sadly, we have few statistics regarding the daily workings of his healing craft, but the record books that he kept during the 1980s put his practice into a broader perspective. To some extent, these record books also allow us to imagine his previous decades of practice. As noted previously, the “condition and treatment of patients” were recorded in a large record book,” but there were two such books and a collection of index cards that together disclose some remarkable and unprecedented insights into at least 70 percent of the Takymian community and beyond. In fact, Nana Donkɔ’s reach was transnational as both a trainer of healers and a healing practitioner. Nonetheless, patient data were kept on loose, unorganized, and fragmented index cards and in two large notebooks with the heading “Kofi Donkor Herbalist Clinic Nyafoma—Techiman B.A.” For instance, on February 20, 1987, Nana Donkɔ treated Adwoa Fordjour (Fodwo) and Ayuba Muhamed from Deema and recorded the information on small, two-by-two-inch index cards with “outpatient card” and “bring this card on each visit” written on each side.

These cards, or at least what remains of them, are too fragmentary to derive a reliable picture of the individuals and families Nana Donkɔ treated. However, the two surviving record books are much more fascinating in their details and revealing in the profile generated for individual patients and the broader communities to which they belonged. While the first record book (“book 1”) recorded 2,073 patients between 1982 and 1988, the second book (“book 2”) contains records of some 5,670 patients who visited Nana Donkɔ between November 1982 and December 1986.86 Taken together, from this total of 7,743 patients we can determine an average of between 1,291 and 1,936 a year; if we multiply the latter yearly average by the sixty or so years of Nana Donkɔ’s healing career, which seems more accurate, he would have diagnosed and treated over 116,000 patients, assuming he worked on nonshrine days as well. Although we are working with incomplete and literally tattered records and will never know what complete records would have revealed, these imprecise numbers more than justify Nana Donkɔ’s acclaim and legacy.

For the 2,073 patients recorded in book 1, a strong statistically significant relationship exists between patients and the variables of occupation, age, village, and region of origin. In those cases in which patients listed their occupation, a sample size of 585 reveals that 380, or 65 percent of patients, were farmers, followed by traders (16 percent) and students (31 percent). Of the total number of patients recorded, 1,747 or 84.3 percent originated from the Brong Ahafo region, 15.1 percent from the Ashanti (Asante) region, several individuals from northern Ghana and the Volta region, and one person, named Afi Douh, from Togo. Although the average age among patients was eighteen years, Nana Donkɔ cared principally for children aged one to three and adults aged twenty to thirty. Individuals aged thirty made the most visits to his healing center, but many infants who had not yet turned one year old also received his care. Analyzing the 108 patients who made the most frequent visits, the majority came to Nana Donkɔ’s compound for healing services in 1984, followed by 1987, 1986, and 1983. Readers may recall that Ghana had one of the highest birthrates in the world during 1984–1985; this may explain the age of those who paid the healer a visit, as well as the volume of visits. Although most of Nana Donkɔ’s patients hailed from the Brong Ahafo region, only 28 percent came from the Takymian township. The remainder came from outside the township—some 12 percent from Akomadan, 4.8 percent from Aworowa, 4.6 from Nkenkasu, and 4.3 from Tanso—but within the Takymian district and Brong Ahafo region.

If the geographic reach of Nana Donkɔ’s practice was noteworthy, his wide appeal among patients who self-identified their religious orientation is remarkable. Of the 682 who disclosed their religious affiliation, 31.2 percent were Roman Catholic, 16.7 percent Muslim, 14.4 Methodist, 9.5 Seventh-Day Adventist, 4.7 percent Presbyterian, 4.5 percent True Church members, and 4.1 percent Pentecostal. Six individuals identified themselves as members of Musama (an “independent African church”), three as members of an African faith church, and two as Halalyuka. We can presume the more than 1,200 individuals who did not self-identify a religious affiliation were adherents of the spiritual culture that Nana Donkɔ embodied, precisely because that spirituality was not a separate institutional form and practice outside of the culture in which they lived.

Nana Donkɔ identified and treated some seven hundred illnesses, as evidenced in books 1 and 2. Patients most often complained about illnesses centered in the stomach or abdomen (yafuni yade), fever with jaundice (asram), illness affecting the flesh or innards (honam yade), illness associated with childbirth (awɔ), malarial fever (ahobene), and illness preventing pregnancy (amidane). Forty-eight individuals came “for medicine.” The treatment protocol or method for delivering the medicines for most of these illnesses involved a combination of drinking the medicinal preparation and receiving it through enema, bath, or dudo. Dudo is a type of medicine consisting of various herbs, bark, and roots kept in a black pot with water; the liquid is used for bathing as a preventive and cure, and the ingredients are specific for each ailment. Using the Ghanaian currency (cedi), most payments for treatment consisted of between twenty to forty cedis (40 percent) and one hundred cedis (23 percent), though in-kind payments of chickens (akokɔ), eggs (nkɔsia), or alcoholic drink (nsa) were included in practice. One-fourth of the patients in book 1 identified as married, with 10.4 percent indicating “under husband” (that is, a woman who is married). The married couple who individually or jointly consulted Nana Donkɔ most frequently were Yaa Donkor and Kwaku Nyamekye. Kwaku was a sixty-year-old farmer and Methodist from the Asante region—the village or township of Akomadan, to be precise—who visited Nana Donkɔ six times “for medicine” and other times for afflictions.
resulting from “negatively charged” medicines (aduto yadee). Apparently, the sickness (yadee) derived from ill-intended medicines (aduto) were severe and protracted, causing Kwaku to make frequent visits to Nana Donko’s compound in search of protective and nullifying medicines.

In book 2 the number of patients is more than double that recorded in book 1 but for a shorter period. Between November 1982 and December 1983 some 5,670 patients flowed into Nana Donko’s compound. Just over one-fourth originated in the township or district of Takymian; the rest—reflecting the profile given for book 1—came from Akomadan (10.6 percent), Aworowa (6.4 percent), and Afrancho (3.9 percent). Both Akomadan and Afrancho are in the northern parts of the Asante region. The patients from these locales consisted of infants or toddlers (several months to three years old) and adults aged twenty to thirty-five, per the entries for the 3,209 individuals for whom age was listed. The average age was nineteen years old. Consistent with book 1, the most frequently treated illnesses were awoo (11.2 percent), anidane (5.9 percent), ahobene (5.7 percent), yaifu and honam yadee (4.7 percent each), and asram (4.2 percent). Although book 1 included treatments administered through baths, enemas, and oral application, book 2 added vapor therapy (pu or pru), steam baths, and nasal drops to Nana Donko’s repertoire.

Also unique to book 2 is the robust data on payment (aseda, “giving thanks”). Of the 2,076 patients for which payment data was recorded, one-fourth or 22.2 percent gave thanks with 400 cedis, an alcoholic drink, and a chicken. Some 11 percent did the same but with 200 cedis; 7.1 percent the same but with 600 cedis; and a combined 8.4 percent made the same offerings but with either 100 or 140 cedis. We should bear in mind that aseda was only given after the patient declared that his or her illness—social, physical, psychic, or otherwise—had been effectively treated. Thus, patients were empowered and payments were contingent on pragmatic outcomes. Since women’s illnesses topped the list of most frequently treated maladies, it should not be surprising that women paid most often, either for themselves or for their children. The top women in the latter category were Adwoa Manu, Grace Yeboah, Alima Kramo, Abiba Kramo, Adwoa Akoma, and Adwoa Apsomsah. In this list, we see the three major types of patients ordered by religious affiliation or spiritual adherence: kramo is the Akan term for a Muslim, Grace was a Christian name received through baptism or upon entering school, and manu (second-born child) and akoma (heart) represent the indigenous spiritual culture. Most intriguingly, patients named Adwoa Manu, Afi Sarpong, Akua Mensah, and Grace Yeboah made the most visits to Nana Donko’s healing facility.

In 1988, when book 1 ends, the Ghana Psychic and Traditional Healers Association issued a “Certificate of Competence and Authority” to “Oduyefo—Okomfo Kofi Donkor.” The certifying document indicated Nana Donko was “a member of the above association and has been critically examined by the Board of Examiners of the National Executive and has been found qualified and competent in various fields of Herbal Treatment.” The certificate was issued on February 29, 1988, with a picture of Nana Donko and with signatures from the national chairperson and secretary. Nana Donko also had a membership card; although it was not filled out, it contained the aims and objectives of the association.

As a member of the Takymian community and its subset of healers, Nana Donko also played the ubiquitous role of attending funerals as family head (abusuapanin) and prominent healer (nsosomfo). Attending to life as a healer also meant attending to matters of death and temporal transition, all filled with ritual obligations, observances, and participation in the fundamental ebb and flow of Ghanaian society. For example, on June 20, 1984, Nana Donko attended the funeral of Daaapanin Nana Amma Tabuua, the fifty-four-year-old “Queenmother of [New] Kenen,” who had recently passed. Funerals occurred often, and they were usually held on Saturdays. Regardless of the deceased’s social standing, most funerals were announced on small two-by-two-inch or three-by-three-inch cards that indicated the chief mourners, kin, and invited personalities. Nana Donko was frequently invited; in one way or another, many of the mourned were his patients or relatives of his patients. Like the index cards that recorded patient information, the backs of these funerary announcements were used to record important information. For example, on January 5, 1988, a note on the back of the funeral announcement for Kwadwo Krah read, “We functioned from morning to evening and had an amount of four hundred and thirty cedis (530.00). With the above amount old man [an affectionate term for Nana Donko] authorized me to give 300 cedis to his wife as feed allowance and also one hundred cedis to buy pito [a beverage with low alcoholic content brewed from fermented millet]. It has now left with 180 cedis.”

Nana Donko also accounted for life’s priorities on the back of those funerary announcements. On one he noted that he and his family worked “from morning to evening,” earned 330 cedis that day; gave much of his daily earnings to his wife, Afa Monofie; bought pito to share with family; and saved the rest. Though profound in his understanding of disease and medicine, Nana Donko was deeply pragmatic and engaged in community affairs and in much of the mundane activities of other Ghanaians. On September 2, 1990, Nana Donko and his elder sister Akosomfo (spiritualist-healer) Adwoa Akumsa and family participated in a send-off party for J. K. Tuffour at the community center in Takymian. Tuffour had recently retired from the police force after twenty-eight years of service. One striking example of Nana Donko’s participation in such activities concerned the national weekly lottery that was established in 1958 as the Department of National Lotteries, one year after Ghana’s political independence. In 2006 the Department of National Lotteries morphed into the National Lotto Authority after having its processes automated in 1979 with mechanized lottery coupons. Nana Donko prob-
ably played the national weekly lotto beginning in the 1960s, though only two lottery tickets, dated September 17, 1988, were found among his papers. Lotto players simply chose five numbers from one to ninety, and winners would cash in their prize coupons at regional offices. Nana Donkɔ would have done so at the regional office in Sunyani. As one can imagine, the lotto was extremely popular during the political and economic turbulence of the 1960s, 1970s, and 1980s. This steady popularity continued into the early 1990s as economic decline in Ghana, before the Gulf oil crisis, raised petroleum prices by 2 percent, affecting transport and foodstuffs prices. For a largely farming population, Ghana’s common folks bore the brunt of this, and their burden grew with inflation pegged at 37 percent and a gross domestic product at 2.7 percent. Farmers and families like that of Nana Donkɔ stubbornly pushed their lives through the jagged contours of Ghana’s unstable political economy.

By 1990 claims of subversive activity and executions by firing squads were recurring themes, along with criticism of PNDC policies, while the second phase of the Economic Recovery Program and extradition treaties between Ghana and its eastern neighbors were implemented under Rawlings’s vision for Ghana. Rawlings’s National Commission for Democracy expanded Ghana’s administrative districts from 65 to 110 and officially recognized the newly created Upper West Region. The commission also presided over national efforts to register voters for district assembly elections across the country, instituting a new minimum wage (set at 218 cedis in 1990), and sought to provide a road map for Ghana’s political future. A 1990 clergy meeting asked for a debate on this future, and an opposition group based in London called the Democratic Alliance of Ghana echoed the clergy in protest and demanded multiparty constitutional rule. The Movement for Freedom and Justice in Accra joined the chorus. Rawlings’s ruling administration did not ignore these calls for transition, but he wanted to be the architect of that transition. In this moment of flux, more than half of the cocoa and coffee plantations were sold to private individuals and businesses in Ghana and abroad, signaling yet another reordering of economy policies along lines praised by the International Monetary Fund and World Bank. In Takyrman the district had also been restructured, reducing the landmass by 25 percent and shrinking its population. With only 39 percent of the majority rural populace of Ghana having access to safe water and 43 percent to health services, the HFH had little choice but to revive the PRHETI program through the appointment of Samuel Oduro-Sarpong as program coordinator in October 1990. Sarpong prepared for the 300 identified healers and the 124 ready for training.

In 1991 the seventy-nine- or eighty-year-old Nana Donkɔ was visited by Margaret Yeakel-Twum, a student associated with anthropologist Michael Warren. Yeakel-Twum’s observations at Nana Donkɔ’s compound provide an important snapshot of his healing practice and the patients he treated. Yeakel-Twum described Nana Donkɔ’s “shrine room” as a “dark room with two small windows, each with a light grate covering the opening.” Inside “there were nine [isposable (spiritual forces) represented by brass pans] that were housed in this shrine room.” The compound area had been transformed into a clinic. Yeakel-Twum wrote,

I would arrive at the clinic and find patients waiting to be seen. Some patients stayed at the clinic for extended treatments or if their homes were a long distance away. Many of the patients who sought out Kofin Donkor did so on references from friends or relatives, often traveling from far away areas. Those who waited did so patiently and quietly, never seeming to be in a hurry to leave. There were days when those who were waiting were not doing so for treatment but to bring payment of some sort for previous services rendered. At this clinic, no one was turned away if they could not pay and payment was not expected until the treatment was effective. Women would proudly bring in babies to show Kofin Donkor, proving that his treatments for infertility had worked again…. infertility was one of the major complaints of women who came to the clinic, which was presented as always a women’s problem.

Yeakel-Twum observed Nana Donkɔ treating boils (mpɛmpɔ), malnutrition (aʃem), snakebites (swkɔ), and many other conditions, but she regarded his clinic as surprisingly unique because the HFH referred their patients to him. “There were other herbalists in the area who had clinics in their compounds,” she continued, “but Kofin Donkor’s seemed to be the oldest and most established clinic in this area.” Nana Donkɔ’s healing facility was well stocked with herbs, a wide range of dried bark, roots, and leaves, gathered locally as well as from distant areas, that were arranged in a cabinet. A fresh pile of medicines lay in the middle of compound, and Yeakel-Twum “was always amazed [when] Nana Kofi Donkor would stand up from his chair, put his crutch under his arm, hobble over to this pile and proceed to point out to his son or another family member the pieces of plant material he needed to work with. Nana [Donkɔ] had slipped and broken his hip about a year ago and was dependent on the crutch for mobility…. It truly was fascinating to watch this process, as I knew very well that Nana knew exactly what plant the root, stem or bark originated from.” In addition, while “Nana [Donkɔ] used his extensive knowledge of herbs in his diagnosis, he also used a stethoscope that had been given to him as a gift from a visiting African-American. He would listen, in particular, to the breathing of the youngest patients who were brought in for treatment.”

Through his “herbal clinic,” Nana Donkɔ also taught and certified healers trained under his leadership. On December 22, 1991, he had a letter written on behalf of his kin and recent healing graduate Nana Akua Asantewaa Asubonten, authenticating her status as Asubonten ɔkwɔ. Nana Donkɔ dictated, “This is to certify that Nana Akua Asantewaa Asubonten Bono Priestess has been an apprenticeship at the above clinic for a period of four years. During her period of
stay, she studied the following: Bono traditional culture, Bono medicine and traditional religion. ... I recommend her for traditional healing license and certificate.” The letter was signed with Nana Donkô’s thumbprint or index finger print inside the stamped seal of the “Nana Kofi Donkor Herbal Clinic.” Nana Donkô also trained Kwasi Appiah and Akwasi Owusu around the same time. Both hailed from the Asante region. Appiah’s family migrated from Koforidua to farm cacao in Asante. He trained for the shom (Akumsa) his great-grandparents collected to build their town, whereas Owusu trained for a shom his uncle had found in the forest and brought to their village of Booho, eight miles north of Kumase, in the 1970s. While Appiah returned to his hometown after graduation, Owusu remained in Takymain, bought a plot of land and built a house, initiated his own healing practice, and in the process named his first son after Nana Donkô—Kwame Sakyi. 

Alongside Nana Donkô’s training and certification of healers, the reconstituted PRHETIH under new field coordinator Oduro-Sarpong represented a different certification process centered on the imperatives of biomedicine and the Christian orthodoxy gripping the nation. The reincarnation of the PRHETIH program came with some new faces in its personnel and some changes from within. Oduro-Sarpong was the first Ghanaian and non–Peace Corp field coordinator; joining him was HFH matron Elizabeth Dwamena, who was a manager of PRHETIH program. After studying the Dormaa Healers’ Project and attending courses in Kumase and at the Centre for Scientific Research into Plant Medicine in Akwatem, Oduro-Sarpong recruited 180 of 300 herbalists for the PRHETIH program. He also mapped out year-end goals: register all herbalists in the Takymain district, train and graduate healers in the program, construct an arboretum, and establish a “databank on all healers in the district” that would allow for follow-up visits and supervisions. Through Oduro-Sarpong, changes to the PRHETIH emblem on its certificates were made, from the “old one [that] portrays a doctor and a fetish priest” to one that would “portray a leaf crossed with a hypodermic Syringe.” As Oduro-Sarpong reasoned, the “former emblem does not represent all the categories of the herbalists who are made up of Christians, Muslims, Fetish Priest(esses) and ‘Ordinary’ herbalists. The new symbol will signify the cooperation between all users of herbs (leaf) and all Western Medical practitioners (syringe).” The new changes to the revitalized PRHETIH program were publicized through press releases to the People’s Daily Graphic, the state-owned daily newspaper. The Ghanaian state, under Rawlings’s PNDC, also revealed in this mood of change.

Transitions
In 1994 the HFH was named a district hospital for Takymain, qualifying it for more government funding and enabling it to offer greater care to the poor. However, the hospital had to celebrate its fortieth anniversary amid the rebuilding of its maternity unit, which had been destroyed by a tornado the previous year. Unlike the HFH, the government’s care for the poor through its community health insurance plan was duly criticized for its inability to improve health care among the impoverished, but more so for its inability to adequately address the politics and “ethnic” clashes that had erupted in northern Ghana. The subplots to these clashes were, on one hand, the cumulative effect of military and civilian rule, inflation, currency devaluation, failed structural adjustment schemes, and indebtedness, and, on the other hand, the country’s inequalities and antagonisms running beneath a veneer of democratic progress following the 1992 presidential elections. The 1994 “ethnic” rivalries over land and political authority exploded in the bloodiest conflict of its kind in the history of the nation, amidst Ghana’s almost-unquestioned acceptance of things foreign and an attendant view of the United States as “God’s country.” In February 1994, some five hundred people were killed in the conflict that gripped the Northern Region of Ghana, with thousands of refugees fleeing to Togo.

The new Rawlings regime imposed an extended state of emergency and dispatched national armed forces to the area. After several people were killed in the regional capital of Tamale, negotiations began but were marred by claims of plots to overthrow the government and by opposition parties withdrawing from the reconciliation process. By August a peace agreement had been reached and a cease-fire went into effect, allowing a negotiating team to focus on its task of facilitating stability. Ironically, the new president and constitution returned to old tactics of arresting individuals who allegedly conspired to overthrow the government, charging them with crimes against the state. Further arrests and killings in the region did not resolve the tensions but rather increased suspicion and conflict among the participants involved and toward the new government. Nana Donkô had often traveled to northern Ghana, learned from its healers, and had many patients who traveled from that region to Takymain to seek out his therapeutic offerings. His approach to the people of Ghana was simple: treat all, regardless of their political or religious standing and affiliation, with an affirmation of their humanity and with care. The Rawlings regime, and consequently the people of Ghana, would have benefited greatly from such a human approach.

The conflicts that erupted in northern Ghana were not contained there and had consequences for the rest of the country. With newly paved roads between Tamale and Takymain, and between Takymain and its regional capital of Sunyani, “people [were] mobile,” as HFH officials observed. However, the extended state of emergency placed travel restrictions on all moving to and from northern Ghana. Takymain was the crossroads between northern and southern Ghana, and so the restrictions emanating from the conflicts also affected those who needed hospitalization or the indigenous therapeutics offered by Nana Donkô and company, the flow of goods and services, and the hundreds of thousands of food
producers and the commerce they transacted at the Takymian market. The Takymian market was the largest three-day market, and the township was the fastest-growing commercial center in the country. Approximately 90 percent of its residents were farmers who planted cassava, yams, maize, and beans and engaged in small-scale trading; 2 percent were full-time merchants; and just over 5 percent were civil servants. The conflicts affected the arrival and departure of people, produce, and manufactured goods through the commercial hub that was Takymian, as well as the number of inpatients and outpatients at the HFH, both of which decreased during the protracted conflicts. For Takymian inhabitants, the six doctors at the HFH translated into one doctor per 20,333 individuals, while the nine mission hospitals (seven Catholic, two Protestant) in the Brong Ahafo region served about 69 percent of the regional population.

HFH records clarify the features all mission hospitals shared but also which programs differentiated the HFH in its response to the exigencies of the times. The HFH developed a credit union called Abosomankotere (chameleon) in May 1971 with 165 members; 1994 reports suggest the credit union continued “to thrive with 201 members.” The HFH responded to the 130 HIV/AIDS cases brought to the hospital with an educational campaign targeting every single village in the district, including schools. To help in the fight against malnutrition and anemia, the 169 active HFH-trained traditional birth attendants were deployed alongside the 201 PRHETI Healers located in ten communities, though further training was put on hold since officials were more concerned with the “supervision of trained traditional healers.” While leaders of diverse cultural groups grappled with the burial of indigent and abandoned group members, the HFH was challenged by a new life-and-death matter: abortions.

Of the sixty-eight cases of induced abortions, about half were done through the insertion of herbs deep into the vagina, and 22 percent were married women who explained that they did so because their last baby was born too young, while 47 percent were unmarried women who had no trade or only incomplete schooling. The unborn, the living, and the deceased remained entangled because they embodied the community in both its transformations and its transitions.

For Nana Donkó and family, life and temporal death were not statistical matters but rather the filaments of the human experience. On April 17, May 7, and June 12, 1995, Nana Donkó was admitted to the HFH. While there, Christian fanatics tried their best to convert him, but their theological arguments failed. Nana Donkó, we are told, could not accept that he had “sinned” and that Jesus would cure his illness if he confessed these “sins.” Gravely ill, he proclaimed that he had committed no acts of negativity (bame) toward anyone. During the three months in and out of the hospital, Catholic priests also sought to convert Nana Donkó through baptism. According to Nana Donkó’s family, the healer “understood the pastor’s language, but [Nana Donkó] gave [the clergyman] a good [proverbial] response and did not change his belief.” On August 8, 1995, Nana Donkó made his transition to asamando (where the ancestors dwell) around age eighty-four at his compound in komfokrrom (healer’s village). In observance of this moment, family and community appropriately exclaimed, “skó akuraa” (he or she has gone to the village), “skó baabi” (he or she has gone someplace), and “dupùn kese a tuta” (a great tree has been uprooted).

Relatives nearby described his transition in the following way. Nana Donkó expected to pass seven days before he died. As a child’s belonging in the Akan world requires waiting seven days before he or she is named—and therefore registered as a member of the human community—so too healers reserve this same right on their way to an ancestral community. On the seventh day, his wife, Afia Monofie, prepared pounded yams made into dough (fufu) and a light soup (nkwasu) for him. While eating, Nana Donkó fell to the ground, shaking, in front of the eating table. He then went into his bedroom, followed by some family members, who witnessed the healer fall again, but this time into a deep trance state. He requested those with him to remove the iron bracelet (kao) on his hand and iron ring (kawa) on his finger. Water and schnapps were brought into the room almost immediately. Water was poured on the mouth of Nana Donkó before the animating life force that fought so hard to stay on earth around 1912/1933 left his physical body. Nana Donkó’s passing occurred when preparations were being made for the annual yam or harvest festival: for this reason, funerary plans were put on hold and his body was sent to the HFH mortuary for preservation—Nana kó aduro ma (Nana went into medicine). Nana Donkó’s body remained on view for seven days before the burial, and thousands of individuals from near and far paid the first of several periodic respects to a person who embodied the best of them and what they could become.


Notes


3. Ibid., 14.
4. Ibid., 21, 24 (quotation).
5. Ibid., 4.
7. Ibid., 2.
8. Ibid., 1.
9. Travel Account to Accompany the Study Guide for the Film "Bono Medicines" (Lone Rock, IA: J. Scott Dodds Productions, 1982), 5. The sacrificial use of goat is inaccurate. Asubonten taboos goat, and so the visitor either misidentified the animal used or simply invented the use of goat.
10. Ibid., 5–6.
11. Ibid., 6.
12. Ibid., 13-14 (italics mine).
13. Ibid., 7.
16. "Kofi Donkor Herbalist Clinic Nyafoma—Techiman B.A.,” unpublished record books kept at Kofi Donkor’s family compound. I have transcribed both books and created a Microsoft Excel file for each. The statistical analysis that appears in this section derives from these files. These data sets are in this author’s possession.
18. Copy of certificate and card in author’s possession.
19. Funeral announcement for Akosua Antwiwea, December 15, 1984, Copy in author’s possession. Note that the date of the announcement card and the date of the event Kofi Dankɔ or a scribe wrote on that card were not the same. I have used the latter.
20. Funeral announcement for Kwadwo Krah, November 15, 1980. Copy in author’s possession. Note that the date of the announcement card and the date of the event Kofi Dankɔ or a scribe wrote on that card were not the same. I have used the latter.
23. Ibid., 8.
25. Ibid., 12.
27. Ibid.
28. Ibid., 14.
32. Ibid., 2.
34. Ibid., 3.
35. Ibid., 3, 20.
37. Ibid., 12, 13.
38. Ibid., 6, 12, 15–16 (quotation).
39. Ibid., 19.
40. Ibid., 9.

Bibliography