

## Health-seeking behaviour of persons with HIV/AIDS in Ghana



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### Abstract

Historically, diseases whose aetiology could not be readily explained have been given supernatural explanations among the various ethnic groups in Ghana. Now HIV infection, with no known cure and origin, has been given a supernatural explanation. Such an explanation of disease causation influences people's attitude to the disease and to infected persons, and influences the health-seeking behaviour of infected persons. Data from a study on the Social Dimensions of HIV/AIDS Infection in Ghana are used to examine the health-seeking behaviour of some persons with AIDS interviewed in 1992. The paper examines the health care outlets used by infected persons and the reasons for using those outlets. Some HIV-infected persons in Ghana felt that they had been bewitched and, therefore, used multiple health care outlets, either serially or simultaneously, hoping that one of them might provide a cure or relief as well as explain the source of the infection. This is in spite of the continuing educational campaign stating that the disease has no cure. Such attitudes towards the disease and health-seeking behaviour should be considered in the design of programs for infected persons.

At the initial period of the identification of HIV/AIDS in sub-Saharan Africa,

.. there were many who believed that here was a disease that was poised to do for Africa's population and even more what decades of family planning had failed to do, that is, arresting and even reversing the continent's fast population growth (Anarfi 1994a:1).

Over a decade into the outbreak and spread of the disease, some of these predictions have given way to sober reflection. Empirical evidence and better articulated models on the social and economic implications (Schoepf 1988; Standing 1992), the demographic effects (United Nations 1994) and the health implications of the disease for individuals and communities in sub-Saharan Africa (Mann, Tarantola and Netter 1992; WHO 1994) have now emerged.

Studies have also appeared on the care received by patients either at home or at hospitals (Anarfi 1992, 1994b; Ankrah 1991), cost-benefit analysis as well as the direct and indirect cost of treating a patient (Ainsworth and Over 1994), evaluations of intervention programs (Asamoah-Adu et al. 1994; Coyle, Boruch and Turner 1991) and the consequences of the epidemic on families (Barnett and Blaikie 1992; Caldwell et al. 1993; WHO 1994).

In spite of the accumulated knowledge about the disease in sub-Saharan Africa in the last decade, our knowledge about some of the post-diagnosis behaviour of patients is fragmentary. Understanding the psycho-social coping mechanisms of infected persons and their families is

as important as the search for a cure for the disease. This paper examines the health-seeking behaviour of HIV patients in Ghana within the existing societal views on diseases with no known cure. The proposition is that belief in supernatural causation of AIDS and the desire to be cured in spite of the available information to the contrary, influences people's health-seeking behaviour. The health care outlets used by infected persons and the reasons for their choice are examined.

## **Background**

In a number of societies, the outbreak of a disease with no known cure or origin may be attributed to the commission of an offence against one's spirits, the ancestors or the gods, or an omission of duty on the part of an infected person. It could also be attributed to a curse from a jealous neighbour, co-wife and even a family member or somebody who has been wronged (Twumasi 1975; Appiah-Kubi 1981). At different times in Ghana, the outbreak of diseases such as tuberculosis, measles and guinea worm has been attributed to supernatural sources (Dickson 1969). And according to Castle (1994), in Mali child mortality could be attributed to the owl or the wind, thus allowing for psychological adaptation to the high infant and child mortality.

There is a belief that Western medicine can provide neither an explanation nor a cure for certain diseases. Therefore, people suffering from a disease whose origin has been attributed to supernatural causes, and their families, may seek explanation and possible cure for the disease at fetish shrines, diviners or spiritualists. The first stage was to find the cause of the disease and this may be done by asking a person suspected of being the cause of the illness to 'confess' to misdeeds which might have brought about the disease or a suspected person may be accused on oath of being responsible for the disease. An accusation levelled on oath was normally settled in public, before a group of elders or at a fetish shrine (Rattray 1929). When the person responsible was found he or she would be expected to pacify the offended god or individual. If it was divined that the illness resulted from an offence by the sick person, then he or she would be expected to cleanse himself or herself of the offence and pacify the community; and after these ceremonies the sick person would be given medication or sent for care. Some of these procedures for identifying the cause of a disease have been adopted by the Ghanaian-based Christian churches in their healing process (Appiah-Kubi 1981). The Prevention of Maternal Mortality Network (1992:283) observed that

women in Accra, Benin, Bo, Calabar and Freetown reported that when [pregnancy] complications arise, the oracles are consulted, and if, for example, the oracle says the complication is due to the woman's insubordination to her husband or elders, she has to apologize and perform cleansing rites before she is taken for treatment.

An event is attributed to 'divine intervention' in the affairs of people when they are not able to deal with a new or unusual circumstance within the context of existing knowledge and practice (Kirby 1994). Although African societies have undergone dramatic socio-cultural changes this century in such areas as formal education, conversion to Christianity and Islam as well as changes in patterns of socialization, the old and new ways of life co-exist and people continue to give supernatural explanations to events. Kirby (1994:64) observed that among the Anafo (Ghana), converts to Christianity when confronted with problems employed '(1) traditional solutions, (2) "syncretic" solutions that were orthodox in appearance but traditional in aim and (3) orthodox solutions (West African Orthodoxy)'. He then concluded that 'one could become Christian without ever confronting or redirecting one's religious problem solving nexus' (Kirby 1994:64). Mbiti (1989:268) also observed that 'Beliefs

connected with magic, witchcraft, the spirits and the living-dead are areas of traditional religions which are in no danger of an immediate abandonment'.

The outbreak of HIV/AIDS in Ghana has been given a similar supernatural explanation. The general view is that infected persons have defiled themselves or the ancestors or broken the moral code of behaviour. The view has been reinforced by the fact that most of the persons initially diagnosed to be HIV-seropositive were females who had been involved in commercial sex. This explains some of the reported reactions to HIV infection as 'they deserve it', or 'they are immoral' (Anarfi 1992; Safo 1993). Shilts (1987) and Sabatier (1988) described similar attitudes towards homosexuals and intravenous drug users in Europe and America.

Also, during periods of uncertainty, individuals and groups tend to find security against feelings of helplessness and hopelessness by believing that it is a natural course of events. Fordham observed that among the Thai

AIDS constitutes a potent metaphor for many of the changes being experienced in contemporary Thailand, for fragmented rural relations, for changing gender relations and, more generally, for everything felt to be wrong in contemporary Thai society (Fordham 1993:4).

One can substitute for Thailand any of the African countries experiencing high HIV infection rates. HIV/AIDS has occurred at a time when sub-Saharan African countries are undergoing severe economic hardships: the World Bank (1981) described the 1980s as Africa's lost decade. In the 1970s and 1980s, sub-Saharan African countries experienced low, and in some cases negative, growth rates in gross domestic product. The decline in the economy led to the neglect and deterioration of social services and to shortages of basic items such as reading materials and detergents.

Some of these problems have been attributed to internal mismanagement of the economy and the effects of distorted external markets (World Bank 1994). The collapse of the economies of some of the countries has been found to be related to the political instability of the 1970s, and the visible presence of the military in the political economy (Fosu 1992; Luckham 1994). This was unlike the period just after independence in the 1960s when there was optimism about Africa's socio-economic development (Killick 1978; Austen 1987).

The virtual collapse of the economies in the 1970s compelled a number of African countries to embark on World Bank and International Monetary Fund-supported structural adjustment programs (SAP). Although these programs have helped to reverse some of the severe economic declines, some observers have pointed to the short-term effects of adjustment on the health and standard of living of some groups. In particular the introduction of cost-recovery in health care and education as part of the IMF conditions has affected the use of health services by the poor and the vulnerable who need them most (Anyinam 1989; UNECA 1989). Thus, the countries that have experienced political and economic instability are also among the highly infected.

In Ghana, as in a number of African countries, the decline in socio-economic conditions created individual and collective vulnerability to HIV infection. During the peak of Ghana's economic decline in the 1970s and 1980s, a number of Ghanaians migrated to other African countries and to Europe and America as economic refugees (Bentsi-Enchill 1983; Adomako 1991). Within the overall socio-economic decline women were affected the most, owing to their already low socio-economic status relative to men. To some people, AIDS represents what has really gone wrong in the political economy of sub-Saharan Africa in the last two decades.

## Source of data

The paper is based on data from the Ghana segment of the study on Social Dimensions of HIV/AIDS Infection in Africa.<sup>1</sup> Among the objectives of the study were to examine the demographic and social-economic background of AIDS patients and their relatives, to assess the knowledge and attitudes of diagnosed persons and to examine post-diagnosis behaviour of HIV-positive persons (Awusabo-Asare and Anarfi 1995).

The respondents were infected persons who agreed to be interviewed. Since the disease has generated mass hysteria in the country, leading to stigmatization and isolation (Safo 1993), it was not easy to assemble infected persons who were willing to be interviewed. For the few who agreed to be interviewed, appointments were set up through AIDS counsellors. The counsellors were people, we realized in the course of the survey, who were trusted by the people with AIDS, but even in spite of that, some of them who initially agreed to be interviewed cancelled their appointments. The respondents were interviewed in their homes, at health centres and at rendezvous, depending on their wishes. Some of them were interviewed by our research assistants and others by counsellors. These variations were made at the wishes of respondents and these constraints need to be borne in mind.

## Results

### *Socio-demographic background of seropositive patients*

One hundred and forty-one seropositive patients, with a sex ratio of 40 males per 100 females, were interviewed over a four-week period (Table 1). Although this was not a strict sampling process, the sex ratio of the respondents is similar to that of officially reported HIV cases in Ghana (Ghana Ministry of Health 1995). Similarly, over 75 per cent of the respondents were aged between 20 and 39 years old, with median ages 25 years for females and 31 for males. Almost all the respondents (95 per cent) were interviewed in urban and large urban areas, although nearly half (45 per cent) reported being born in areas classified as rural. This is due to the fact that most of the interviews occurred at health centres in towns where the patients had reported for counselling and follow-up. Three-quarters of the respondents were either Akan (44 per cent) or Ga-Adangbe (32 per cent). A Catholic hospital in the Krobo area, occupied by the Ga-Adangbe, has one of the best home-care support services in the country (Awusabo-Asare 1994). Approached through them, the infected persons involved in their project readily agreed to be interviewed; this partly explains the fairly large proportion of respondents from this ethnic group. On the other hand, the Akan as the largest single ethnic group in the country are found in five of the eight regions surveyed, a factor which also accounts for the high proportion of Akan among the respondents.

A quarter of the respondents had no formal education; nearly 60 per cent had had ten years or more of formal education. For both males and females the proportion with basic education is higher than in the general population (Ghana 1989). Some of the respondents were not physically capable of working: over 40 per cent reported that they were unemployed. Of the economically active respondents, the majority were in low-level professional and

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<sup>1</sup>The study on Social Dimensions of HIV/AIDS Infection involves research from Australia, Ghana, Nigeria and Uganda. The study is supported by the Swedish Agency for Research and Economic Cooperation with Developing Countries (SAREC) with technical assistance from the Australian National University, Canberra.

clerical occupations. Some of the observations will have to be validated with a large sample because detailed background data are not routinely collected from infected persons.

Over 90 per cent of the male and 80 per cent of the female respondents were Christians; only one female reported traditional religion. It is likely that the number reporting 'no religion' may be adherents of traditional religion and also religious affiliation was likely to be distorted for at least two reasons. First, during the interviewing, some of the respondents claimed to have had religious conversion as a result of their HIV infection. Second, the support services provided by some mission hospitals could have influenced the reporting of religious affiliation since some of the respondents depended on such assistance.

Only about a quarter of the respondents were married. The rest were either single (never married), divorced, separated or widowed. Of those ever married and reporting form of first marriage (66 persons), two-thirds married under customary law and 25 per cent cohabited with their partners. These two forms of marriage allow polygyny which has no legal backing. Only one person had married in church (under the Ordinance). Eight of the females reported being in polygynous marriage, as first (4) or second (4) wives. The results show that the disease has diffused in the country and now affects people in all socio-demographic and economic categories. It is no longer an issue of risk groups or risk environments but one of people overall being potentially at risk.

**Table 1**  
**Socio-demographic background of the respondents**

	Males	Females	Both sexes
	%	%	%
Age group			
15-19	2.5	5.9	5.0
20-24	2.5	16.8	12.8
25-29	17.5	30.7	26.9
30-34	40.0	16.8	23.4
35-39	7.5	15.8	13.5
40+	30.0	13.9	18.4
Place of residence			
Rural	7.5	4.0	5.0
Urban	50.0	50.5	50.4
Large Urban	42.5	45.5	44.6
Place of birth			
Rural	55.0	40.6	44.7
Urban	35.0	30.7	31.9
Large Urban	10.0	28.7	23.4
Education (highest attained)			
None	15.0	30.7	26.2
Primary	12.5	21.8	19.1
Middle/JSS	57.5	40.6	45.4
Secondary/higher	15.0	7.0	9.2

**Table 1 continued**

Current main occupation			
Sub-professional	7.5	2.0	3.5
Clerical	20.0	33.7	29.8
Farmers/fisherman	22.5	5.0	9.9

Transport	5.0	0.0	1.4
Crafts & production	12.5	5.9	7.8
Service	2.5	7.9	6.4
No response	30.0	45.5	41.1
<b>Ethnic group</b>			
Twi	10.0	10.9	10.6
Fante	12.5	11.9	12.1
Other Akan	37.5	17.8	23.4
Ga-Adangbe	20.0	36.6	31.9
Ewe	12.5	6.9	8.5
Mole-Dagbani	2.5	6.9	5.7
Other Ghanaians	5.0	7.9	7.1
Non-Ghanaians	0.0	1.0	0.7
<b>Religion</b>			
No religion	7.5	16.8	14.2
Catholic	22.5	13.9	16.3
Protestant	27.5	21.8	23.4
Other Christian	42.5	34.7	36.9
Muslim	0.0	11.9	8.5
Traditional	0.0	1.0	0.7
<b>Marital status</b>			
Single	40.0	38.6	39.0
Married	32.5	23.8	26.2
Separated	12.5	10.9	11.3
Divorced	7.5	21.8	17.7
Widowed	7.5	5.0	5.7
<b>Number of times married</b>			
1	44.0	58.1	54.0
2	44.0	35.5	37.9
3	8.0	6.4	6.9
4 or more	4.0	0.0	1.2

### ***Knowledge about HIV/AIDS and sources of transmission***

Ghana acknowledged the public health threat of AIDS and started to inform people about it long before the first case was diagnosed in the country in March 1986. The major reason for initiating educational campaigns was that people 'should not be allowed to die of ignorance'. Various evaluations of the campaigns indicate that the majority of Ghanaians have heard about AIDS (Addo-Yobo and Lovel 1992; McCombie and Anarfi, 1992). Results from the study confirm this high level of awareness. About 90 per cent of the respondents indicated that they had heard of the disease before they were infected (Table 2). Only fifteen (10%) of them, 13 females and two males, had not heard of the disease before they were infected. Knowledge of mode of infection up to a maximum of three responses is shown in Table 2.

**Table 2**  
**Knowledge about sources of infection**

Heard about disease before infection			
Response	Males	Females	Both sexes
Yes	95.0	87.1	89.4

No	5.0		12.9		10.6
Total	100.0		100.0		100.0
No.	40		101		141
<b>Sources of HIV/AIDS infection heard about</b>					
			Males		
Source	First	Second	Third	Total	% of total
Sex	33	2	1	36	90.0
Blood transfusion	1	14	4	19	47.5
Body cuts	0	0	4	4	10.0
Unsterilized/sharp items	1	6	5	12	30.0
Mother to child	0	7	5	12	30.0
Handshake	1	0	0	1	2.5
Others	0	0	1	1	2.5
Don't know	4	4	4	12	30.0
Total	40	33	24	—	—
			Females		
Source	First	Second	Third	Total	% of total
Sex	80	2	1	83	89.2
Blood transfusion	0	20	4	24	25.8
Body cuts	0	2	0	2	2.2
Unsterilized/sharp items	0	17	6	23	24.7
Mother to child	2	6	13	21	22.6
Handshake	2	1	0	3	3.2
Others	0	1	0	1	1.1
Don't know	9	9	9	27	29.0
Total	93	58	33	—	—

HIV infection through heterosexual contact was the most commonly known, with 90 per cent of the respondents who had heard about the disease mentioning it. Other sources of infection were reported by less than a third of the respondents, with little variation by sex: 32 per cent reported blood transfusion, 26 per cent the use of unsterilized items and 25 per cent from mother to child (Table 2). The high rate of knowledge about heterosexual spread of the disease may be due to the emphasis on this mode of transmission in mass media campaigns in Ghana. Other possible sources of infection such as blood transfusion, scarification by traditional healers using unsterilized items and injections by itinerant drug sellers and even at some health centres are rarely mentioned. Injection, for instance, as a mode of infection needs to be stressed in sub-Saharan Africa because of what may be described as an 'injection' culture. In Mwaza (Tanzania), for instance, the refusal of some health personnel to give injections led to problems at some health facilities (Vos et al. 1993). Similarly in Ghana, people demand injections for all types of ailments. The popular belief is that without an injection a treatment is not effective; and itinerant drug sellers use this knowledge to administer injections for all ailments, especially in rural areas. Vertical transmission, although associated with heterosexual sex, was also not mentioned by most of the respondents. Attention should be given to other sources of infection, even if they are not the major sources of transmission in Ghana at the moment. They are potential sources for the spread of HIV.

Pre-infection knowledge about HIV is difficult to ascertain. It is possible that some of the respondents became aware of the disease after they had been infected. It could also be that the respondents were aware of HIV before they were infected. However, the fact that some AIDS patients reported handshaking as a mode of infection is a cause for concern about what people

claim to know about HIV/AIDS infection in the country. Such misconceptions need to be addressed.

### ***Health-seeking behaviour***

People's health-seeking behaviour, to a large extent, depends upon their understanding and interpretation of the causes of their sickness. Where people accept the germ theory of disease causation, their attitude to the search for a cure to a disease will be different from the attitude of those who attribute the disease to a supernatural cause. Table 3 shows the health outlets used after being diagnosed HIV-positive. The facilities reported were hospital, followed distantly by clinic, spiritualist and traditional healers. The data point to the spectrum of health care services used by people with AIDS. Hospitals predominate because they are the point at which people are diagnosed and informed about their serostatus. In a number of cases doctors confirm their worst fears, a situation reflected in the records at the St. Francis Xavier Hospital (1992). Secondly, respondents were identified through health centres and were interviewed at modern health facilities or by health personnel, which may have affected responses on outlets used.

Traditional healers were mentioned in the first instance by about ten of the females and two of the males while in the second instance four males and one female reportedly used their services. Spiritualists were the second major outlet for the female respondents (after hospital) in the second set of reporting. Only one male and two females reported pharmacies. The use of pharmacies points to some element of self-medication, although this is not explicitly indicated. Pharmacies, widely available in villages and towns, are used for the treatment of a wide range of ailments. In sub-Saharan Africa, observations indicate that self-medication is the first source of health-care followed by traditional healers (Good 1988). Perhaps such conditions could not be observed because people might not have considered self-medication in HIV treatment to be an issue worth reporting. Further studies will need to directly explore this aspect including the sequence of the use of types of health care services.

The reasons for visiting two of the health facilities reported above are given in Table 4. Data were collected for up to four sources but only two are reported as a result of small numbers after the first two. Ninety-seven per cent of the males and 92 per cent of the females reported using the facilities for treatment; only three females and one male reported using them for counselling. Others visited for consultation, prayers or protection.

**Table 3**  
**Health facilities visited by diagnosed persons**

Facility	Males			
	First		Second	
	No.	%	No.	%
Hospital	29	76.3	17	70.8
Private clinic	6	15.8	1	4.2
Pharmacy	1	2.6	0	0.0
Traditional healer	2	5.3	4	16.7
Spiritualist	0	0.0	2	8.3
Total	38	100.0	24	100.0
Facility	Females			
	No.	%	No.	%
Hospital	82	81.2	37	72.5
Private clinic	5	5.0	2	3.9
Pharmacy	2	2.0	0	0.0

Traditional healer	10	9.9	1	2.0
Spiritualist	2	2.0	11	21.6
Total	101	100.1	51	100.0

**Table 4**  
Reasons for visiting reported facility

Reason	Males				Females			
	First		Second		First		Second	
	No.	%	No.	%	No.	%	No.	%
Treatment	37	97.4	22	91.7	95	94.0	49	96.0
Counselling	1	2.6	0	0.0	3	3.0	0	0.0
Consultation	0	0.0	0	0.0	2	2.0	1	2.0
Protection	0	0.0	1	4.2	0	0.0	1	2.0
Prayers	0	0.0	1	4.2	0	0.0	0	0.0
Others	0	0.0	0	0.0	1	1.0	0	0.0
Total	38	100.0	24	100.1	101	100.0	51	100.0

All but one of the 36 males who reported using hospitals, clinics and pharmacies in the first instance went there for treatment; the other one reported going to a hospital for counselling. Similarly, 97 per cent of the females reported using hospitals for treatment. Two males and 12 females also consulted traditional healers and spiritualists. Both men reported using them for treatment; nine of the females visited for treatment, two for consultation and one because she did not want people to know that she was HIV seropositive (Table 5). Although traditional healers and spiritualists are major participants in the treatment and management of diseases generally (Good 1988), they were mentioned by only a handful of the respondents. The few people who visited traditional healers or spiritualists did so to seek treatment and also for consultation, protection or prayers because they thought they had been bewitched or cursed.

Although traditional healers and spiritualists are known to provide psychological and emotional support for sick people and their relatives (Appiah-Kubi 1981), none of the respondents had visited them for counselling. Similarly only one person reported visiting a hospital for counselling. It appeared the respondents did not consider the counselling and emotional support offered by hospitals and traditional healers as important components of the healing process. The facilities are perceived to be for treatment only.

**Table 5**  
Facility used by reason for visiting

Reason	Hospital/clinic/pharmacy		Traditional healers/spiritualists		Total	
	Males	Females	Males	Females	Males	Females
Treatment	35	86	2	9	37	95
Counselling	1	3	0	0	1	3
Protection/prayers/ consultation/others	0	0	0	3	0	3
Total	36	89	2	12	38	101

## **Discussion**

HIV infection has ramifications beyond mere infection. Its outbreak has evoked strong emotions and reactions some of which underlie some of the behaviour exhibited by infected people. Given the social interpretation of the causes of some diseases such as HIV infection, persons with AIDS and the family members responsible for their care may search for a cure, however elusive, for two reasons: first, to restore the person to good health since ill-health not only implies physical breakdown of the body's mechanism, but also connotes social disequilibrium between the sick person and other family members or the community (Twumasi 1975); second, to clear the family name of the shame and stigma associated with diseases of that nature (Bleek 1981). Thus, in spite of public education that HIV infection cannot be cured at present, infected individuals and families continue to search for a cure. In general, people pursue options in life which are consistent with their world view (Kirby 1994); and a supernatural explanation for HIV fits into some people's views about the causes of such diseases.

To a large extent, the health-seeking behaviour of the respondents is similar to what has been observed for other diseases whose origin cannot be readily explained. Although in general people accept the germ theory of disease causation, fundamental questions may be raised about the occurrence of a disease at a particular time or why a disease affects specific individuals. In an attempt to find answers to such questions the supernatural explanation emerges. Such reactions have been observed with tuberculosis, guinea worm, cancer and other rare diseases in Ghana in spite of the availability of cures for some of them. The common diseases such as malaria, diarrhoea and chicken-pox are readily accepted as the result of breakdown of bodily functions. However, under certain circumstances death from common diseases such as malaria and diarrhoea may be questioned: why it occurred to a particular person. On the other hand, the supernatural explanation of ill-health makes it possible to rationalize difficult situations, especially when attempts to treat the patient fail (Castle 1994). HIV fits into the mode of diseases whose origin and mode of infection are questioned and given supernatural explanations.

Because of the supernatural explanation given to HIV infection in some cases, traditional healers and spiritualists have become two of the health care outlets used. In Ghana, as in other sub-Saharan African countries, a number of traditional healers claim to have a cure for AIDS. A well-known traditional healer who claimed to have a cure for AIDS, and whose claim became a national issue between 1989 and 1993, was Nana Drobo of Nwoaso in the Brong-Ahafo Region.<sup>2</sup> His claim even acquired an international dimension when he reportedly cured an HIV seropositive patient from France. He also visited Japan in 1992 at the invitation of some Japanese researchers because of his claims. On his return from Japan, however, he accused his hosts of attempting to trick him into revealing his treatment. Fanned by the Ghanaian press, his claim came to be accepted by the public; the Government as well as the orthodox medical establishment were accused of not assisting Nana Drobo to cure more infected people and promote his drug. Nana Drobo died in 1993, but even after his death some people continue to believe in the efficacy of his drugs. His claim is being investigated because some people believe that his drug could help to relieve the suffering and prolong the lives of AIDS patients. They feel that the initial work of Nana Drobo should have been given support.

Claims for the cure of AIDS by traditional healers and spiritualists have been reported by Musara (1991), Lindan et al. (1991) and Irwin et al. (1991) in East and Central Africa. Goncalves (1994) reports that in parts of East Africa traditional healers have made fortunes with their claims of cures for AIDS. In Zimbabwe, a traditional healer who claimed to have a

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<sup>2</sup>Because of the nature of his claim and his popularity in the country, we visited his 'healing' facility in March 1992 as part of the field exercise for the study.

cure for AIDS was not allowed to advertise because of the possible negative effect of his claims on intervention programs (Musara 1991).

An infected person may resort to multiple health outlets hoping that one of them can provide some relief even against all odds. Unlike the situation with their counterparts in the more developed countries, AZT is not available for them, so their hope is to get an equivalent medication from other sources. Therefore, in dealing with HIV/AIDS in sub-Saharan Africa, it is necessary to consider the social meaning of diseases, and the role traditional healers and spiritualists play in the search for a cure, even if one is not readily available.

A probability is that all the outlets used were not reported, or not in the sequence in which they occurred, for several reasons including recall lapse, the nature of the data collection and the circumstances surrounding the occurrence of the disease. Some of the initial conclusions may also be affected by small numbers in the sample. It should also be recalled that these were people who were willing to respond to the survey. Therefore, a large sample would be needed to validate some of the observations. An alternative is systematic data collection on diagnosed persons in Ghana as they report for counselling and treatment, but within the context of respect for their privacy. This will enable detailed studies to be made on the background as well as the pre-diagnosis and post-diagnosis knowledge and health-seeking behaviour of people with AIDS in Ghana.

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