

HELP-SEEKING AND COPING STRATEGIES IN ONCHOCERCIASIS AFFLICTED COMMUNITIES IN THE CONTEXT OF GLOBALISATION

Albert Kanlisi Awedoba

Introduction

It would appear that globalisation permeates all nooks and corners of Ghana. Its manifestations in the urban area are palpable and pervasive but no rural village can be said to be insulated. Globalisation affects all aspects of life and this includes help-seeking for the ill and those who are at risk of falling ill. It influences the patterns of help-seeking and the strategies that individuals and communities devise for coping with their health problems or preventing illness. The result of this effect of globalisation is eclecticism, an ingenious blending of diverse approaches and traditions in health seeking behaviours, as people are influenced not only by indigenous knowledge but also by new knowledge and information obtained from friends and relatives and by educational messages from biomedical practitioners and by experiences gained through travel or residence outside their villages or even in a neighbouring country.

The wide-ranging effects of globalisation are illustrated by attempts to treat onchocerciasis, a disease that has been endemic in rural communities in almost all regions of Ghana. Onchocerciasis according to Murdoch et al. (1993), has been regarded by WHO as one of the world's major health problems. It is known to most people as *river blindness*. It is less commonly realised however that onchocerciasis has other manifestations such as skin disease. It was more than a century ago (1875) that a British surgeon then working in the Gold Coast concluded that the local skin disease 'crawler' (identified here as chronic papular onchodermatitis) was in fact caused by microfilariae in the skin (Hughes and Daly 1951; Patterson 1978; Murdoch et al. 1993). From these uncertain beginnings onchocerciasis has come to be being widely researched and described by medical scientists. However, it was not until recently that the dermatological aspects of the disease, particularly the sociology of onchocercal skin disease, have started to receive attention.¹ As Burnham (1995) remarked, the study of the social and economic aspects of the disease is still in its infancy. The disease remains endemic to large areas of Africa and Latin America (WHO 1966; 1987) and onchocercal dermatitis is its most common manifestation in humans (Pacque et al. 1991). It accounted for 884,000 Disability Adjusted Life Years (DALYs) in 1990, according to WHO, and over half of this is attributable to itching.

The known cause of the disease is *Onchocerca volvulus* a filarial worm, transmitted by an infected simulium fly (*Simulium damnosum*), also known as the "blackfly" which breeds in fast flowing rivers in both forest and savannah zones. The adult worm lives in nodules within the human body and produces microfilariae in the thousands. Many of the signs and symptoms of onchocerciasis come about as a result of the death of the microfilariae in the skin, which produces toxic effects (Murdoch et al. op. cit. & Burnham, 1991 and 1995) Conditions for which a psycho-social study was conducted in 1994 with WHO sponsorship include the papular rashes of acute papular onchodermatitis (APOD) and chronic papular onchodermatitis (CPOD), lichenified onchodermatitis (LOD) or "lizard skin", the toughing of the skin especially on the feet, and Depigmentation (DPGM), also known as Leopard skin or colouration of the lower feet or shin. Other conditions attributed to onchocerciasis include nodules, skin atrophy or the premature ageing of the skin, hanging groins etc. The killing of vast numbers of the microfilariae in the

body accounts for river blindness and the skin problems in question. Though found in both forest and savannah, the skin disease, unlike the ocular variety, is associated more with an endemic forest ecosystem (Amazigo 1994: 322; Anderson et al. 1974a; 1974b).

Few parts of Ghana can boast of never having been endemic to some degree. The disease has therefore been of some concern to the Ministry of Health and the World Health Organization for over a decade now. Between 1993 and 2000, WHO/TDR has sponsored and funded several socio-medical studies on the disease in Ghana in the Lower Black Volta Basin and in the southwestern river basins of the Bia, Tano, Pra-Ofin and Ankobra. The Aowin-Suaman District of the Western Region has been the focus of some of these studies. The comments being made here are informed by research experiences and data collected largely in this district and elsewhere in the southwestern river basin communities.

Profile of the Aowin-Suaman

Aowin-Suaman is a remote District in the northwestern corner of the Western Region. It shares borders with the Republic of Cote d'Ivoire; the Brussa or Aowin people who are the indigenes are found in Ghana and Cote d'Ivoire (in the latter they are known as "Anyi"). Individual Brussas have kin on both sides of the border and regular contacts, including visits, are maintained between kin on both sides. The Aowin-Suaman District, like most of the onchocerciasis endemic districts in Ghana, is rural. The area is deficient in hospitals, schools, roads and other modern amenities. It is not unusual for the district to be cut off from the rest of Ghana at the peak of the rainy season. However, it attracts people from all over Ghana, including retired civil servants, who come here to invest in cash crops such as cocoa, palm oil and a little rubber. In addition, youth from the area and some companies are undertaking mainly surface mining. In addition to the local people who account for over 80% of the population in the rural communities researched, other Ghanaian ethnic groups and individuals from neighboring West African countries are found. A census of adults in several endemic communities in the Aowin-Suaman District conducted in 1995 indicated that about 81% of a sample of 1008 were Brussas, 11.5% were from southern Ghanaian Regions other than the Western Region, 1.4% were from the Northern Regions, and 1.1% were foreigners.

Much of the Aowin-Suaman District is clothed in tropical rain forest but the effects of years of timber extraction are noticeable. The area receives considerable rainfall, and it may have the highest rainfall in the country. It rains throughout the year and much of the rain water drains into the Tano and Ankobra rivers. Most communities that lie close to these rivers and their tributaries were at one time or the other hyper-endemic for onchocerciasis. The remoteness of the district perhaps accounts for the late introduction of mass treatment of communities with ivermectin; even as at 1995 there were still communities that had not been treated systematically. Such communities were targeted for the studies in question. The skin or dermatological conditions caused by the disease are prevalent in many southern Ghanaian communities, including the Aowin-Suaman area but for some unknown reason there is less river blindness in the southern, forested parts of the country.

Perceptions of Onchocerciasis Skin Disease

Perceptions on onchocerciasis skin disease were based on presentations of vignettes to non-affected informants accompanied by photographs depicting two of the papular conditions: depigmentation in a male and chronic papular onchodermatitis on the back of a female. In the case of affected respondents, reference was made to the lesions diagnosed by the physician. In many cases these could be pointed out, although it has been known that some affected individuals do not manifest the clinical signs and symptoms of the disease. Questions asked in interviews

included local terms for the conditions, perceived causes of the condition, treatment and help-seeking as well as people's ideas for the prevention of the disease.

Entitling Some Onchocercal Skin Diseases

In the Aowin Suaman District, onchocercal skin diseases were known by a variety of names, as the table below shows. The variation reflects, among other things, the ethnic and linguistic differences that were encountered in the District. Though the local Brassas are numerically dominant, there were also people speaking closely related languages, that is Wassa, Nzema, Sehwi and Twi speakers and these constitute about 13% of the sample.

Table 1: Local Brussa Illness Terms for Onchocercal Skin Conditions

Local Term	DPGM	CPOD	LOD	Total
Akele	2	40	0	42
Asee/Esse	1	29	0	30
Kokole	26	1	2	29
Nsaye/Seye/Osee	0	24	2	26
Epini	9	4	6	19
Nzooso	8	6	5	19
Totooto	0	12	0	12
Nvefere	0	10	0	10
Ahokcka/keka	1	7	1	9
Asahena	8	0	0	8
Dobe	2	6	0	8
Mebekye	3	0	1	4
Kanametie/Mebete/Metie	2	2	0	4

The predominant term for DPGM was *kokole* with variants such as *koko* and *ngokole*, which could be used alone or in combination with other words such as *sabeng* or *sabena*. The spotty pinkish coloration of depigmentation no doubt accounts for the use of the term *kokole* or *koko*, which in many Volta Comoe languages represents a spectrum of colours that includes red, brown, yellow and other associated hues². CPOD was known to some as *akele*, and to others as *asee* or *seye* (*Nsaye*, *Osee*), all of which are perhaps phonetic variants. The application of the terms *epini* and *nzooso* to both DPGM and LOD suggests the similarity between the two; both involve a colour change. In the case of LOD, the skin may darken in some individuals in addition to thickening. The lesions also tend to show on the feet of the affected. The term *kanametie* suggests how bothersome the itching that is commonly associated with onchocercal skin disease is felt to be. The phrase which translates as "don't mind my scratching, speak on for I am listening" alludes to the perception that when itching sets in, scratching becomes compulsory for an affected person, although that behaviour is not approved socially. It seems impolite to others, as the person busily scratching away seems not to pay attention to what interlocutors are saying.

Perceived Problems of Onchocercal Skin Disease

Both affected and non-affected people in the endemic communities are bothered by the itching that the disease induces and also by the ugly appearance on a body surface ruined by lesions and scratch marks. Itching leads to insomnia and the affected say they have difficulty sleeping at night and some in addition suffer headaches. Insomnia is reported to lead to fatigue

the following day. There is a minority who feel that itching is associated in some vague way with blindness. Itching is felt to lead to scratching. This affects the worker's productivity as work time is shared between productive work and scratching. Both scratching and the unsightly skin appearance are issues that generate stigma in both sexes but more so for the young female. The cumulative effect of the problems of onchocercal skin disease is worry and if this is not contained the individual may lose weight and even die eventually. The comments cited show how the affected people perceive the problems associated with their condition.

Work and Itching

I scratch a lot when it itches and I am not able to continue with my itinerant petty trading... I also feel dizzy [CPOD: female, 26]

The itching affects my life in the sense that I cannot concentrate on anything that I might happen to be doing when it starts. It makes me waste time in the process.

[APOD]

when I am weeding or working on my farm, I feel the itching when I start to sweat. ... whenever it happens I stop the work and come home [CPOD: male, 17].

It at times interferes with my farming life in that sometimes in the midst of farming, I have to stop and scratch the place which itches [DPGM female, 35]

Itching and Stigma

it itches me so much so that even in public places, I am forced to scratch my bottom and my arm. [CPOD]

when people meet and I am there, the itching calls for scratching and this embarrasses me [DPGM: male 54]

Appearance and Shame

The coloration of my legs also disturbs me as I feel shy to pass where people are gathered [LOD: female, 30]

It has affected my life because; if you look at your friends and neighbours who don't have it but that you have it, it is painful. [DPGM: male 65]

the black coloration of my leg worries me as my friends have smooth skins whereas mine is coloured. [LOD: female, 16]

It itches me and this disturbs my sleep. The appearance of the papular rashes on my skin also makes me worried as skin does not look smooth [APOD: female, 30]

It is the itching that worries me. Its appearance on the buttocks also worries me [APOD: female, 20]

Respondents' comments showed that the condition, especially the itching that results, also affects movement and mobility and possibly even personal hygiene, as people feel the itch intensify when they bathe, do sweat inducing work or walk in the hot sun. On clothing, we encounter responses such as the following: "I find it difficult to wear clothing because.. my skin itches and I feel very uneasy". This was said by a 38 year old female with CPOD while a 45 year old man with DPGM maintains that he cannot expose the lower feet to public view by wearing a pair of shorts: "I try to wear trousers most of the time. I feel that the colour is becoming so white."

Some onchocercal skin lesions are more worrying than others. Nodules, called *pole* in the Brussa language, for example are not taken seriously; when word got round in one of the study villages that the physician was palpating for nodules (an accepted rapid assessment technique) village youth joked about it in a way which seemed to suggest that it was nothing to bother about. The community in question was hyper-endemic and most people had a nodule somewhere on the

body; moreover, nodules are not usually painful. There were also informants who did not regard depigmentation as a disease. It was to them only a sign of old age. This again is understandable in a hyper-endemic community where many affected adults aged over 30 years would present this chronic condition. Others said they thought it was due to the cuts that a farmer suffers as he walks in the bushes to his farms in the tropical forest.

General Patterns of Help-Seeking Exemplified by some Sites

To answer the question, to what extent onchocercal skin disease impacts on help-seeking, we need to know what the help-seeking options are in communities and what types are generally favoured. Table 2 provides data from the communities in which the baseline study of the efficacy of Ivermectin was conducted.

Table 2: Help-Seeking for All Cases of Ill-health: Ivermectin Sample*

Help-Seeking	Spontaneous Mention		Probed Responses ^a	
	(N=996)		(N=997)	
Self-help ^b	453	45.5%	499	49.9%
Chemist-Drugstore	492	49.4%	655	65.7%
Hospital	175	17.6%	237	23.8%
Traditional Healer	30	3.0%	135	13.5%
Others	10	1.0%	29	2.9%

*‘Ivermectin Sample’ This refers to the data collected in the Enchi District of the Western Region of Ghana in connection with a study of the effect of Ivermectin on the treatment of onchocerciasis.

- a) Where applicable “Probed” responses result from respondents being asked if they have utilised a suggested help-seeking mode. Respondents might affirm with emphasis or deny the suggestion. In the case of spontaneously mentioned responses no suggestions were made to the respondent. The latter set of responses are given more weight.
- b) Self-help includes use of local recipes, herbs, enemas, ointments and some pharmaceuticals. The latter might be borrowed from others, or they might be old medications acquired for some other condition

The local drugstores were mentioned most frequently as facilities where respondents went for help when they were unwell. Next in importance is self-help which exploits local knowledge of treatment, using local and non-local materials. In addition to the open-ended questions respondents were asked if they had used specified modes of help-seeking. The outcome of the question is a 5% jump in the use of self-help. Use of the hospital jumped by 6% while use of drugstore and traditional healers jumped by 16% and 10 % points respectively.

While probes usually help to remind respondents, we do not usually expect wide differences in frequency between spontaneously disclosed information and information obtained through prompting, and when the margins of difference between spontaneously mentioned and affirmations due to probing vary widely between categories, it becomes necessary to explain why this would be so. The implication of such hikes might be that respondents were reticent talking about drugstore use and traditional healing. We may surmise that the ritual associations of traditional practice makes respondents less willing to talk about this mode to interviewers. In the case of the drugstore, its frequent use in the community may explain an inclination in respondents to take it for granted.

It is undeniable that these communities relied more on the drug store than on any other help-seeking mode. Table 3 shows that over half the sample by their admission used the drugstore most often, while just over ten percent preferred or used clinic or hospital services most often. One in ten did not have an opinion on the issue or declined to express a preference. The favourite drugs purchased were painkillers and sedatives which include paracetamol, also referred to as para and Indocin (Indomethecine MSD), also known locally as *akokorabebobol* [lit. “the old one can now play football”]. These drugs are rarely used specifically to treat onchocercal skin conditions or their symptoms. While the biomedical facility runs a distant third, interest in the traditional healing is apparently negligible.

Table 3: Most Frequently Used Mode of Help-Seeking:
According to Ivermectin Sample

Most Used	Frequency	Percent
Self-help	234	23.6%
Chemist-Drugstore	503	50.7%
Hospital	100	10.1%
Traditional Healer	35	3.5%
Others	12	1.2%
None	108	10.9%
Total	992	100.0%

Reasons for Preference for a Particular Mode of Help-Seeking

Respondents were requested to state their preferences and explanations for their preferred help-seeking modes; that is those they maintain they used most often. Reasons for the choices these rural people tended to make range from experience with a particular type of help-seeking to the issue of cost and proximity. Financial and proximity reasons explain why hospitals would not be used frequently because there were none in the immediate vicinity of the villages in question at the time of the research.

Table 4: Reason for Importance of a Help-Seeking Mode
Ivermectin Sample (N=880; multiple mentions permitted)

	Frequency	Percent
Experience	401	45.6%
Financial Cost	293	33.3%
Accessibility	251	28.5%
Reputation	80	9.1%
Referral	21	2.4%
Spiritual power	15	1.7%
Others	28	3.2%
Uncertain	10	1.1%

The distance from Assemkrom, one of the study sites which was also hyper-endemic, to Enchi, the District capital where the only hospital is located, was over 60 kms and vehicular transport was not readily available, except for market days. The road was not good and it took the visit of a head of state for cosmetic repairs to be made on the road. For some Assemkrom people (living in “oversea”, as it was jokingly said), it was better to hazard a canoe crossing of the Tano to reach the Eikwe hospital in the Jomoro District. The Government’s “cash and carry” policy meant that

hospitals charged fees for their services and the medications and this adds to the financial burden of the ill. What is more, as Coleman (1997) illustrates, district level health care services might, in the Ghanaian context, cost the user more than the charges at the Regional hospitals for comparable services

The affected respondents' comments are reproduced below in illustration of their views on the subject.

Cost factors

1. Home remedy. I chose this kind of help because it costs no money and it also relieves me of constipation
2. Drug store alone. Financial problems prevent my visiting the hospital. So I do the next best thing---the drug store

Effectiveness

1. 'I buy it just to relieve my bodily itching'
2. 'Drug Store. When I come back from work, because of pains, I take drugs but with the enema it is occasional'
3. 'Because my condition can be diagnosed better by expert doctor'

Experience

1. 'Local Herbs. I have tried the hospital to no avail. Now I think I should try the herbal recipes too'
2. 'Only the Drug Store. I only know about the "pilis" which, I think are effective for my condition. I have never been to the hospital in my life'
3. 'Hospital. At the hospital I am examined physically'.

Accessibility

1. 'Because of cost and proximity I do buy tablets to treat minor ailments'
2. 'The seller in the chemist shops understands my problem, when I explain to her what [is] worrying me she gives me medicines which give me [some relief]'

Help-Seeking for Onchocercal Skin Disease

To understand why local people might or might not seek treatment for their onchocercal skin lesions, we need to refer to their perceptions of the disease, their awareness of availability of treatment, what they think would be the outcome of treatment or non-treatment, among other things. As Sugar et al. (1994) point out, the factors impinging on care seeking are many and include: "... belief systems and stigma attached to particular symptoms, previous experiences in seeking care in the household and from others, expectations about seriousness and outcome, accessibility of different care providers, and educational and economic levels."These, far from being isolated variables, are related.

On the question of severity over 54 % of the sample of affected people regarded the diseases as severe and it can therefore be expected that half of the affected sample would seek help on this score all things being equal. Nearly nine non-affected persons out of ten also feel that the disease is severe and it can be expected the non-affected people would encourage the affected to seek treatment, if possible. In answer to an open-end question both affected and non-affected alike remarked that the skin conditions in question affected the quality of life.

The appearance of the lesions caused shame to the affected, a view shared by affected and non-affected alike. The affected in particular were worried by the itching which results from the condition. Most affected people thought there was treatment for their condition, even if they did

not always admit to knowing where that treatment is located. There is however, relatively more uncertainty about the availability of treatment for DPGM.

Table 5: Perception of Severity of OSD

Seriousness	Ghanaian Sample**		African Sample***	
	Affected	Non-Affected	Affected	Non-Affected
Not Serious	26.6%	4.3%	18.1%	25.8%
Moderately Serious	18.1%	4.3%	26.8%	12.2%
Very Serious	54.3%	88.8%	58.8%	56.3%
Uncertain	1.1%	2.6%	3.4%	5.6%
Total	94	116	626	655

***'Ghanaian sample' and the Ghanaian Skin Study sample are synonymous and refer to the data collected from Ghanaian respondents to the 1995 multi-country WHO study of onchocercal skin disease.

*** 'African Sample'. This refers to WHO multi-country study of onchocercal skin disease in several Nigerian sites, Cameroon and Uganda in 1995. Ghana was another of the sites but for the purposes of this paper the Ghanaian data have been excluded.

Table 6: Availability of Effective Treatment for OSD
(Perceptions of Affected Ghanaian Skin Study Sample)

LESSON	EFFECTIVE TREATMENT				Total
	Yes	No	Poss	Uncertain	
APOD	8	0	0	2	10
CPOD	31	0	0	2	33
DPGM	18	2	1	7	28
LOD	18	0	1	3	22
Total	75	2	2	14	93

Respondents admitted that they did not all find the various types of help-seeking beneficial that they had used in the past, see Table 7 below. Comparing the responses of affected and non-affected Ghanaian respondents, it turns out that the percentage of the non-affected who were optimistic the lesions would heal with treatment was higher than that of the optimistic affected.

Table 7: Perceived Outcome of OSD Treatment
(The Perceptions of Affected Ghanaian Skin Study Sample)

LESSON	Uncertain	Cure %	Improvement	Total
APOD	2	8 (80.0)	0	19
CPOD	2	31 (91.2)	1	34
DPGM	3	20 (71.4)	5	28
LOD	1	20 (90.9)	1	22
Total	8	79 (80.0)	7	94

The findings suggest a high level of confidence in both categories of respondents, and by implication the communities can be said to hold the view that not only is there effective treatment, people would be cured if they were treated.

The question of what the outcome might be if the conditions in question were not treated was asked both affected and non-affected. Table 8 displays the findings.

Table 8: Perceived Outcome of Treatment of OSD
(The Perception of the Non-Affected Ghanaian Skin Sample)

LESSON	Cure	TREATMENT OUTCOME				Total
		%	Improve	Stable	Worsen	
CPOD	64	95.5	3	0	0	67
DPGM	33	82.5	3	3	1	40
Total	97	90.7	6	3	1	107

Respondents admitted that they did not all find the various types of help-seeking that they had used in the past beneficial, see Table 9 below. While for general help-seeking for all cases of ill-health, as Tables 1 and 2 above reflect, drugstores are most often relied upon, responses for help-seeking specific to onchocercal disease suggest that self-help and home care are more frequently used than drugstores. The reduced importance of drugstores in help-seeking for onchocercal conditions can be attributed to the inability of the affected or their family and associates to determine what pharmaceuticals are efficacious for these conditions. Local people tend to buy their medications across the counter rather than depend on a drugstore keeper who, the community know, has no training for dispensing medications. Thus, the utility of the drugstore declines for those who do not have confidence in the drugseller but could not on the other hand determine what pharmaceuticals would be effective for onchocercal skin conditions. Respondents were however most satisfied with bio-medical health care although just over 27% had used this facility in the past for treatment of onchocercal skin disease.

In Table 9, Figures for "Usefulness" are weighted: "yes" scores 3, "mixed possible" scores 1 and zero for "uncertain" and a "no" response. The percentage score is based on the maximum (i.e. all cases saying "yes" and scoring 3 for usefulness).

Table 9: Probed Help-Seeking and Usefulness
(Views of Affected Ghanaian Skin Study Sample)

TYPE	USED		USEFULNESS	
	Freq	PCT	Freq	PCT
Self	45	47.9	53	39.3
Home	22	23.4	20	30.3
Friends & Relatives	4	4.3	6	50.0
Chemists etc	16	17.0	21	46.7
Bio-Medical	26	27.7	54	72.0
Trad Healer	5	5.3	4	33.3
Faith-Healer	1	1.1	1	33.3

Clearly, affected people would have liked to go to the hospitals for treatment but they cannot get to them, and this is for a variety of reasons, some of which have already been discussed above.

Coping Strategies

The affected in the communities studied did not seem to hold on to a common cause for their onchocercal conditions. They advanced diverse causes ranging from germs in the body or blood, drinking unwholesome river water, contact with affected persons, insect bites, particularly the blackfly which in Brussa and Twi is referred to as *ndumoa* literally, "blackfly" or *nkontea*. Those who thought it was the blackfly remarked that its bite induced a rash and itching. Surprisingly, only one person advanced supernatural causes as explanation of onchocercal conditions. The views of the non-affected are not too different. 42.2% of them blamed the river water, 21.6% blamed the problem on blood related disease and 19.8% thought it was due to insect bites. Though the majority do not have suggestions for the prevention of the disease, of those who made suggestions 32.7% think people should stop drinking the river water, 10.2% advise against intimate contact with the affected, 8.2% advise the wearing of appropriate clothing to the bush. It does not therefore come as a surprise that coping strategies were concerned more with practical action than the application of spiritual means for help seeking.

From the open-ended questions that generated the responses on symptoms we also noticed some respondents talk about the ways in which they coped with their onchocercal disease problems. These coping strategies can be paraphrased in the form of dos and don'ts as we have done below. The following remark by a 34 year old respondent with LOD illustrates some of the ways in which affected people coped with the condition.

The condition itches very much and it becomes very serious when I am beaten by rain. At times it becomes so serious that I have to suspend it (the affected part) on fire to reduce the itching. I scratch it a lot. I also use (*mefe*) *abesentrew* to cover it to reduce the itchy sensation.

Below are a variety of coping means that individuals have devised for themselves; some of these such as scratching with a rough object or exposing the itchy part of the body to a hot object come almost by instinct.

Use *Alata Samina* (local soap)

It only itches me. When I bathe with *Alata Samina*...it stops itching [CPOD: male, 39]

Apply *Gin and Corn Dough Mixture*

To soothe it (i.e. the itch), I would mix corn dough and *akpeteshie* (local gin) and apply to the affected area. I feel a little relief when I apply this..[CPOD: female, 50]

Drink *Local Gin*

I had to take in large quantities of local gin *Akpeteshie* before I would get some relief. [CPOD male, 37]

Buy *Ampicillin From Drug Store*

It itches me sometimes and .. I go to the local drug store to buy ampicillin which reduces the itching a bit [CPOD: female, 23]

I then had to resort to using ampicillin and tetracycline capsules mixed with palm kernel oil to apply to the legs. It was this which finally cured the condition somewhat [DPGM: male, 30]

Anytime I walk in the sun and later go home, I will scratch my body all the time [CPOD: female, 16]

Apply *Liniment*

I apply some liniment on such occasions and it then stops. But it recurs every now and then. [LOD: male, 23]

Use A Cutting Tool

The condition itches a lot and I am usually compelled to scratch. I even go to the extent of using a knife to scratch myself in the hope of finding relief to the itching [LOD: female, 45]

When my body begins to itch, I have to stop work and scratch it with either a cutlass or whatever I find (handy).[CPOD: male, 71]

Table 10: Suggestions for Prevention of Onchocercal Skin Disease
(All Samples from Ghanaian Skin Study Sites)*

Preventive	Affected		Non-affected		Total	
	Freq	Pct	Freq	Pct	Freq	Pct
Treat affected bio-medically	27	24.5%	26	20.6%	53	22.5%
Ensure domestic water is good	15	13.6%	35	27.8%	50	21.2%
Maintain good hygiene	13	11.8%	26	20.6%	39	16.5%
Doctors should recommend	10	9.1%	1	0.8%	11	4.7%
Prayers and rituals	5	4.5%	1	0.8%	6	2.5%
Not a disease, no preventive	4	3.6%	0	0.0%	4	1.7%
Wear protective clothing	3	2.7%	7	5.6%	10	4.2%
Spray and eradicate vector	3	2.7%	4	3.2%	7	2.9%
Mass treatment of communities	3	2.7%	4	3.2%	7	2.9%
Investigate causes	1	0.9%	4	3.2%	5	2.1%
Community preventives	2	1.8%	3	2.4%	5	2.1%
Don't know	23	20.9%	9	7.1%	32	13.6%
Others	1	0.9%	6	4.8%	7	2.9%
Total	110	100.00%	126	100.00%	236	100.00%

* Some respondents suggested more than one mode of prevention

Prevention of Disease

Associated with what people do to cope with the disease are their ideas on the prevention of the disease. Such ideas illustrate aspects of globalisation and the eclecticism that prevails in the management of health and illness.

Responses such as those on which the table below is based show that in these remote communities can be found knowledgeable people conversant with modern, western approaches living side by side with people whose ways are still influenced by traditional modes of the health-seeking and prevention of illness. While there were those who advocated the use of traditional modes including the application of prayer and ritual therapies of the *memome* type that Ebin (1994) discusses, there were also people who called for biomedical intervention, the use of insecticides and even mass spaying of the affected areas.

Discussion

Onchocerciasis takes a considerable toll on the quality of life of the affected people in the communities studied. It is perceived as a disease by most people, even if there is no agreement on what local terms to use in the designation of the disease. Severe cases generate stigma for the affected as they cannot expose those parts of the body where the lesions are located.

Nevertheless, there is sometimes the need to expose the body, especially when the tropical weather and excess humidity make it feel sticky and people perspire profusely. Because they resemble measles, the papular conditions are also dreaded. There was fear that these conditions might be a source of contagion. There is a perceived association between itching and onchocerciasis disease, indeed the itch is perhaps the most dreaded aspect of the disease. People suggested that when the itching of the eyes becomes chronic blindness can ultimately result.

One of the down sides of globalisation, paradoxically, is inequality. Inequalities exist between the so called "developed" Northern countries and the "developing" South states, between the deprived rural community and the relatively better off urban center in Ghana and in the case of health issues, this means inequalities also in the access to health care. While, as Coleman (1997) argues, biomedical healthcare is relatively cheaper in the urban areas than in the rural areas, rural incomes remain much lower than urban incomes. This has repercussions for the treatment of onchocerciasis and its control in the endemic communities.

People generally see the need to treat most onchocercal skin conditions. Choices and options are available to the affected. Effective choice is based on knowledge, perceived efficacy, consultation with others, personal experience, location of facility, cost effectiveness of seeking help from a particular facility. Biomedical facilities are generally favoured but they are not always seen to be cost effective. The only hospital in the area is remote and at the time of the study only one doctor was at post. The hospital did not have ivermectin at the time of the study and none was distributed as a means of mass treatment of endemic communities until after the study. The "overseas" areas are unlikely to obtain regular mass treatment, as is required if the disease is to be controlled, until health staff are equipped and motivated to visit these areas. For the mass treatment to be effective, all members of the endemic communities above five years should be treated by annual doses for at least twelve or so years. If mass treatment cannot be sustained for so long and if communities cannot be persuaded to continue with the treatment, perhaps because of initial side effects of the drug, then the programme may not yield the expected results and the disease could remain in the endemic communities. Fortunately, studies show that mass treatment with ivermectin could work through a community directed distribution approach and this could be the way out for the so called "overseas" communities; however the medical authorities will have to enhance the programme if this approach is to work.

On a general note, it should be pointed out that the poor state of intra-district roads-- most were unmotorable and excessive rainfall made road maintenance difficult--meant that villagers in the highly endemic communities had to walk the distance to Enchi, the district headquarters, or hire a taxi for the visit. As they presented the condition they paid the hospital fees for any drugs dispensed. More often the doctor prescribed drugs to be purchased from the drugstore or pharmacy. This suggests problems of accessibility and finance for seeking general biomedical health care. If hospitals are inaccessible or unaffordable, then drugstores will come in handy. In the case of onchocerciasis, some of those who presented their case at the hospital said they obtained only a temporary relief but no cure and the itching did not really stop. Drugstores were however more accessible and each sizable village community had its drugstore. The keeper was often a local person who was prepared to sell drugs across the counter without question. He filled out whatever prescriptions were presented, he gave advice to clients also. He understood his people and to those asking for credit he gave drugs out on credit. Moreover, the drugstore was perceived as an extension to the hospital and the drugstore keeper was often addressed as 'doctor'. It seemed to make sense that village people would find the drugstore cost-effective. It is nearer, there is less waste of time, some of the medications that the doctor prescribed were known to be available at the drugstore. If you know from experience that the doctor usually prescribes a certain drug, or have been advised that a certain drug is effective, then why would

you not go to the drugstore? The latter has virtually no opening and closing hours which means that a busy farmer can go to the drugstore and yet not miss farm work, or else go to the farm first and in the evening visit the drugstore. The keeper moreover is more friendly and less officious.

Home remedies recommend themselves for the treatment of onchocercal skin diseases. People have learnt to cope in various ways. There seems to be a stock of local knowledge that people depend on for seeking help. Herbs of various kinds are used. Eventually, people have adopted more eclectic ways which permit the combination of pharmaceuticals.

The causes of the disease were not generally known to the people. There was a vague perception that insect bites were responsible. The environment spawns many varieties of insects whose bite is irritating. For some people, disease prevention should take the form of wearing clothing that would cover the body and prevent insect bites. A few people who appear to know about the larviidal programmes of the Onchocerciasis Control Programme in the lower Volta zone suggested that the offending insects be removed through mass spraying. For those who associated the disease with water, due perhaps to the popularity of the term "river blindness", the water supply ought to be improved. People should not wade in the rivers (which is hard for a person who lives by winning sand from the river bed), and should not drink river water.

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Notes

¹ See Pearson et al. (1985), Brieger et al. (1986; 1987), Amazigo (1994), Ovuga (1995), Awedoba (1997) and Johnson et al. (1994).

² Brussa and Akan belong to this group of languages.