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Of 'prostitutes' and 'AIDS people': Feminization of HIV and AIDS in South-eastern Ghana

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Abstract

In sub-Saharan Africa, more women than men live with HIV and women bear the largest proportion of the burden of care that is due to the epidemic. Only a few studies have documented the precise details of how women in countries with low HIV prevalence became the worst affected by the epidemic. In Ghana, the historical factors that account for high HIV infections among women and the emergence of women-led community-based HIV interventions have been less researched. This paper examines the historical (political-economic), cultural and personal factors that account for the high HIV prevalence in Manya Klo, the area worst impacted by HIV in Ghana. The paper presents the social history of the pandemic in Manya Klo and explains why Klo women are considered to be the sources of HIV in Ghana. It suggests that concentrating interventions on women helps to reduce the impact of HIV and inform national interventions. Women-focused interventions may, however, alienate other groups that can contribute to improving the lives of families affected by HIV. Therefore, women-focused interventions must be planned in a manner that engages multiple stakeholders.

Key words: Manya Krobo, queen mothers, female migration, female sex work, orphans and vulnerable children, community-based HIV initiatives

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Résumé

En Afrique au Sud du Sahara, plus de femmes que d'hommes vivent avec le VIH et les femmes portent la plus grande partie du fardeau causé par l'épidémie. Seules quelques études ont pu démontrer en détails comment les femmes des pays à faible prévalence du VIH sont devenues les plus touchées par l'épidémie. Au Ghana, les facteurs historiques à l'origine des fortes infections du VIH parmi les femmes et l'émergence de groupes communautaires de femmes liés à la sensibilisation du virus ont été moins étudiés. Cet article examine les facteurs historiques, culturels et personnels responsables de la forte prévalence du VIH dans Manya Klo, la zone du Ghana où le VIH est le plus présent. Il cerne le contexte social de la pandémie dans la région de Manya Klo et explique pourquoi ces femmes sont considérées comme sources du VIH au Ghana. Il y est suggéré que concentrer les interventions sur les femmes aide à réduire l'impact du VIH et à informer les actions de sensibilisation et de prévention nationales. Les interventions axées sur les femmes peuvent, toutefois, aliéner d'autres groupes qui pourraient contribuer à améliorer la vie des familles touchées par le virus. En conséquence, ces interventions doivent être planifiées de manière à mobiliser de nombreuses parties prenantes.

The problem: women and HIV/AIDS in sub-Saharan Africa

The HIV/AIDS epidemic in sub-Saharan Africa is 'feminized' (Telfer 2004: 247-8; Budowski and Guzman 1998; see Chant 2003) because women are disproportionately infected by HIV and also bear a larger responsibility for dealing with its devastating social, economic and psychological consequences (Karim and Karim 2008; UNAIDS 2005a). More than half of the 35 million people living with HIV (PLHIV) globally are females and 75% of HIV positive women in the world live in sub-Saharan Africa (UNAIDS 2015). Women foster about 80% of over 14 million AIDS-related orphans in sub-Saharan Africa and provide for family members with AIDS (UNAIDS 2010; see Howard et al. 2006).

HIV statistics show women are saddled by the epidemic. The statistics, however, reveal little about the exact circumstances through which women in any specific socio-cultural context become carriers of the virus and the bearers of its associated burdens. Also, HIV studies provide fewer details about the historical and cultural factors that make women in some cultural settings more exposed to HIV.

Significant investments in technology, education, social protection, communications for behaviour change and targeting vulnerable populations in the last three decades have helped to save and improve the lives of PLHIV. Sharing best practices and scaling up effective interventions have also been important to this work. Global researchers and practitioners continue to search for effective interventions, as well as create understanding between what people assume the AIDS experience is like and what people who live with HIV and or its impact really experience (Kerouedan 2010). Challenges, however, remain because most PLHIV are women who are also poor and very vulnerable. Women are still considered to be 'vectors,' 'sources' and 'reservoirs' of HIV (Richter 2013).

Developing effective interventions, however, depends on fully understanding women's experiences within their communities, and the communities themselves. Researchers must identify and analyse factors contributing to HIV prevalence in women in particular communities, which is vital to prevent new infections or reduce their impact (World Bank 2008). As well, researchers still must examine the likely consequences of the feminized pandemic and how to alleviate its associated tragedies.

Evidence suggests HIV interventions are more effective if they make women's well-being the central focus and are based on the lived experiences of women, especially those who are more susceptible to the virus. Understanding the historical and cultural context of their struggles to survive and their vulnerability to the epidemic will help to prevent new infections and inform other interventions. Also, beneficiary communities must be empowered to participate in planning and advocating for HIV and not merely become

implementers of programs planned by external agencies and based on external assumptions (UNICEF 2013).

In West Africa, migrant female sex workers (FSWs), that is, women who provide sexual services in exchange for money, goods or other benefits, have been blamed for the spread of HIV (GAC 2012). In Ghana, there is a paucity of data on why Ghanaian migrant FSWs are associated with the emergence and spread of the virus. The lack of data is because studies on FSWs focus on prostitution and trafficking as moral and or criminal phenomena and not as issues that affect the survival of women (Agustin 2006).

In Ghana, the women of the Krobo Traditional Areas, comprising Manya Klo and Yilo Klo, are generally considered to be 'the face of HIV/AIDS' because they are the worst hit by the pandemic. Unfortunately, very little is known about the historical, economic and social factors that led to the high HIV prevalence and its devastating impact on the society. Similarly, interventions by women to mitigate the impact of the pandemic have received little attention from researchers. Some have suggested that the reason for Ghanaian women's migration is "shrouded in mystery" and hard to uncover (M4DCoP 2014).

Study purpose.

This paper fills a critical gap in the knowledge on HIV in Ghana. It describes the political, economic, social and personal factors that account for the perception that Klo women of the Krobo Traditional Areas are the sources of HIV in Ghana. The paper examines the factors that account for the very high HIV prevalence, analyses its impact and the extent to which interventions by women have helped to mitigate its devastating impact. Finally, it summarises lessons learned from the community and how those lessons inform HIV interventions in Ghana and beyond.

The focus on Manya Klo is very appropriate because the feminized pandemic in that community shows the variations in HIV prevalence in Ghana

and also mirrors the larger data for high HIV-prevalence areas in sub-Saharan Africa. Knowledge of the history of the pandemic and the experiences of female interventionists from Manya Klo could inform current and future research and interventions. In particular, such knowledge will improve interventions that empower women and strengthen their cooperation with their male counterparts.

Data sources

This paper is based on over a decade's lived experience in Manya and Yilo Klo. During this period, the author worked on HIV-related programs in different capacities. The roles include: as part of a team that implemented one of the first comprehensive HIV treatment, care and support program in sub-Saharan Africa; contributed to the development of the national HIV/AIDS strategy and the national HIV/AIDS monitoring and evaluation framework; conducted qualitative research and surveys on the pandemic; evaluated the quality of HIV-related services (results of the evaluation informed the planning and delivery of behavioural change programs and clinical services); advised traditional leaders, NGOs, academics, health workers and CBOs on HIV-related projects and research; trained health and social/community workers on HIV-related stigma and discrimination, and conducted a doctoral fieldwork that focused on HIV-related orphanhood. Mixed methods (participant observation, focus group discussions, semi-structured interviews, key informant interviews and surveys) were used to collect the data. A review of secondary data sources was conducted to identify and clarify gaps in feminization of HIV in Ghana.

The feminized social epidemiological context of HIV in Ghana and Manya Klo

Manya Klo is in the Eastern region of south-eastern Ghana, about 80

kilometres north-east of Accra, the national capital. It comprises the Lower Manya Krobo Municipality ('Lower Manya') and Upper Manya Krobo district ('Upper Manya') with a combined population of 161,318 (GSS 2012). Researchers and state officials refer to Klo people (Manya and their Yilo neighbours, population 87,847) as *Krobos* and their land as *Krobo*. The people, however, refer to themselves as *Kloli* (singular *Klono*) and to their land as Klo. In this paper, Manya Klo refers to Lower Manya and Upper Manya Klo and Klo refers to Manya and Yilo Klo.

Ghanaians perceive Klo women as 'importers' of HIV to Ghana from the Ivory Coast. The first case of HIV was recorded in Ghana in 1986 and the first HIV sentinel surveillance (HSS), based on pregnant women attending antenatal clinics, was conducted in 1992. In 2001, HIV prevalence in Manya Klo was between 14% and 18% (Bosu and Dzokoto 2001). Although prevalence declined to 7.8% in 2010, it increased to 11.6% in 2014, against a national prevalence of 1.3% (GAC 2014). In fact, Manya Klo has recorded the highest HIV prevalence in 19 out of 22 HSS.

In 2013, 57.5% of all PLHIV in Ghana were women and 42.5% were men (GAC 2014). Although knowledge of HIV in Ghana is "almost universal", 98% among women and 99% among men, women are more at risk for contracting HIV. Women are more likely to engage in higher-risk sexual intercourse, that is, with a non-marital, non-cohabiting partner. In 2008, 23% of women and 42% of men engaged in higher-risk sex, and only 25% of women and 45% of men used a condom during their last higher-risk sexual intercourse. Overall, men have more lifetime sexual partners (five) than women (two) (GSS, GHS and Macro 2009). Regarding FSWs, over 25% reported having sex without a condom, but under coercion from their partners (GAC 2012). Fifty percent of FSWs in a study said they either did not use condom or did not use it consistently with their clients (Adu-Oppong et al. 2007).

The above statistics highlight the factors (biological, power, gender and poverty) that increase women's vulnerability to HIV and also explain why

almost a third of new HIV infections are directly attributed to FSWs (GAC 2012). For example, low condom use among FSWs is due to poverty, lack of empowerment to negotiate condom use with clients, lack of access to free condoms, and lack of education on HIV prevention. Only 14% of FSWs received education on condom use (Adu-Oppong et al. 2007; see Asamoah-Adu et al. 1994).

Women are more vulnerable even where treatment and support exist. In 2011, an estimated 74% of HIV-positive pregnant women received antiretroviral treatment (ART) to prevent the transmission of HIV to their children. Also, although there were twice as many females (42,764) as men (19,178) on ART, more women (52.7%) died of AIDS (2006-2011) than men 47.3% (GAC 2012).

Data on Lower Manya suggest more women than men are living with HIV in Manya Klo. Of all those who tested positive for HIV in 2011, 65.5% were women and 34.5% were men (LMK-DHMT 2012). AIDS was the fifth leading cause (3%) of hospital bed occupancy, and the leading cause (26.7%) of all deaths (LMK-DHMT 2010). Of the 220 AIDS-related deaths recorded in 2011, more than two-thirds (67.3%) were women and 32.7% men (LMK-DHMT 2012). Aside from being disproportionately infected by HIV, Klo women also support their HIV-infected relatives and a high number of orphans.

In the view of most Ghanaians, the HIV/AIDS statistics confirm what is already well-known, which is, 'Klo women brought AIDS to Ghana'. The next sections of the paper examine the historical, cultural and personal factors that may account for the high HIV prevalence in Klo and interventions to reduce its impact.

Factors leading to the predominance of women in HIV and AIDS

A. *Weak political economy, cultural obligations and personal aspirations*

Women have always used migration as a survival strategy, that is, to search for a better life. However, migration studies focus on "mainstream-malestream" mobility of men and ignore the mobility of women (Morokvasic 2010: 25; Caritas 2011). Researchers in Ghana are beginning to study women's migration, but these researchers highlight the negative impact of women's migration (Pickbourn 2011). For example, researchers have identified a negative link between the migration of Klo women to the Ivory Coast, women's participation in sex work and the emergence and spread of HIV in Ghana (Anarfi 2005; Ampofo 2001; Anarfi, Appiah and Awusabo-Asare 1997). The migration of Klo women must be analysed within the larger context of Ghana's political-economy.

The political-economic development of Ghana in the post-independence era contributed to the migration of Klo women. The construction of the Akosombo hydroelectric dam in the 1960s created the Volta Lake, which is 4% (8500 square kilometres) of Ghana's total land area and the largest man-made lake in the world. The dam constituted a brutal assault on the socio-economic lives of Kloli and other riverine communities. The dam alienated the people, mostly farmers, from their sources of livelihoods. Eighty thousand people in 52 communities were relocated, fertile farm land was lost, and the government's resettlement scheme failed to shield the victims of the dam construction from the consequences of the relocation. The people could not afford mechanized agriculture, which replaced the traditional farming methods (Amanor 2006). Mechanized large-scale farming was possible with government support, but after the overthrow in 1966 of President Kwame Nkrumah, no other government supported mechanized farming by the resettled populations. Apart from not being adequately compensated, the resettled populations did not have the technical skills to take up employment in the new industrialized economy (Tamakloe 1994; Lassailly-Jacob 1996).

The loss of land and its impact on livelihoods needs to be examined more closely to understand fully its ramifications on contemporary Manya Klo in general and women's survival in particular. According to Field, Kloli believe

land is the most valuable property a man could invest in and pass on to his children. Consequently, they invested their capital in acquiring fertile lands from their Akan neighbours, especially from the late nineteenth century. Land, to them, was life and the loss of land led to suicides. Farming on these lands was so successful that the three major food markets in Klo provided food to half of the non-agricultural population of the country. Women became rich through processing and marketing farm produce (Field 1943). In addition to food farming, they were also successful in cultivating oil palm and cocoa for export (Amanor 2006: 5; see Wilson 1991). Due to their massive wealth, Field described Kloli as: "The ascendant people…at the beginning of their history," and predicted that Kloli would be the owners and users of most of the agricultural land of [Ghana] (Field 1943: 64). Land loss, therefore, signified loss of livelihoods, loss of wealth accumulated over generations, and the impetus for development, with very few alternatives for survival (Goody [1976] 1993: 4-8).

Others suggest women were forced to migrate because, compared to men, women were worse impacted by the loss of land. According to Amanor (2001) women grew poorer due to their lack of rights to land. Inheritance of land was gendered and land was passed on to males, even when there were older female children (Amanor 2001: 20). This gender bias worsened the weak socio-economic status of women and pushed them to search for the better life away from home (Ampofo 2001). Historical records and evidence from in-depth interviews with traditional female and male leaders attest to the industriousness and success of Klo women. Very little of this success is due to women's direct title to land. Women's economic production was tied to food processing and marketing (Field 1941; Steegstra 2005: 102-105) and not because they owned the land on which they worked.

As indicated above, men appeared to be worse affected by the loss of land. In the patrilineal Klo society, it is men who 'move out' in order to provide for their families. Women 'take care of the home'. The loss of land meant men lost their wealth and power as providers and controllers of the means of production.

Above and beyond this, men were alienated from the new industrial economy due to their lack of technical skills to find employment in the new industries. Under these circumstances, the propensity to migrate and actually migrating would have been greater for men than for women.

Although men migrated during the period of economic hardship, researchers have not examined the possible linkages between the lack of economic opportunities for men, male migration and the emergence of HIV in Ghana. The silence on the migration of Klo men ignores men's role in the spread of HIV. Klo men migrated mostly to Nigeria. Informants suggest that even though fewer men than women migrated, some male returnees had HIV. A 70 year old man described how his three "hard working sons" who went to Nigeria "came back to die" of AIDS and left behind their children.

Loss of livelihoods exacerbated economic hardships. The success of industrialization that followed the construction of the dam was short-lived and economic growth slowed down dramatically. The collapsed economy worsened the living conditions in the resettlement towns (Tamakloe 1994). The stagnant economy of Akuse, an inland port and a vibrant commercial town that served as the district headquarters of multi-national trading companies such as the United Africa Company, CFAO, and G.B. Olivant, provides insight into the collapse of the local economy. Between 1970 and 2000, the population of Akuse increased by less than 1% due to emigration and the lack of opportunities for economic growth (GSS 2005). Meanwhile, the national population increased by 2.4% between 1960 and 1970 and 2.7% between 1984 and 2000 (GSS, GHS and Macro 2009). The local problems were worsened by a very weak national economy, which resulted in the adoption of structural adjustment programmes in the 1980s. The programmes led to job losses, wage cuts, reduced access to schooling, health, and social services, food insecurity, and the collapse of rural economies due to non-availability of subsidies to agricultural inputs (Mikell 1995: 7).

The changes in economic fortunes had negative impacts on the social organizations of kin groups, especially in the way that kin groups maintained

their livelihoods and survival. It also reduced the capacity of kinfolks to support each other. Nonetheless, economic factors alone cannot explain the large-scale migration of Klo women. To understand more fully why more women migrated, there is the need to examine certain aspects of the socialization of Klo girls.

Klo girls are trained from a very early age to become successful traders. They are taught to trade, make money and invest their profits in a manner akin to the protestant ethic (cf. Weber 1958). The goal of this training is for girls to become economically independent and less dependent on their male counterparts. It is very dignifying for successful women to support their relatives and be important insurance to older people. Consequently, women feel obligated to provide for their relatives. The pursuit of the status of ideal Klo woman as an active agent of economic independence and social change increased the pressure on young women to seek economic success. Since women lack formal education as a means of upward social mobility, they honour their familial responsibilities as a means to gaining prestige and respect among their people (cf. Little 1972). The need for personal success and social recognition compelled some Klo women to migrate in search of material wealth.

B. *Supportive environment, social networks and migration of young women*

As the Klo economy weakened, the migrants and expatriate (Americans, Italians and others) moved out. Local workers went to emerging cities to seek better living conditions. By the early 1970s, young women were migrating to other West African countries with booming economies to seek better economic fortunes. The majority of them went to the Ivory Coast. Young women, including FSWs also migrated because the economy that supported sex work had weakened. Some of the women migrated in order to seek refuge from undesirable marriages or were indebted from their businesses (Sauvé et al. 2002; Ampofo 2001).

In contrast to the harsh conditions in Klo, young women were attracted by certain conditions and economic opportunities in the Ivory Coast. Economic migration empowers women with self-esteem, economic independence, exposure to new ideas and lifestyles that enhance their social and political participation in their community of origin. Generally, Ghanaian female migrants invest in their families through petty trading and informal businesses that enable them to contribute to the wellbeing of their relatives (Caritas 2011). They also invest in children's education (Pickbourn 2011). In Manya Klo, women who migrated to the Ivory Coast were regarded as hardworking, economically successful and role models. They were sources of pride. They remitted money to their families, invested in businesses, and employed their relatives and neighbours. When they visited Manya Klo, mostly during festive occasions, they brought lots of material possessions especially wax prints (textiles), jewellery, and money. Fashionable clothes were symbols of female economic independence, and the collection of wax prints was evidence of wealth (Gott 2009). Young women joined the Abidjan bandwagon because they too wanted material things and, more importantly, to honour their obligations towards their families and become ideal Klo women. One female returnee explained the pressure she felt to provide for her family:

> We were aware of the [living] conditions back home. We had our own problems. We have to have money otherwise children would not go to school and the old people would have no support. It was better to go out, work and send money home, than to sit here with your empty hands. What would we be doing here? There is no shame in helping your own family. Every woman works hard to help her family, so why wouldn't I help my family? (Personal interview)

In addition to economic opportunities, political stability, easy integration of immigrants into Ivorian society and anonymity of FSW environment made the Ivory Coast the most popular destination in West Africa. In Klo, sexual relations are governed by very strict social norms. There are many taboos surrounding sex outside of marriage. Hence sex work is a highly stigmatized

venture. FSWs risked societal ridicule, rejection, and other forms of negative sanctions. For example, it would be almost impossible for a known sex worker to be married (Ampofo 2001). Therefore, for FSWs, work was 'safer' outside of their hometown. In the Ivory Coast, it was possible for Ghanaian women to engage in sex work and remain 'unknown'. Furthermore, sex work was more profitable in the Ivory Coast than in Ghana (Anarfi 2005).

Also, Ghana and the Ivory Coast have two different legal frameworks in relation to sex work. In Ghana, sex work and sex work-related activities, such as soliciting, facilitating or living off the earnings of sex work, are illegal. In the Ivory Coast, sex work is not criminalized, but procuring and soliciting sex in public places are illegal (Ngugi et. al. 2012). This means that the legal environment in Ivory Coast was more conducive for sex work than that of Ghana.

Female migrants are likely to feel isolated due to separation from their families and partners. They are also more likely to be exploited due to the lack of social support network, income insecurity, linguistic differences and power imbalances between them as jobseekers and their employers (Sojourner Project 2011). Klo women in the Ivory Coast were even more vulnerable because they lacked the practical, linguistic (French) and literacy skills to earn a living in the formal Ivorian economy. This means that even though women were motivated to migrate, potential migrants required special assistance to travel.

Ghanaian migrants in the Ivory Coast form a close-knit group that facilitated the migration of Ghanaian women to that country. There were also ethnic-based associations and networks through which immigrants of the same ethnic background received additional support that helped new migrants to settle in their new country. Kloli maintain very strong ties with their people, no matter how far away they are from home (Field 1943: 62). Even when they migrate, their hometown remains a central feature of how they organize their lives, including honouring their responsibilities in their places of origin (cf. Middleton 1979). As migrants, they constituted themselves into strong economic groups that supported each other (Hill 1997). This means there were

strong links between the Klo ethnic groups in the Ivory Coast and kin groups in Klo.

In addition to national and ethnic groups, there were occupation-based associations, such as the sex workers association, that provided assistance to enable FSWs deal with their vulnerabilities as migrant FSWs (Little 1972: 284-286). As the Klo population in the Ivory Coast grew and became more established, the ethnic and non-kin networks facilitated the recruitment and introduction of the new relatives into sex work as a means to survival (Sauvé et al. 2002; see Anarfi and Awusabo-Asare 1993; Anarfi 1993).

There were networks in Klo that were functionally similar and also closely linked to networks in the Ivory Coast. Oral accounts suggest the majority of Klo women were transported to the Ivory Coast through a network of locally based drivers who plied the Ghana-Ivory Coast routes, initially at 'no cost'. The 'special transportation arrangements' were brokered between drivers and relatives in the Ivory Coast. Terms of the arrangements varied, but they invariably turned the new recruits into *bagasi*, that is, 'baggage' or 'properties' of these transporters. This pimp-like arrangement made new recruits debtors to their sponsors. New girls were entrapped in a complicated and sometimes violent circumstance. They had to survive on their own, with *bagasi* debts to settle, as well as remit money to their families back home.

Not all Klo women migrated with the intent to engage in sex work. According to the queen mothers (traditional female leaders) (also see Wilson and Bartels 2003: 16) some of the migrant women were bead traders. Some traders on their return to Klo were accompanied by their female friends and relatives, some of whom might have engaged in sex trade in times of economic hardship. The journey to the Ivory Coast and the behavioural choices made thereafter were not without consequences.

Ghanaian migrants in the Ivory Coast mostly inhabited the southern-eastern part of that country that includes the capital Abidjan. This area is a popular destination for Ivorian and other West African nationals because of its wealth, which comes from mostly cocoa and coffee production. The wealth of the

inhabitants supported lifestyles such as men having multiple wives, concubines as well as patronising sex workers. The wealth and lifestyle increased the residents' susceptibility to HIV (Maiga 2007). This region has the highest HIV prevalence in the Ivory Coast (Côte d' Ivoire 2014).

C. *Klo women and HIV in Ghana*

The link between the migration of Klo women and HIV is based on a combination of HIV facts, anecdotal evidence and misperceptions about FSWs. By the end of the 1980s, half of all the FSWs in the Ivory Coast were migrants from Ghana, the majority with Klo background (Oppong and Kalipeni 1996: 104-105). This is significant because the environment of sex work has elements such as multiple sexual partners, violence, unsafe sexual practices, drug use and sexually transmitted infections (STIs) all of which increase susceptibility to HIV infections. Although this does not necessarily mean that FSWs were responsible for spreading the virus (Richter 2013), in Ghana, migrant FSWs from Klo are perceived to be the source of HIV.

FSWs and their clients have a high prevalence of HIV and STIs and therefore constitute a core group in the spread of HIV and other STIs compared to the general population (Prüss-Ustün et al. 2013; Vuylsteke et al. 2012). FSWs in the Ivory Coast have the highest HIV prevalence in West Africa. HIV prevalence in FSWs at an Abidjan clinic was 89% in 1992 and 33% in 1998 (Ghys et al. 2002). Other estimates include 38% to 80% prevalence from 1986 to 1994 (Vuylsteke et al. 2001), 26.6% in 2001 (UNAIDS 2002) and 28.6% in 2010 (UNAIDS 2011). The male-female HIV infection ratio in the general population in the mid-1990s was 1:5 (Oppong and Kalipeni 1996).

Across West Africa, there is a very high HIV prevalence among women with a history of travelling to Ivory Coast. Hence the perception that Ivory Coast been-to spread HIV. In Niamey, the capital of Niger, 70% HIV prevalence was recorded among women with a history of migrating to Ivory Coast. HIV prevalence in FSWs in Togo is between 13.1% and 29.5% (Pitché

et al. 2014). In Ghana, the first case of HIV was found in FSWs who had returned from the Ivory Coast. Analyses of HIV infection trends in Ghana suggest the majority of the early PLHIV were predominantly female Klo returnees. It is widely believed that Klo returnees brought HIV into Ghana; new HIV infections spread through the returnees and their local partners to the rest of the country (GAC 2012). This perception is based on the assumption that FSWs and their clients are the most likely to be infected with and spread HIV (GAC 2010).

The impact of HIV/AIDS is most severe among Klo women with a history of travelling to the Ivory Coast. In a survey in Manya Klo, Atobrah (2004) found over 80% of all deceased mothers of orphans migrated for economic reasons. Nearly two-third (63%) migrated to Abidjan and 5% to Nigeria. About 13% migrated to commercial and mining towns in Ghana that are also associated with FSWs and high HIV prevalence. Only 17% of deceased mothers never migrated (2004: 73). In the view of Ghanaians, these statistics and the general impact of HIV on Manya Klo are evidence that Klo women brought HIV in to Ghana.

The crisis unfolds: HIV, women, and the image of a society

By the mid-1980s, migrating to the Ivory Coast was unattractive to young Klo women. Families were dealing with the calamitous repercussions of the migration of their kinswomen and men. The returnees, mostly women 'returned home to die'. Some women did not return because *a be hewami kolaa* (they were very sick), *a be sika* (they had no money) and *a hɛmi pue si* (they were ashamed). Those who did not return 'posted' their children to their families; they put their children on buses and gave them directions to 'go home'. The children travelled all by themselves or under the guidance of drivers or adult returnees to trace unknown relatives. Some of the returnees were pregnant. Very little is known about the fathers of most of these children.

The impact of AIDS on Manya Klo is not only the deaths of the socially and economically productive population, and the growing numbers of orphans. HIV tainted the image of Klo and Kloli. Klo lost much of its pride and popularity among Ghanaians. The area was known for its industrious farmers and traders (Field 1943; Amanor 2006), the *dipo* initiation rituals for girls, food markets, legendary mountains and scenic beauty. Klo has for centuries played a significant role in the West African and global trade in beads as the sole supplier of the unique beads made from powdered glass (Wilson and Bartels 2003). By the mid-1990s, Klo was a highly stigmatized geo-political entity due to high HIV prevalence and rampant deaths of young people. The image of Klo women was tarnished as conversations about HIV in Ghana centred on Klo women. Klo became synonymous with very beautiful, but promiscuous women who are literally produced for the sex industry (Drah 2003; Steegstra 2005: 6). One queen mother described the challenge of being a Klo woman and a traditional leader at the peak of the pandemic:

> It was hard to come out and say I am a Klo woman, let alone claim to be a queen mother. You could not let other people know that you are from Klo. They looked at you in a way…. And the comments they make about Klo people in general. They think all Klo women are prostitutes and have HIV. Even today, we still hear such negative things about us. We are the "AIDS people". (Key informant interview).

HIV led to the breakdown of the mechanism of kin support and interdependence. Generally, remittances allow migrants to remain in close contacts with their kinsfolk. They serve as insurance that guarantee re-entry and facilitate the reintegration of returnees into their society (IOM 2009). Female Klo returnees with HIV were less fortunate. Their remittances did not guarantee a smooth re-entry into their families due to the stigma associated with HIV. Some of them were abandoned without support from their kinsfolk.

Under these circumstances, it is important to learn about the manner in which Manya Kloli reacted to the feminized pandemic. This allows us to better

understand how the response has been feminized by the myriad roles of women, especially by the queen mothers.

The evolution of local response to the pandemic

A. *The silence, the denial and grandmother's burden*

The impact of the pandemic was most severe in the late 1990s and early 2000s, partly because the initial reaction by political leaders and Klo citizens was denial and an intense resistance to preventive interventions. Speaking about AIDS was tantamount to disgracing Klo. Those who contravened the 'no AIDS talk' rule suffered severe consequences. This situation affected HIV prevention and research. Health workers who spoke about HIV prevention were either threatened or attacked. In 2001, researchers from the Department of Community Health at the University of Ghana Medical School were forced to postpone their fieldwork in Manya Klo for a study on the vulnerabilities of young FSWs. The fieldworkers were threatened for "trying to talk to people about AIDS and disgrace the people".

The silence and denial, however, worsened the plight of PLHIV as they were denied support. Returnees who were hitherto role models were severely stigmatized and discriminated against due to HIV. The PLHIV and their kinsfolk that provided them with care were described in very derogatory terms. For example, PLHIV were "outcasts", *Abidjanbi* (the Abidjan people as the source of HIV), *tlomi* (baggage or burden) and *tso* (stick). These terms are symbolic and literal. They describe the arrival of the human 'baggage' (PLHIV). The stick symbolized the "weak", "skinny" and "bony" returnee with AIDS and also the physically frail older female caregiver. The stick also represented the material and social support that older women and the PLHIV need to survive or "walk on their own feet". The terms are significant for two reasons. The reference to previously successful, highly-regarded and hardworking breadwinners as objects and outcasts shows the enormity of the

HIV burden, especially the physical and psychological abuses and other indignities that PLHIV and their caregivers contend with. Also, these examples show how HIV/AIDS disintegrated social bonds among Kloli who, according to Field (1943), maintain very strong ties regardless of their life circumstances. Some family members denied PLHIV support because they did not want to suffer the stigma and discrimination associated with PLHIV and their caregivers.

The death toll from AIDS as well as the economic cost to Klo is not known. Nonetheless, anecdotal evidence from family members suggests the death toll and financial losses due to AIDS are very high. Families sold their moveable and unmoveable properties to provide support to relatives with HIV. One queen mother, who is also a grandmother, described how eleven of her female and male siblings and cousins who went to Ivory Coast all died of AIDS. What used to be the most popular section of her family compound house, "the place where most of the family's problems were solved by the Abidjan people", is now the most dilapidated and desolate part of the compound. The treasures that filled the rooms, for which reason the doors were constantly kept under lock and key, are all gone. The rooms are empty. These days, the doors are hardly shut. They swing in the direction of the wind. The veranda adjoining the rooms is filled with six rusted empty metal suitcases that belonged to the deceased, a symbolic evidence of the void they left in the family.

Although funerals are important customary ceremonies, kinsmen were overwhelmed by the number of AIDS-related deaths and some families buried their relatives unannounced and without funerals. Older women bore the brunt of dealing with AIDS-related morbidities and mortalities. They were responsible for the sick, most of them bedridden. They prepared corpses for burial with their bare hands, unaware of the health hazards that were involved. The physical care could have resulted in a different kind of crisis, however, women assumed more responsibility and leadership to reverse the effects of HIV.

B. *From resistance to resilience to pacesetting: local response meets external support*

Across sub-Saharan Africa, there are several community-based women's interventions that support families affected by HIV/AIDS (Campbell 2003; Foster 2002). There are 371 queen mothers in Manya Klo. In 1989, the customary institution of queen mothers metamorphosed into a pseudo-formal group, the Manya Krobo Queen Mothers Association (MKQMA). The objectives of the MKQMA are to strengthen governance by the queen mothers and to provide a platform for cooperation and support among them (Drah 2014). Since the late 1990s, however, the MKQMA has focused almost exclusively on alleviating the impact of HIV. The queen mothers were overwhelmed by the illnesses, deaths and the general burden of AIDS-related care, and yet they could not intervene in any significant way. They, too, were caught in the initial state of societal denial. They also lacked the basic knowledge about the virus and did not have access to any resources. Above all, they had to contend with the negative and sometimes violent public reactions to intervention. One queen mother described their frustrations at the time:

> We were aware the thing [HIV] was wreaking a lot of harm on us. We were really overwhelmed by the problem. We had never seen anything like it. People were dying…. Everywhere you went, there were people mourning. As people died, many more were falling sick and [extended family] support was growing less…. We did not have the means to reduce the pain. We couldn't do anything about it. We couldn't say anything. Our people were not happy that we were called 'prostitutes' and 'the AIDS people'.

In 1999, the District Director of Health Services of Manya Klo started private HIV information sessions for six queen mothers. The queen mothers disseminated the knowledge acquired through these sessions to their citizens through small group meetings and community durbars. In 2000, Family Health International (FHI), a United States-based international NGO boosted the efforts by the queen mothers through technical and financial assistance to the MKQMA. FHI's support enabled the MKQMA to rent an office, carry out

trainings, workshops, community meetings and information-sharing. The queen mothers intensified public education, shared their experiences and accessed donor support. By 2002, several NGOs and CBOs followed the leadership of MKQMA and disseminated information on HIV prevention across Klo through plays, education materials and radio campaigns. Some of these groups received funds from donors.

In 2002, FHI piloted the Support Treatment and Antiretroviral Therapy (START) Program in Manya Klo to provide treatment, care and support to PLHIV in public health facilities. FHI partnered government agencies and CBOs in Klo, including MKQMA, to increase access to HIV prevention and clinical services (Ritzenthaler 2005).

By the end of 2005, six NGOs/CBOs with 36 staff and 686 peer educators funded by FHI provided information throughout Klo. Over 6,000 PLHIV had received ART and HIV/AIDS services have been integrated into the national health care system to increase access to cheaper life-saving clinical services and support. Support for orphans also began with the help of other NGOs. Kloli and Ghanaians were motivated to test for HIV and access HIV-related services in addition to medicines. Discussions on AIDS were more open and more focused on strengthening existing programs to better support PLHIV and their families (FHI 2006).

START became the blueprint for engaging community-NGO-state partnerships to improve the lives of PLHIV and their families. A great deal of FHI's success (community mobilization, behaviour change, treatment, and PLHIV support networks) is attributed to the exemplary leadership of the queen mothers (FHI 2006; Ritzenthaler 2005).

The significance of feminized HIV interventions in Manya Klo

As shown above, feminization as a concept helps to identify factors behind high HIV prevalence in women and its effects on women. Feminization also helps to construct stereotypes **(**Budowski and Guzman 1998), such as women as a category of people highly susceptible to HIV, bearers of the AIDS burden

and ameliorators of the associated pain. Feminization of HIV care confirms 'caregiving' as women's work and therefore justifies women-focused policies and programs (cf. Chant 2003). The portrayal of women as victims of structural inequities, plus the fact that HIV exacerbates women's marginalized status, are woven into policies and programs for alleviating the impact of AIDS (UNAIDS 2005b). This means HIV/AIDS interventions are designed to address the structural conditions, like poverty, inequity (in gender, health and education), discrimination and marginalization that expose women to HIV infections and related problems. Ultimately, HIV interventions must empower women to improve their living conditions (UNAIDS 2008; Elengi-Molaye et al. 2001; see Ogden, Esim and Grown 2006).

In Ghana, HIV interventions are feminized. Their goal is to address the inequities and the social expectations of gender by placing emphasis on women as victims and caregivers (GAC 2012: 14). As examples, the objective of the *National Orphans and Vulnerable Children (OVC) Guidelines* is to improve the lives in the households of women by improving the lives of their orphans. It also aims to address issues of gender inequality associated with orphanhood (GAC and MOWAC 2005). The *Domestic Violence Act 2007* aims to protect women (and men) against domestic violence. The *Ghana Growth and Poverty Reduction Strategy* (2005) targets women to improve their living conditions. The goal of the national HIV strategy is to half new HIV infections by 2015 by focusing on FSWs and their partners. The strategy also includes, strengthening health systems to provide services that will prevent mothers from transmitting the virus to their infants. These interventions appear to be effective. In 2011, 72.5% of clients accessing ART were women, an increase from 66.9% in 2009 (GAC 2012).

Like the national interventions, the interventions in Manya Klo focus on women. The District Health Management Team (DHMT) will reduce the impact of AIDS on women by reducing new infections. It will also provide 90% of pregnant HIV-positive women with services to prevent them from transmitting the virus to their infants, and train and equip mother support

groups. The DHMT will improve home-based care and incorporate HIV prevention and support activities into existing women-focused interventions. The final objective of the DHMT is to collaborate with women's groups to target HIV-positive mothers, pregnant women, orphans, and children with HIV (LMK-DHMT 2012).

Feminization of interventions in Manya Klo has had tremendous impact on national HIV programmes. Aside from being the epicentre of HIV, Manya Klo is also a centre of excellence for how community leaders in general and female leaders in particular can mobilize their communities for HIV and development programmes. The national guidelines for counselling and testing for HIV and clinical management of AIDS were developed based on FHI program in Klo. Through FHI, health workers in Klo have developed very high competencies and skills and now provide technical support to HIV/AIDS training programs across the country. Lessons learned from Klo continue to inform AIDS treatment services across Ghana and the developing world (FHI 2004).

Manya Klo queen mothers are pioneers in community anti-AIDS campaigns and community development. Through their HIV/AIDS activities, queen mothers, like other women's groups, are influencing change by dealing with some of the economic, social, and cultural factors that contribute to gender inequality in their communities (USAID 2005). Politicians and development agencies leverage their influence to bring development to their towns and villages. They have been deemed more effective than NGOs and their initiative has become the model for female community leaders' involvement in AIDS-related activities in Ghana. Queen mothers from different parts of Ghana are emulating the leadership initiatives by Manya Klo queen mothers and are mobilizing to prevent HIV and deal with its effects, including caring for orphans. According to officials of the Ghana AIDS Commission (GAC), in 2000, MKQMA was the only group of traditional female leaders doing HIV work in Ghana. By 2010 there were 20 queen mothers' (HIV) associations.

The national OVC guidelines are based on the community- and family-centred approach used by the queen mothers to provide care for orphans. The

policy provides strong support for the Manya queen mothers' approach and discourages other forms of support, especially institutional care. The policy recognizes the gendered basis of child caregiving roles and seeks more resources for women (GAC and MOWAC 2005; RoG 2005).

The successes of the queen mothers have been recognized nationally and internationally. In 2005, the MKQMA was commended by the National OVC Forum as the best orphan programme in Ghana. They share their experiences at national and international meetings and have collaborative projects with NGOs and research/academic institutions from across the globe. They are even featured in YouTube videos. Overall, Klo queen mothers are now recognized for their success and hard work and not for 'bringing AIDS to Ghana'.

Ethnographically speaking, the feminized context of AIDS in Manya Klo presents a different perspective on the pattern of HIV infection among women in other parts of sub-Saharan Africa. High rates of infection in FSWs may be due to a combination of factors that increase their risk to HIV. Low or no education, lack of knowledge about the modes of HIV transmission and prevention, limited access to healthcare services and prevention services, multiple sexual partners, gender inequalities and low social status combine to expose FSWs to HIV (Vulysteke et al. 2012). The link between women's economic status and the risk of being infected with HIV, however, cannot be ignored (Karim 2008). According to Webb (1996), Zambian women of high social standing are likely to be infected with HIV and die of AIDS because they are most likely to have male sexual partners who are rich, operate in formal sectors of the economy and have a wider sexual network. In Klo, however, the majority of PLHIV are women with low socio-economic status.

Additionally, the high HIV infections in Klo are due to economic migration by women. This is in contrast to southern Africa where most of the HIV infections are due to male migrant workers who live for long periods away from their families and so they are constrained to patronize FSWs and also establish other sexual relationships (Karim 2008: 245-248; Lurie et al. 2004; Robbins 2002: 241-242; O'Laughlin 1998; Townsend 1997).

Although the feminized interventions are making an impact at the individual and household levels, these interventions also tend to be sources of tension. Feminization as a strategy could be the basis for including or excluding certain social groups from HIV programmes, either in planning or delivering services (Elengi-Molaye et al. 2001). In particular, feminized interventions ignore men as actors and resources that must be leveraged to alleviate the burden on women. They also do not address the unmet needs of men, which would improve women's lives (Karim 2008). In Ghana, even though women are more likely to be infected by men with HIV, men lag behind women in accessing HIV prevention and treatment services (GAC 2010: 26).

Evidence from other feminized interventions suggests the singular targeting of women and the corresponding alienation of their male counterparts may help to achieve short-term success, such as generate resources for women. These interventions, however, create problems for women in the long-term. Chant (2003) reports that Costa Rican women in an anti-domestic-violence program thought it was baseless to learn about their human rights if their men did not participate because men remained unchanged. They thought they would be better off if their men participated in the program.

In Manya Klo, the feminization of HIV interventions is helping to improve the lives of PLHIV. However, as a strategy, feminization of interventions limits the participation of groups whose contributions are vital to meeting the needs of PLHIV and their families. This may lead to conflict. Klo is a patrilineal society. This means chiefs ('fathers of the land') are the heads of the lineage and therefore wield more power than queen mothers ('mothers of the land'). As the 'parents of the land', chiefs and queen mothers have a shared-responsibility to protect their citizens. Therefore, they work collaboratively to develop programs to support the well-being of their citizens, including PLHIV. The queen mothers' primary responsibility is to 'take care' of women and children and the chiefs are responsible for providing caregiving resources to the queen mothers. For this reason, chiefs consider HIV work a critical

component of their mandate as fathers and 'not just a women's issue' or 'women's work'.

In keeping with the traditional political organization, queen mothers can only participate in programmes approved by their chiefs. Queen mothers must have approval of chiefs before they work with any government agency or NGOs. Chiefs must also approve of the dissemination and or application of the knowledge and skills they acquire from any project. Despite this customary arrangement, research participants attest to great cooperation between queen mothers and chiefs. The queen mothers recognize that their successes are due in large part to the immense and unwavering support they receive from their chiefs. Chiefs are supportive of queen mothers mobilizing their communities. The chiefs and CBO staff, however, opined that state and donor agencies deliberately ignore interventions led by non-female groups. They contended that donors ignore men and then complain about 'men's lack of interest in HIV programmes'. They asserted that 'male absence' and 'men's lack of action' are used as justifications for marginalizing men and concentrating on empowering women. Ironically, it is the chiefs that approve the queen mothers' collaborations with donors.

Women and HIV/AIDS in Ghana: the way forward

Research on HIV/AIDS in Ghana in the past three decades has focused intensely on addressing the immediate causes of HIV infection, such as lack of condom and access to reproductive health services. There has been less emphasis on unravelling the political-economic and cultural factors that increase women's vulnerability to HIV. Also, very little is known about the roles of male traditional leaders in HIV interventions. Consequently, interventions are based on knowledge that does not completely reflect the reality about the pandemic. The different phases of the pandemic and the different stakeholders that contribute to improving the lives of those infected and affected must be identified and analysed. Such analyses will help to develop

evidence-based interventions and strengthen current interventions to better address the unmet needs of affected communities.

Data from Klo suggest multiple factors lead to high HIV infection in women. Lack of economic opportunities, the pressure on young women to fulfil their customary obligations as ideal women and breadwinners, plus the pursuit of personal ambitions compelled women to migrate, participate in sex work and eventually 'import' HIV into Ghana. Women bear the double burden as the most HIV-infected and having the responsibility for mitigating its multiple impacts.

Despite the feminization of HIV, there is the need for multi-dimensional and multi-stakeholder interventions to deal effectively with its tragic consequences. Currently, interventions are focused almost exclusively on women and ignore the potential impact that the strategic engagement of men could have on the quality of life in households impacted by HIV. The neglect of men hampers efforts to strengthen women's role as leaders and caregivers. For instance, chiefs and other male traditional leaders support women's initiatives, but researchers often ignore the contributions of these male stakeholders. Very little data exists on men's contribution to queen mother-led programmes and how to sustain and strengthen collaboration between chiefs and queen mothers.

Although the queen mothers' work is considered successful, it could be bolstered by operating differently to harness untapped resources. Queen mothers and chiefs have already consolidated many children's issues, such as child labour, education, health and nutrition into HIV programs. This approach has provided the opportunity to effectively align local efforts and government and non-government programs. Further collaboration between the chiefs and queen mothers would allow for leveraging opportunity for even greater gains. Male traditional leaders should be encouraged and empowered to perform their roles as advocates for women infected and impacted by HIV. In line with their customary roles, chiefs should be actively engaged (not alienated) to address the circumstances that increase women's susceptibility to HIV infection.

The focus and scope of research on migrant women and sex work must be re-considered. Women's migration should be assessed on the basis of the overall impact of migration on families and migrants and not only on the basis of its negative impact. Due to the high HIV prevalence attributed to women's migration, there has been a general negative perception of migration by women. Consequently, researchers have paid very little attention to the significant contributions that migrant women make to their families (especially to the vulnerable, elderly and children). The economic interpretation of migration as an activity influenced by personal choices needs to be re-examined. Such interpretation ignores the influence of relatives, friends and other social groups in the decision to migrate and actually facilitating the process. In addition, the scope of HIV research must transcend the conceptualization of sex work by migrant females as a moral and criminal issue to include analyses of the lived experiences of women.

Although migration to the Ivory Coast by Klo women has drastically declined, the economic hardships that forced young women to migrate in search of a better life persist in even more severe forms. Therefore, research must inform policies and programs on the benefits and negative consequences of migration by women. Further research is required to ensure interventions are based on contextual evidence. Specifically, research should explore opportunities to improve the capacity of female leaders for strategic intervention planning and implementation. Female leaders must be trained on building strategic partnerships with male traditional leaders, development experts, policy makers, NGO/CBOs and academia to develop more efficient systems of support that respond to and are accountable to the needs of women.

Researchers should also help female and male traditional leaders to better align interventions and resources with their customary roles and the aspirations of their people. External stakeholders should work harder at identifying local stakeholders in order to build enduring partnerships to strengthen projects that aim to improve the well-being of women. Finally, all interventionists must

ensure efforts to encourage men to support women's initiatives do not allow men to take over women's work.

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List of Acronyms

AIDS	Acquired immune deficiency syndrome
ART	Antiretroviral treatment
CBO	Community-based organization
CFAO	Compagnie Française de l'Afrique Occidentale
DHMT	District Health Management Team
FHI	Family Health International
FSW	Female sex worker
GAC	Ghana AIDS Commission
GHS	Ghana Health Service
GSS	Ghana Statistical Service
HIV	Human immunodeficiency virus
HSS	HIV sentinel surveillance
IOM	International Organization for Migration

LMK	Lower Manya Krobo
M4DCoP	Migration for Development Community of Practice
MKQMA	Manya Krobo Queen Mothers Association
MOWAC	Ministry of Women and Children
NGO	Non-governmental organization
OVC	Orphans and vulnerable children
PLHIV	People living with HIV
START	Support Treatment and Antiretroviral Therapy
STIs	Sexually transmitted infections
UNAIDS	The Joint United Nations Programme on HIV and AIDS
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development