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REINVENTING AFRICAN CHIEFTAINCY IN THE AGE OF AIDS, GENDER, GOVERNANCE, AND DEVELOPMENT

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6 Building AIDS Competence in Manya Krobo and the Role of the Manya Krobo Queen Mothers Association

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INTRODUCTION

This case study traces and situates the activities of the Manya Krobo Queen Mothers Association within the AIDS-competence framework. The Manya Krobo Queen Mothers served as change agents in the progression of AIDS competence in Manya Krobo by contributing to the recognition of HIV infection, mobilizing awareness, partnerships and resources, and engaging in actions to reduce vulnerability and mitigate the impacts of HIV/AIDS. The Manya Krobo Queen Mothers contributed substantially to building AIDS competence in Manya Krobo and consequent positive outcomes for HIV/AIDS risk and impact mitigation and individual and social empowerment and well-being. However, the progression and sustainability of AIDS competence in Manya Krobo confronts several challenges and constraints. This chapter discusses and analyzes the

progression, outcomes, and challenges and constraints of building, sustaining, and scaling up AIDS competence in Manya Krobo communities. The case study provides a detailed overview of the history and background of Manya Krobo, Krobo society, its system of traditional leadership, and the HIV/AIDS epidemic that currently threatens its people.

HISTORY OF KROBO SOCIETY

In his seminal work on the Krobo people, Hugo Huber (1963) traces the history and traditional social and religious practices of the Krobos. The Manya Krobo traditional area was formed circa 1500 ("Ghanaian Traditional Polities"; http://rulers.org/ghantrad.html), however, the name *Krobo* does not appear on maps until 1769 (Huber 1963). Krobos are the indigenous and predominant inhabitants of the Manya Krobo and Yilo Krobo districts in Ghana's Eastern Region (Huber 1963; Sauvé, Dzokoto, Opare, Ekow Kaitoo, Khonde, Mondor, Bekoe, and Pepin 2002). Krobos also settled in other territories, including the villages of the Akyem Abuakwa area, located in Ghana's Eastern Region (Huber 1963). The people now known as Krobos were originally driven to Krobo Mountain from 1700 to the 1740s to escape warfare and slave raiding (Steegstra 2002) as it offered refuge from invading Asanti armies (Huber 1963). Huber (1963) suggests that these original groups immigrated as linguistically and ethnically diverse small kinship groups, who subsequently employed a single language and system of rule. The chieftaincy system was not introduced until years later (Huber 1963). The Krobo area, originally colonized by the Danish Gold Coast protectorate was taken over by the British in 1849 (Steegstra 2002). At that time, Krobos were one of the largest producers of palm oil for the Gold Coast colony. Krobos continue to this day to be extensively engaged in farming and agricultural activities.

The Manya Krobo traditional area comprises both Lower and Upper Manya in the six divisions of the traditional area. Manya Krobo is 75 kilometres northeast of Accra and 20 kilometres south of the Akosombo dam (Sauvé et al. 2002). The capital is Odumase-Krobo, located in Lower Manya Krobo. The estimated population of the traditional area is 160,873 (MKQMA 2003a). Upper Manya Krobo consists of widely dispersed

farming communities and villages. Lower Manya Krobo is the economic centre of the traditional area, and thus market activities, including selling, petty trading, and retail activities take place in the communities in Lower Manya Krobo.

Krobo society and system of chieftaincy are patrilineal in that children belong to the kin group of their father (Huber 1963). Huber (1963) defines a 'house' as "a minor agnatic group of various spans" (71). Houses contain monogamous or polygamous households and are multi-generational. They may also contain the unmarried brothers and sisters or close patrilineal relatives of the head. Members of the house grant significant respect and cooperation to the head of the house. When the head of the house dies, the next senior male member of the house automatically succeeds the former head. Members of a house are subject to its rituals and customs and the elders of the house exercise considerable and lasting authority over members of the house. For instance, even when female children marry into another family and reside in their husband's "house," they retain *membership* (and the concomitant rights and obligations) in their father's paternal "house" and group (Huber 1963). While children often retain ties to their mother's paternal house, primary identification resides with their father's paternal house.

Krobos living in the Manya Krobo district speak the Krobo language, commonly called *Adangme* (Huber 1963). The Krobo language resembles *Ga*, a language spoken by approximately 4 per cent of Ghanaians (U.S. Department of State 2004). Substantial numbers[1] of Krobos do not read, write or speak English. Junior Secondary Schools in the Manya Krobo district provide basic English language instruction in their curriculum, but this was not always the case.[2] Poverty is widespread across the Manya Krobo district and Manya Krobo has high levels of hunger, malnutrition, and poor and inadequate housing and proper sanitation facilities. There is a high rate of unemployment among inhabitants, and much of the economic activity that takes place is subsistence-based. While Lower Manya Krobo serves as the economic centre, Upper Manya Krobo consists mainly of small rural and scattered communities and villages. The transportation infrastructure in both Lower and Upper Manya Krobo consists of poor and deteriorating roads. While a paved single-lane road connects Upper and Lower Manya Krobo, community and village roads are extremely poor and difficult to access.

Krobos are predominantly Christian, with Presbyterian, Anglican, and Catholic churches serving the majority of inhabitants. It is widely accepted that the work of the Basel missionaries, beginning in 1856, entrenched Christianity in Krobo society (Huber 1963). The Basel missionaries, hailing mainly from Württemberg, a rural area in southwestern Germany, established a mission station in 1858 in Odumase (Arlt 1995). This mission station existed in Odumase from 1858 until 1917, when German nationals were forced to leave the Gold Coast Colony in World War I (Steegstra 2002). However, their lasting influence on Krobo society and religion is palpable. The descendants of the Basel missionaries retain ties to Krobo society and visit Manya Krobo to visit the graves of relatives and reconnect with the Presbyterian Church and its fellowship.[3]

Among the Krobos, kinship groups or individuals own land. The head of the kinship group, with input from elder members, makes decisions concerning the use and distribution of ancestral land (Huber 1963). Huber, in 1963, states that the eldest son inherits land, and if a man has more than one legal wife, there will be an equal distribution of land among first sons. Huber (1963) notes that widows are not entitled to assume control of the land of her dead husband, except, temporarily, when there are no males at all in the deceased man's family. Huber writes in 1963 that "a woman, as a rule, does not own land," but this practice may in fact be changing. Further research on land tenure practices in Manya Krobo is required to reveal the extent of changes in land tenure practices and patterns in female land ownership.

Many social and customary rituals and taboos are specific to Krobos. Indeed, while Huber (1963) identifies many of these, children at a Planned Parenthood Association of Ghana (PPAG) peer education group happily proclaimed many of these taboos and traditions to the peer education leader. The children concurred with Huber's (1963) statement that custom prohibit Krobos from marrying or having a sexual relationship with a person that descends from the same house. They also identified that Krobos do not eat snails, a taboo originating from old folklore that a snail rescued Krobos in a prior war. Krobos also believe that you should not sing while taking a bath, sit in a doorway (as this is where spirits are said to linger), sweep in the night, whistle in the night, leave a glass out in the night, keep chairs out in the sun, or sit on mortar as it will impair fertility (PPAG meeting observation, 2 August 2004).

The Krobo people have strong and enduring traditional belief systems and practices. There is a strong sense of community solidarity and commitment to one's neighbours and family. Regular festivals and public gatherings, including the annual Ngmayem and Yokama Day festivals, provide opportunities for community members to celebrate their common cultural history and practices. Krobos may be renowned in Ghana for their beautifully crafted beads[4], but indeed, it is their vibrant cultural practices and community solidarity that are remarkable.

QUEENMOTHERSHIP AND CHIEFTAINCY IN MANYA KROBO

Chieftaincy in Ghana and in Manya Krobo has an organizational, reporting and authority structure. As indicated, Krobo society is patrilineal and thus chiefs and queenmothers are selected from the royal homes of the father's line. Thus, queenmothers' female children cannot become queenmothers in their particular stool but may become queenmothers in their fathers' area if he belongs to a royal home.

The paramount chief, Nene Sakite II, is the highest and most powerful chief in the traditional area and represents the district at the Regional House of Chiefs. Nene Sakite II was installed in January 1998 as the "konor" or paramount chief of the area after an eight-year period without a konor. Konor Nene Azu Mate Kole II served as paramount chief of the Manya Krobo traditional area from 1939 until his death in 1990. The paramount queenmother, the female counterpart in the hierarchical structure is *Nana* Mamle Okyleou. She is the most powerful female traditional leader in Manya Krobo.

The Manya Krobo Queen Mothers Association (MKQMA), established in 1989, consists of 371 queenmothers from across the six divisions of Manya Krobo. The paramount queenmother, *Nana* Mamle Oklyeou, and the deputy paramount queenmother, Manye Esther Nartekie, are the highest-ranking queenmothers. Djase, a queenmother, follows next in the hierarchy. Djase is responsible for installing the paramount queenmother and other queenmothers. After Djase, there are six divisional queenmothers, representing the six divisions of the Manya Krobo traditional area. At public gatherings or queenmother meetings, these queenmothers

sit alongside the paramount queenmother, deputy paramount queenmother, Djase, and their elders at the front of a room. Sub-queenmothers follow next in the hierarchy and each represents and is responsible for a particular community or village in Manya Krobo. The reporting structure follows the hierarchy in the sense that sub-queenmothers raise issues and discuss problems particular to their community with their divisional queenmother *before* going to the deputy paramount or paramount queenmother. If the issue cannot be settled at that level or requires the approval or input of the paramountcy,[5] the sub-queenmother or divisional queenmother will raise the issue with the deputy paramount or paramount queenmother (Interview, Manye Nartekie, 2 August 2004).

Each queenmother has at least one elder in their community with whom they consult and report. Elders instruct queenmothers on "how to talk, how to dress, and streamline your life" (Manye Nartekie, 2 August 2004). Essentially, elders "police" the queenmothers in their communities. The paramountcy is served by four elders (Interview, Manye Nartekie, 2 August 2004). A linguist also serves the deputy and paramount queenmothers. The linguist speaks for the paramountcy and has the power to grant or deny access to the paramountcy. Queenmothers in Manya Krobo, as well as in other kingdoms in Ghana, serve for life. They do not usually "de-stool" chiefs or queenmothers, in Manya Krobo, but this practice varies from area to area (Interview, Manye Nartekie, 2 August 2004). Well-established systems of chieftaincy and queenmothership have long served the residents of the Manya Krobo traditional area. Chiefs and queenmothers serve alongside in an established hierarchy and organizational structure. While chiefs retain more power and authority in their communities than queenmothers, they are expected to maintain good relations and complement each other's efforts at governance.

HIV/AIDS IN MANYA KROBO

The Manya Krobo district and traditional area is widely recognized as having the highest HIV prevalence in Ghana (Interviews: Mrs. Gifty Ofori, 28 July 2004; Dr. Charles Nyarko, 7 August 2004). HIV surveillance for the Agomanya sentinel site, a community within the district

of Manya Krobo, indicated that adult HIV prevalence in 2003 was 9.2 per cent. This is a rate nearly three times the national average at 3.6 per cent (NACP/GHS 2003). The Eastern Region of Ghana also reported the highest regional HIV prevalence rate at 6.1 per cent (NACP/GHS 2003).

Atua Government Hospital and St. Martin de Porres Catholic Mission Hospital are located in the Manya Krobo district and within five kilometres of one another (Sauvé et al. 2002). In 2001, a study conducted in the two hospitals revealed that 14.9 per cent of prenatal women tested positive for HIV (Sauvé et al. 2002). This is the highest rate ever reported among prenatal clinic patients in West Africa, with the exception of one sentinel site in Nigeria (Sauvé et al. 2002). The study also revealed that HIV prevalence was nearly twice as high among the Krobos as among women belonging to other ethnic groups. Furthermore, among the Krobos, HIV infection was strongly correlated with both minimal schooling (having attended primary school only) and having lived in Côte d'Ivoire (Sauvé et al. 2002). In fact, Sauvé et al. (2002) and Dr. Charles Nyarko[6] contend that high rates of HIV prevalence in the Manya Krobo area, particularly among Krobos, appears to be related to migration to Côte d'Ivoire following the construction of the Akosombo Dam. In 1965, construction of the Akosombo Dam on Lake Volta was completed. Lake Volta is the largest manmade lake in the world and extends from Akosombo Dam in southeastern Ghana to the town of Yapei, 520 kilometres to the north. The lake generates electricity, provides inland transportation, and serves as a resource for irrigation and fish farming (U.S. Department of State 2004). The construction of the Akosombo Dam flooded acres of land, which consequently displaced many farmers and people from their homes. Indeed, over 80,000 people were relocated to fifty-two townships. Resettlement resulted in economic displacement and local poverty and forced people to migrate to places like Côte d'Ivoire in order to seek work. Many female migrants engaged in commercial sex work in Côte d'Ivoire. HIV was likely introduced in the communities when women returned home for short visits orfestive occasions, or when economic conditions improved in the area (Sauvé et al. 2002).

With an adult HIV prevalence rate that is between 250 and 400 per cent higher[7] than the national median, Manya Krobo communities face extraordinary challenges in HIV/AIDS control and impact mitigation.

Subsequent sections explore the role of the Manya Krobo queenmothers in confronting the HIV/AIDS epidemic in their communities.

PROGRESSION OF AIDS COMPETENCE IN MANYA KROBO AND THE MKQMA

Identification of HIV Infection and Shock Response

Lamboray and Skevington (2001) indicate that the first stage in the progression towards AIDS competence is the identification of HIV infection. They maintain that communities must first acknowledge that there is a problem and that this typically occurs after the collective shock of loss of community members (Lamboray and Skevington 2001). In 1988/89, doctors reported HIV to the late konor of the Manya Krobo traditional area, Nene Azu Mate Kole II. The konor responded by mobilizing his chiefs and queenmothers to become educated about HIV/AIDS. However, the death of the konor in 1990 appears to have halted these activities until his replacement in 1998. Dr. Charles Nyarko, chief medical officer at St. Martin de Porres Mission Hospital in Odumase-Krobo, cites the eight-year gap between the death of the late konor and the 1998 installation of the current konor, Nene Sakite II, as a contributing factor to the spread of HIV/AIDS in the area (Interview, Dr. Charles Nyarko, 7 August 2004).

In 2000, after witnessing countless families struggle with the devastating impacts of a perplexing syndrome referred to as HIV/AIDS by the hospitals, Manye Nartekie, Manye Mamle Oklyeou, and Manye Makutsu, queenmothers from Lower Manya Krobo, approached the District Health Management Team (DHMT) for guidance and assistance. The queenmothers were referred to Family Health International (FHI), a non-governmental organization, for information and training. Dr. Kwame Essah, country director for FHI recalls how the queenmothers came to Accra to meet with him at the FHI office and indicated that they needed to "do something about HIV/AIDS" (27 July 2004). Dr. Essah and Deputy Queenmother Manye Nartekie held additional meetings to discuss partnership opportunities. Dr. Essah later met with the paramount chief,

Nene Sakite II, where he "wholeheartedly gave his support" to the partnership between FHI and the MKQMA (Interview, Dr. Kwame Essah, 27 July 2004).

FHI agreed to partner with the queenmothers because they "recognized the important role that they play in society" and believed they would be credible and influential voices for conveying information about HIV/AIDS (Interview, Dr. Kwame Essah, 27 July 2004). FHI determined that they needed to provide the queenmothers with accurate information on HIV and its transmission and build their capacity to deliver education locally. Training was facilitated by FHI and the National AIDS Control Programme (NACP). Professional counsellors from the NACP delivered extensive HIV/AIDS, sexual, and reproductive health education and training in both English and the local language (MKQMA 2003a). Three groups of queenmothers from Lower Manya Krobo and Upper Manya Krobo (Asesewa and Otrokper) received training in two- to three-week modules. In March 2001, queenmothers from Lower Manya Krobo were first to be trained. Queenmothers from Upper Manya Krobo were trained in late 2001 and early 2002. In total, 170 queenmothers participated in the training.

Following their training, the MKQMA transferred their knowledge to the communities by developing and implementing widespread HIV/AIDS awareness and prevention programming across Manya Krobo. FHI agreed to assist the queenmothers but indicated that "these are programmes that you are going to run yourselves." The queenmothers agreed to collaborate with FHI in program development but would manage and implement the programs themselves. FHI provided technical support in designing their HIV/AIDS prevention programs and worked with the queenmothers to secure funding for their activities. Funding initially came from the U.S. Agency for International Development (USAID) under the IMPACT program; however, the program was discontinued in 2004. The Department for International Development (DFID) – the international development agency of the government of the United Kingdom – currently provides funding[8] through the "Start" program.

Before the Manya Krobo Queen Mothers launched their HIV awareness and prevention programs, there were pervasive myths and misinformation surrounding HIV. Previously, Krobos refused to admit that HIV/AIDS was an actual disease and attributed symptoms of HIV/AIDS to

curses or the supernatural ("Krobos Now Admit HIV/AIDS Is Real," 24 November 2001). The article "Krobos Now Admit HIV/AIDS Is Real" (http://www.mclglobal.com/History/Nov2001/24k2001/24k1r.html credits the "tireless efforts" of the Manya Krobo Queen Mothers with debunking erroneous notions of HIV/AIDS and providing Krobos with accurate information on the nature of HIV and its transmission.

Queenmothers from Upper Manya Krobo admitted that prior to their training they also believed that a "ju-ju" – a superstition or curse – caused the symptoms and illnesses associated with HIV (Group Meetings, 5 and 9 August 2004). Queenmothers stated that they noticed people becoming ill and dying but did not know what was causing it (other than a curse) (Group Meetings, 5 and 9 August 2004). They noticed that some of the girls who were returning home after an absence (usually for *dipo* or puberty rites ceremonies) came home with illnesses and rashes that could not be explained or attributed to any known diseases or conditions (Group Meetings: Asesewa, 9 August 2004). Thus, queenmothers from Upper Manya Krobo (Otrokper and Asesewa) had incomplete or inaccurate information on HIV until the time of their training in 2002.

The shock response in Manya Krobo that Lamboray and Skevington (2001) suggest follows the recognition of HIV infection was largely one of ignorance and silence. Because people did not have full knowledge surrounding HIV and thought it was caused by the supernatural, they could not properly protect themselves from HIV. Furthermore, because discussing sexuality was considered taboo, a culture of silence persisted in Manya Krobo (Interview, Dr. Charles Nyarko, 9 August 2004; MKQMA 2003b).

Increasing HIV/AIDS Awareness and Reducing Vulnerability

Lamboray and Skevington (2001) state that, following recognition of HIV and the shock response, change agents act to raise HIV awareness and reduce the community's vulnerability to HIV/AIDS. Change agents transfer knowledge to the community and work to transform attitudes and behaviours to raise awareness and reduce the community's vulnerability to new HIV infections. Lamboray and Skevington (2001) argue that this is achieved by the efforts of change agents in collaboration with community and local partners. Lamboray and Skevington (2001) suggest

that partnerships represent a "people-centered interaction between key social groups, service providers, and facilitators or catalysts" (514). Change agents work with key social groups, service providers, and partners to develop and deliver HIV/AIDS awareness and prevention programming. In this case, the Manya Krobo Queen Mothers, particularly the queenmothers from Lower Manya Krobo, acted as change agents by actively seeking out information and support and then working with partners to develop and implement widespread HIV/AIDS awareness and prevention programming. The queenmothers partnered with FHI, NACP, and Planned Parenthood of Ghana (PPAG) to develop programs and tools to raise HIV/AIDS awareness, discuss sexual and reproductive health, and reduce vulnerability to HIV. Lamboray and Skevington (2001) maintain that this approach is most effective for developing AIDS competence. Awareness and prevention programs are more successful when they are designed by local people for their own use because they are more likely to account for cultural, attitudinal, and behavioural factors that may be susceptible to or in need of change within communities (Lamboray and Skevington 2001).

Lamboray and Skevington (2001) contend that AIDS competence produces positive and effective changes in social and individual behaviours and environments because it employs locally and culturally appropriate HIV/AIDS social marketing materials and strategies. The Manya Krobo Queen Mothers developed locally and culturally appropriate participatory and interactive HIV/AIDS social marketing approaches. For instance, with the assistance of FHI, they devised a set of cue cards, written in both English and the local language, that depict Krobo women and girls in a variety of situations that pose potential safety and health risks. The cue cards are visual and interactive tools that depict women and girls in situations where teachers, taxi drivers, or male partners are asking them for sex. The cue cards ask participants to suggest ways that the girl can respond that will ensure her personal safety and/or protect her from exposure to HIV. Furthermore, the cue cards ask such questions as "what will be the reaction of the man?" and "how can she avoid becoming pregnant or infected with HIV?" The cue cards also deal with situations in which girls may be exposed to alcohol or violence in their families or relationships and ask participants to consider what options and behaviours the girls could exercise to seek help and/or protect themselves from risky

situations and behaviours. The cue cards also depict positive outcomes that result from healthy choices and behaviours. Queenmothers and peer educators each carry a set of the cue cards with them in their FHI-donated HIV/AIDS education and prevention toolkit. The toolkit also contains informational leaflets, a reporting book, male and female condoms, and a condom "model" (a wooden model penis) with which the queenmothers demonstrate the proper use of a condom.

The MKQMA and FHI produced a docudrama entitled "In Sickness and in Health" (or "*Hiomio, Hewamimio*" in the local language). Similar to the cue cards, the docudrama depicts Krobos in situations that place them at risk of contracting HIV and illustrates potential health and social consequences associated with risky sexual and social behaviours and decisions. The docudrama portrays Krobo actors, is set in Manya Krobo communities, and is produced in English and the local language. FHI procured a portable television and VCR to enable the queenmothers to show the docudrama at public gatherings. The queenmothers also invite groups to view the docudrama at their resource centre in Lower Manya Krobo. The cue cards, the toolkit, and the docudrama are locally developed, culturally appropriate social marketing tools that provide valuable information and resources to raise HIV awareness and reduce vulnerability to new HIV infections. Furthermore, because they are delivered by queenmothers, they are more likely to be perceived as credible and worthwhile due to the queenmothers' prominence and perceived legitimacy within their communities.

The MKQMA sought to access as many people in the community as possible to deliver social marketing tools and impart HIV awareness and prevention information. However, they operate with very limited resources. Therefore, Mrs. Gifty Ofori, the program officer from FHI who worked with the MKQMA, indicated that it was imperative that programs adhere to a "low-cost or no-cost" approach (Interview, 28 July 2004). Thus, the queenmothers sought opportunities to deliver low-cost or no-cost programs. They used large public events such as church gatherings, funerals, and festivals as opportunities to discuss HIV/AIDS and present the docudrama. They also continued to make home visits and used these visits as an opportunity to discuss HIV/AIDS and sexual and reproductive health with family members, including men. The queenmothers visit schools as part of their traditional duties but, following their training,

used these visits to hold discussions on HIV/AIDS. Children actively engage in these discussions and approach individual queenmothers for further information or counselling. Queenmothers meet with teachers to instruct them on issues of HIV/AIDS and to ensure that teachers are refraining from sexual relations with students (Group Meeting, 5 August 2004). Queenmothers regularly attend parent-teacher advisory (PTA) meetings to advise parents on HIV/AIDS and sexual and reproductive health and encourage them to talk openly with their children on these issues. In Manya Krobo, the queenmothers are credible and influential community leaders who delivered awareness-raising programs on a low-cost or no-cost approach.

Queenmothers' traditional duties relate to the welfare of women, children, and families. The MKQMA decided that it was important to raise HIV/AIDS awareness among children and youth and provide them with accurate information and choices for their sexual and reproductive health. They believed that if you accessed children's belief systems and practices at an early age, they would make sound choices into adulthood (Interview, Manye Nartekie, 2 August 2004). Accordingly, the queenmothers established a partnership with Planned Parenthood of Ghana to provide education on adolescent sexual health and HIV/AIDS. Prior to the partnership with PPAG, the MKQMA worked with children and youth in their communities in their homes and schools, however, the PPAG program trains peer educators to work with children and youth. PPAG provides Krobo peer educators with training, support, and tools such as books, flipcharts, leaflets. and handouts (Interview, Ms. Rebecca Anyan, 6 August 2004). Peer educators deliver the PPAG curriculum in local settings twice weekly with Krobo children and youth.

In order to reduce community vulnerability to further HIV infections, the queenmothers sought to transform individual and social behaviours and attitudes. Since 2001/2002, queenmothers have used every opportunity to interact with community members to raise HIV awareness. However, moving from awareness to behavioural change poses a formidable challenge. Sexual behaviours and social attitudes are resistant to change, and thus it is important to sustain prevention and awareness efforts and experiment with different methods to influence individual and social behaviours. Preventing new HIV infections is a priority for Manya Krobo communities and requires that people change their sexual behaviours and

practices. Queenmothers encourage children and youth to abstain from sex and, if they cannot, to use a condom in each sexual encounter. They encourage men to use condoms during every sexual encounter. If men engage in polygamous or extra-marital sexual relationships, they are advised to use a condom every time, even with their wives. They were informed that if they did not use a condom they were putting themselves, their partners, and their children at significant risk of contracting HIV, falling ill, and dying (Group Meeting, 5 August 2004).

FHI/NACP training instructed the queenmothers on the proper use of condoms and provided each queenmother with a model of the penis to demonstrate proper condom application and disposal. Queenmothers now provide demonstrations during home visits and public gatherings. Condoms are supplied by the Ministry of Health (through the DHMT) and the Ghana Social Marketing Foundation (Interview, Dr. Kwame Essah, 27 July 2004) and distributed by queenmothers during community meetings and home visits. Queenmothers also noted that community members will come to their homes to request condoms (Group Meeting, 9 August 2004). By talking openly and widely about HIV/AIDS and sexual and reproductive health, queenmothers broke the culture of silence in their communities and provided community members with information and resources to reduce their vulnerability to further HIV infections.

Prior to the implementation of the widespread HIV awareness and prevention programs in Manya Krobo, sexuality was a taboo topic and HIV was treated as a superstition or curse. Queenmothers from Upper Manya Krobo (Otrokper) stated that there was initially some reticence from the community in broaching these topics (Interviews: Manye Otrokper; Manye Beatrice Kofi; Manye Mawuger, 5 August 2004). However, this changed as the queenmothers proceeded with local social marketing programs to raise HIV awareness and reduce the community's vulnerability to further infections. FHI provided each queenmother with a golf shirt that displays the MKQMA, FHI, and USAID logos. The back of the shirt displays in large black letters, the message: "*Mo Bimi Noko*," which translates into "ask me something about HIV/AIDS." Queenmothers confirm that substantial numbers of people are doing just that; queenmothers are regularly approached for condoms and information on HIV/AIDS and sexual and reproductive health.

The Manya Krobo Queen Mothers positioned themselves as change agents by actively seeking out assistance to confront and control the HIV/AIDS epidemic in their communities. Family Health International, the National AIDS Control Programme, Planned Parenthood of Ghana, the District Health Management Team, and the Ghana Social Marketing Foundation furnished the training and tools necessary for the queenmothers to develop, implement, and disseminate HIV/AIDS awareness and prevention information and tools. Given their special legitimacy and prominence in their communities, they were able to gain widespread access to the community to deliver social marketing messages and tools that were perceived as credible and deserving of consideration.

Actions to Mitigate Impacts and Alleviate Risk

Lamboray and Skevington (2001) suggest that AIDS competence arises when communities take action to mitigate the impacts of HIV/AIDS and work to reduce risk of exposure to further HIV infections. This goes beyond awareness-raising and prevention of HIV through behavioural change; it entails examining social and systemic factors that expose or predispose individuals and the community to the risks and impacts of HIV. Communities develop programs that attempt to mitigate the impacts of HIV and reduce vulnerability to further HIV infections. The Manya Krobo Queen Mothers recognized that it was not sufficient to raise awareness and provide HIV prevention information and resources. Communities were already affected by HIV/AIDS and they needed to consider what traditional and social practices made them vulnerable to HIV as well as devise strategies on how to support and care for people living with or affected by HIV/AIDS. They acknowledged that this would require substantial resources and thus engaged in resource mobilization and local partnerships to support and sustain these activities. The actions taken by the queenmothers to mitigate the impacts of HIV and reduce the risk of vulnerability to HIV include:

1. identifying traditional or social practices that potentially expose people to HIV;
2. transferring knowledge and skills training to vulnerable and marginalized populations, including women, children, and youth;
3. knowledge and skills training for local health and service providers, including local undertakers and traditional birth attendants;
4. mobilizing resources for orphans and vulnerable children and their foster families;
5. forming partnerships with local hospitals to increase utilization of voluntary counselling and testing (VCT), prevention of mother-to-child transmission (PMTCT), antiretroviral treatment for HIV/AIDS (ART), and general health services; and
6. forming partnerships with non-governmental organizations and universities to advise and support their programs.

Identifying potentially harmful social practices

Huber (1963) suggests that the *dipo* rituals exceed all others in terms of their importance to female Krobos. Yearly, occurring between the months of March and May, hundreds of Krobo girls take part in *dipo* rituals (Steegstra 2002). Ceremonies and rituals are held throughout the day, with some variation from "house" to "house." These revered rituals signify the passage into womanhood for female Krobos. Parents present their daughters to a priest or priestess who pours a libation and requests the blessings of the gods upon the rituals. Following this, ceremonies under the supervision of the elder women or queenmothers mark each girl as an initiate. The women adorn the girls with strings of beads and cloth. Each girl receives *yi-si-pomi* or a shaving of their head. The shaving of the head is in accordance with Krobo custom and fashion (Huber 1963). Previously, the blade used to shave the head was used for several initiates. Recognizing that this potentially exposed girls to HIV, the Manya Krobo Queen Mothers appealed to the elders, the priests and priestesses,

to enact a policy of "one blade per initiate" (Group Meeting, 5 August 2004). The queenmothers explained that, if even one girl was infected with HIV, it could be transmitted to any of the initiates that shared her blade. The elders, priests, and priestesses cooperated, and *yi-si-pomi* is now performed with one blade per initiate.

In co-operation with the priest, priestesses, parents, and district hospital health workers, queenmothers used the opportunities provided by *dipo* festivals and gatherings to include HIV/AIDS education in the traditional training and graduation period (MKQMA 2003a). Furthermore, sixty *dipo* graduates were recruited by the MKQMA to act as peer educators. They were provided training in peer education techniques for HIV/AIDS and sexual reproductive health education and now deliver these programs in their communities with the support of the queenmothers (MKQMA 2003a).

Transferring HIV/AIDS knowledge and skills

AIDS competence relies upon widespread community awareness and capacity-building. One of the key components identified by UNITAR in building AIDS competence requires change agents to share their knowledge with those whom they think will benefit ("Knowledge Assets for AIDS Competence"; http://www.unitar.org/acp/KAssetsG/AIDSCompetence.htm). The queenmothers identified several key target groups for HIV awareness and prevention training. The queenmothers felt it was important to target children and youth and therefore implemented peer education and advocated for school-based HIV/AIDS education programming. The queenmothers also emphasize the importance of educating women and girls and providing them with income-generating skills and opportunities and thus implemented education and skills initiatives to address these needs.

The queenmothers also recognized that local service providers could benefit from HIV/AIDS awareness and prevention training. Local undertakers and traditional birth attendants were identified as targets for HIV/AIDS education and prevention training. When people die in Manya Krobo, local undertakers prepare the dead body for burial. Local undertakers are predominantly women, as women are mainly responsible for bathing people. When PLWHA die, undertakers do not necessarily know

the cause of death, and the queenmothers were concerned that they may handle the body in a manner that exposes them to HIV (MKQMA 2003a). The queenmothers organized a five-day training workshop for sixty-five local undertakers, which took place 26–30 November 2002. Training discussed HIV/AIDS transmission and prevention as well as practices and materials for handling dead bodies (MKQMA 2002a). Hands-on training was provided at the Atua Government Hospital and Akuse Government Hospital mortuary (Group Meeting, MKLUA, 3 August 2004; MKQMA 2003a). Before they received training, local undertakers admitted that they never used disinfectants, rubber gloves, face masks, or aprons when handling dead bodies. Subsequent to their training, the local undertakers formed an association: the Manya Krobo Local Undertakers Association (MKLUA) and now meet regularly. Members of the MKLUA indicate they now consistently employ the practices recommended in training (Group Meeting, MKLUA, 3 August 2004). Furthermore, they are now able to impart their knowledge, respond to questions about HIV and recommend VCT to fellow community members.

Traditional birth attendants (TBAs) provide traditional antenatal and birth delivery care for pregnant Krobo women and girls. Traditional birth attendants employed traditional methods in birth delivery and did not use gloves, clothing, or substances that would protect them from diseases or infections in the delivering woman. The queenmothers were concerned that, if a delivering woman was HIV positive, TBAs were at significant risk of exposure. Thus, the MKQMA organized training for 65 TBAs. In addition to HIV/AIDS education and prevention awareness, the women were trained in proper hand-washing and instrument sterilization techniques. Furthermore, TBAs were informed on where to refer pregnant women for antenatal, labour management, newborn infant care, and postnatal care (MKQMA 2003a). In particular, women who are HIV positive or suspected of having HIV are referred to Atua Hospital or St. Martin de Porres Hospital for VCT and/or PMTCT services. TBAs advise pregnant women under their care to be tested for HIV and provide information on the benefits of testing. Traditional birth attendants confirm that they now regularly employ the practices and materials advised in their training (Group Meeting, MKTBAA, 6 August 2004).

Queenmothers were particularly concerned about women and girls' vulnerability to HIV. Women complained about husbands who forced

them to have sex and threatened to remove them from the home if they did not comply. Women also told of how difficult it was to insist that their husbands use condoms. Some women confessed to the queenmothers that they were in difficult and vulnerable positions in their marriages. The queenmothers felt that, even if men could not be persuaded to change their behaviour, women should be economically empowered to have greater control over their choices and lives. Many women in Manya Krobo did not have any skills training or sources of employment. Typically, women supported their husbands on farms, sold water by the roadside, and did other casual labour work (Interview, Mrs. Gifty Ofori, 28 July 2004). In 2003, the queenmothers formed the "Smart Ladies Club" by recruiting fifty local, unemployed women over the age of fifteen (MKQMA 2003a). In January 2003, the "Smart Ladies" participated in a five-day workshop that emphasized HIV awareness and prevention and taught the women how to properly use male and female condoms. "Smart Ladies" now serve as peer educators and meet regularly at the MKQMA secretariat.

The MKQMA provided the "Smart Ladies" with vocational skills training. The women participated in a one-year training program in business skills, bead-making, tie-and-dye, soap-making, cookery, and housekeeping services (Interview, Mrs. Gifty Ofori, 28 July 2004). Individual queenmothers also train women in their communities. For example, Manye Maku-Kpong provided soap-making training for sixty women in her community. Manye Maku-Kpong supplied the materials and arranged for a skilled soap-maker to teach the women. Manye Maku-Kpong asserts that selling soap can provide women with some financial freedom and extra income for the household (Interview, Manye Maku-Kpong, 7 August 2004). Women's voices and choices may be constrained if they have no other choice but to rely on their husbands or families for their basic needs. Economic empowerment for women is essential to their social and sexual emancipation and consequently their reduced vulnerability to HIV.

Resource mobilization for care and support of HIV/AIDS orphans

During home visits, queenmothers reported increasing numbers of orphans living in child-headed households, with relatives or neighbours. In 2001, the Manya Krobo Queen Mothers Association began to identify and register each orphan child at their secretariat. They have currently

identified and registered over a thousand HIV/AIDS orphans (MKQMA 2003a). Many of these orphans live with relatives of their deceased parents, including elderly grandparents. The queenmothers are foster parents for a substantial number of these children. Some of the queenmothers report having up to six orphans in their care, in addition to their biological children. Orphans and vulnerable children (OVC) in Manya Krobo do not live in orphanages and, for the most part, are well integrated into homes in the community (Interview, Ms. Rebecca Anyan, 6 August 2004). However, the queenmothers were concerned about the added financial burden on foster parents of providing food, clothing, and school fees for the orphans. They were concerned that these children would not be able to attend school if their foster parents could not afford school fees or uniforms or required the children to work to support the household. The Manya Krobo Queen Mothers appealed to Catholic Relief Services (CRS), a charitable organization, to provide food support for the orphans. Catholic Relief Services agreed to deliver monthly supplies of wheat, soy bean oil, and wheat-soy-bean blend (known locally as "Tom Brown") for four hundred orphans. Food aid from CRS helps to relieve some of the pressure on foster families.

The Manya Krobo Queen Mothers submitted a proposal to the Ghana AIDS Commission (GAC) for funding for school fees, books, and uniforms for orphans in Manya Krobo. The GAC provided 300 million cedis (approx. CDN$42,000) to provide school fees, uniforms, shoes, books, and school supplies for four hundred orphans for a one-year period.[9] The MKQMA must re-apply annually to receive funding from GAC. Dr. Sylvie Anie of the Ghana AIDS Commission suggests that the MKQMA is an essential "conduit for the provision of care and support [for orphans and vulnerable children]" (Interview, Dr. Sylvie Anie, 29 July 2004).

Partnership formation

In order to develop and implement HIV/AIDS awareness, prevention, and care and support programs, the MKQMA partnered with several key organizations. The partnership established between FHI and the MKQMA has been crucial to their success. FHI facilitated training for 170 queenmothers, 50 local women ("Smart Ladies"), 65 local undertakers, and 65 traditional birth attendants. FHI also negotiated with the Presbyterian

Church in Manya Krobo to donate an old building to serve as a resource centre for the queenmothers. FHI procured funding from USAID to renovate the building and provide salaries for four staff members, including a secretary, program manager, and two program assistants. FHI provided a computer, printer, office supplies, and a television and VCR (for viewing the FHI/MKQMA-produced docudrama, "In Sickness and in Health"). FHI also supplied a program officer to work in Manya Krobo alongside the queenmothers. Mrs. Gifty Ofori mentored and monitored the work of the queenmothers. She encouraged the queenmothers to apply their skills and transfer their knowledge to the broader community (Interview, 28 July 2004). She met regularly with the queenmothers and asked them to report on the work that they had done in their communities and answered their questions or concerns. Her role with the queenmothers was extremely important, especially immediately following their training. Mrs. Ofori motivated and supported the queenmothers, acted as a troubleshooter, and required the queenmothers to be accountable to her and FHI. She argued:

> If you just teach people and they go home [and do nothing] you have only affected a small group. But if you motivate them and tell them how important it is to go out, and make them feel that there's a need for them to go out then they themselves want to walk out and do something. (Interview, 28 July 2004)

The partnership with FHI provided technical, funding, and motivational support to the MKQMA and thus built their capacity to implement widespread HIV/AIDS awareness, prevention, and care and support programming.

The MKQMA partnered with local hospitals to increase utilization of voluntary counselling and testing (VCT), prevention-of-mother-to-child (PMTCT) services, and to provide care and support for people living with HIV/AIDS. Dr. Charles Nyarko reports that the queenmothers approached him to discuss ideas on how to encourage people to avail themselves of HIV testing and health services provided at the hospital. In conjunction with FHI and the hospitals, the queenmothers devised a "referral and discharge" form that they provide to individuals in the community. The form advises people to go to the hospital to receive VCT,

PMTCT, antiretroviral treatment (ART) to fight HIV/AIDS, prenatal or antenatal care, and other general health services. The individual presents the form to hospital staff and receives the recommended services. The hospital staff signs the form and may offer recommendations for follow-up care or visits. The individual returns the form to the queenmother when she makes a home visit. This informs the queenmother whether advised services were received and allows her to monitor the health of an individual and to provide extra care and support where required. The referral form thus serves as a type of accountability mechanism, as people are more likely to seek out care and testing if they feel that another individual, especially a queenmother, is interested in their care. Results of VCT are never disclosed to queenmothers unless the individual wishes to share their status. Queenmothers now function as intermediaries between the community and health service providers, which Dr. Nyarko claims has contributed substantially to increased utilization of VCT and PMTCT services (Interview, 9 August 2004).

The MKQMA took several actions to reduce vulnerability to HIV and to mitigate the impacts of HIV. They identified traditional and social practices that potentially exposed people to HIV. Furthermore, they identified and provided information and skills training to key social groups and service providers that were particularly vulnerable to HIV, including women, children, traditional birth attendants, and local undertakers. Their resource mobilization efforts secured funding and food aid for school fees, uniforms, books, etc. for four hundred HIV/AIDS orphans. Partnerships developed their own capacity, which allowed them to transfer their knowledge to the broader community. They also partnered with hospitals to increase utilization of important HIV/AIDS preventative and care services. Ultimately, there is a "multiplier effect" attached to these actions. By training and educating local people in HIV/AIDS awareness, prevention, and care and support issues, they invariably impart their skills and knowledge within their own family and community circles. For instance, TBAs and local undertakers now speak to families about HIV/AIDS, recommend testing, and make referrals to local health providers and hospitals. Children and youth participating in peer education forums can talk to their own peers and siblings about HIV/AIDS and sexual and reproductive health. Women can talk to their husbands, children, and

friends. Knowledge and skills training radiates out from the individual and touches the lives of many.

Assessing Progress and Adapting to Change

The MKQMA has been engaged in building AIDS competence since 2000 when they first approached the DHMT for guidance and assistance. Since that time, over 170 queenmothers, 130 local service providers, 60 *Dipo* graduates, 50 local women, hundreds of local children and youth, and countless numbers of Manya Krobo community members have been beneficiaries of HIV/AIDS awareness and prevention education and training. Furthermore, through partnership formation and resource mobilization, the MKQMA has provided care and support for HIV/AIDS orphans, vocational skills training for local women, and peer education programs for children and youth and have facilitated improved access and utilization of HIV testing, treatment, and health care services. The MKQMA has thus reached the fifth stage in building AIDS competence as outlined by Lamboray and Skevington (2001).

Lamboray and Skevington (2001) maintain that once the awareness has been raised and actions taken to reduce vulnerability to HIV, AIDS-competent communities assess their own progress by soliciting and responding to feedback from the community and adapting their programs and skills as required. AIDS competence requires continual assessment and updating of skills and programs. Lamboray and Skevington (2001) suggest that, as the nature of the community's epidemic changes, so must the responses from the community. This requires program leaders and local service providers to continually update their knowledge and skills. Queenmothers from the MKQMA, particularly the program manager (Manye Nartekie) and program assistant (Manye Makutsu), regularly participate in training and information workshops that address, for example, economic empowerment, social marketing techniques, and care and support for PLWHA (Akuaku 2004). Queenmothers from Upper Manya Krobo confirm that core program staff (program manager and assistants) provide them with regular training and information updates (Group Meetings, August 5 and 9, 2004). The queenmothers maintain regular contact with local service providers to discuss their needs and progress. They maintain regular communication with FHI and GAC and

provide them with quarterly financial and progress reports. However, the MKQMA has not participated in any formal or research review of their programs. However, given their limited resources and that the programs in both Upper and Lower Manya Krobo have only been in place for two to three years, it is expected that program and progress evaluations will be conducted over the next several years. Queenmothers are now in the planning stages for anticipating future program needs.

OUTCOMES OF AIDS COMPETENCE

Lamboray and Skevington (2001) argue that several positive outcomes arise in AIDS-competent communities. Furthermore, because communities AIDS competence is in constant progression, Lamboray and Skevington (2001) state, "the more AIDS competent a community becomes, the more likely they will be to have a range of good outcomes" (519). The development of AIDS competence yields positive outcomes such as: 1) perceived HIV risk reduction; 2) less HIV infection; 3) more care and support for people living with or affected by HIV/AIDS; 4) increased autonomy; and 5) and improved quality of life in the communities. Manya Krobo communities have demonstrated many of these positive outcomes.

Perceived Risk Reduction

There are several indications that HIV awareness social marketing tools and campaigns have effectively reduced the risk of contracting and/or transmitting HIV in Manya Krobo. Awareness of HIV and prevention strategies is now widespread in Manya Krobo. Local people know how to protect themselves and where to obtain condoms, VCT, PMTCT, and ART. They also know that they can approach the queenmothers as community health workers for information and referrals. At group meetings with the Manya Krobo Queen Mothers (2, 5, and 9 August 2004), they indicated that condom purchasing from local vendors and queenmothers has increased substantially. They also indicated that HIV is now a familiar and popular topic of conversation in the communities and is regularly discussed at public gatherings (Group Meeting, 5 August 2004). They

stated that initially there was some reticence in discussing issues of HIV and sexual and reproductive health; however, queenmothers from Upper Manya Krobo maintain that these attitudes have largely dissipated and now describe people as accepting and attentive (Interviews: Manye Gladys Teye, 9 August 2004; Manye Nartekie, 26 July and 2 August 2004; Manye Otrokper, 5 August 2004; Manye Beatrice Kofi, 5 August 2004). Dr. Charles Nyarko from St. Martin de Porres Hospital confirms that the activities of the queenmothers have contributed to increased unitization of VCT, PMTCT, and ART services (Interview, 9 August 2004). Furthermore, the queenmothers suggest that this has resulted in decreased utilization of "quack doctors" – unlicensed individuals practising in the community (Group Meeting, 5 August 2004). Queenmothers encourage people, especially in the rural Upper Manya Krobo to travel to local hospitals and clinics to determine their HIV status or to receive medical care by licensed practitioners. Awareness of HIV and prevention strategies has increased substantially in Manya Krobo, which reduces the risks of new HIV infections. While baseline and subsequent demographic health surveys to measure HIV and sexual health attitudes and behaviours in Manya Krobo do not exist, the *de facto* baseline – widespread ignorance about HIV, negligible condom usage, and little collaboration or cohesion between traditional leaders and community organizations, service providers, and health practitioners – implies that social marketing, training, and partnership efforts have contributed to heightened awareness and thus perceived risk reduction to HIV.

Less HIV Infection

Lamboray and Skevington (2001) argue that AIDS-competent communities experience less HIV infection. The rationale is that, as vulnerability to HIV decreases and behaviours change, the incidence of new infections declines. However, this is often difficult to measure, at least in the short term. HIV surveillance reports prevalence or the percentage of the population living with HIV/AIDS. Thus, if prevalence rates drop, it may reflect that incidence (actual number of new infections over a given period) is decreasing *and/or* that people have died from HIV/AIDS. Stable prevalence rates can indicate that the number of new infections is being matched by the number of AIDS-related deaths. Thus, as Dr. Kwame Essah (FHI)

indicates, it is difficult to measure success using prevalence as an indicator (Interview, 27 July 2004). Incidence is a better measurement because it provides the number of *new* infections over a given period. Dr. Essah argues that the successes in Manya Krobo may not be empirically measurable; they relate to the improved climate of awareness, acceptance, care, and support (Interview, 27 July 2004).

More Care

Dr. Sylvie Anie of the Ghana AIDS Commission argues that one of the important successes emanating from the AIDS-competence-building activities of the MKQMA is the improved care and support of HIV/AIDS orphans in Manya Krobo. Dr. Anie argued that the study conducted by the GAC reveals improved social and academic outcomes for HIV/AIDS orphans following their inclusion in MKQMA programs. For instance, differences in orphans – before and after care – in their health status, school records and other quality of life indicators can clearly be seen (Interview, Dr. Sylvie Anie, 28 July 2004). Queenmothers have contributed to their care by securing food support, funds for school fees and materials and by engaging orphans in after-school and vacation peer education and other activities. While Dr. Anie acknowledges that there is "room for improvement and expansion," she argues that there are important successes in orphan care in Manya Krobo (Interview, 28 July 2004).

Increased Autonomy

AIDS competence is a bottom-up approach to creating HIV awareness, prevention, and care and support in communities. Programs and initiatives are community-owned and led and take full account of the cultural and social factors that may be susceptible to change. Change agents within the community, such as traditional leaders, assume leadership roles, but the community is expected to fully participate in programs, provide feedback, and engage in the process of developing AIDS competence. Lamboray and Skevington (2001) suggest that the full involvement of the community is imperative to building AIDS competence. This approach provides significant autonomy for communities to develop locally and culturally appropriate responses to HIV/AIDS and adapt responses as deemed necessary.

External agencies do not impose programs on the community but support and build the community's capacity to design and implement their own strategies. The MKQMA has taken a leadership position in building AIDS competence in their communities; however, community members, including Paramount Chief Nene Sakite II, clergy, community-based organizations, schools, vendors, women, children, hospitals, service providers, and health practitioners, have been both beneficiaries and facilitators of HIV awareness, prevention, and care and support activities. This is a community well-positioned to control and confront the epidemic.

Improved Quality of Life

Lamboray and Skevington (2001) predict that quality of life is improved in AIDS-competent communities from the point at which the community acknowledges that they have an HIV/AIDS problem. Experience with communities engaging in AIDS-competence building indicates that there is a net gain in terms of positive outcomes as a result of being AIDS-competent (Lamboray and Skevington 2001). Again, this is difficult to empirically measure without a significant time and financial investment. However, it can be determined that quality of life in Manya Krobo has been enriched through AIDS-competence-building actions and activities. Countless numbers of local people have new knowledge and skills that they did not possess prior to AIDS-competence-building actions and activities. HIV/AIDS orphans and their foster families have new sources of support. There is a spirit of openness and responsibility to respond to HIV/AIDS and care for those who are living with or affected by the disease. These indicators indeed suggest that AIDS-competence-building has created an improved quality of life for people living in Manya Krobo.

CHALLENGES AND CONSTRAINTS TO BUILDING AIDS COMPETENCE

Despite the successes, several constraints and challenges confront Manya Krobo communities in building and scaling up AIDS competence. Key challenges and issues to be addressed are:

1. poverty and financial constraints;
2. deficiencies in health infrastructure;
3. rural program delivery issues;
4. the care and needs of HIV/AIDS orphans over the short and long-term;
5. women's social and economic empowerment and equality;
6. greater involvement of men and chiefs;
7. moving toward behavioural change; and
8. the participation of queenmothers on local and national decision-making bodies.

Each of these challenges threatens and/or precludes the sustainability and scaling up of current programming. The concluding section addresses these challenges and provides recommendations for policy, practice, and research.

1. Poverty and Financial Constraints

The foremost challenge facing Manya Krobo is the sheer poverty of the area. Poverty and illiteracy rates are very high and there is massive unemployment (MKQMA 2003a). Traditional birth attendants and local undertakers find it challenging to pay for the materials that FHI training advised. They stated that clients usually do not have money to pay the TBA and thus they must pay out-of-pocket for first-aid kits, aspirin, anti-coagulants, bed sheets, blankets, flashlights, boots, aprons, and surgical gloves (Group Meeting, 6 August 2004). While many of the programs use a low-cost/no-cost approach, poverty and financial difficulties threaten

the sustainability of the programs and preclude opportunities for growth and development. While the MKQMA has facilitated the acquisition of knowledge and skills resources, deprivation of material resources threatens people's basic survival, their willingness and ability to translate knowledge into behavioural change, and the survival of the programs themselves. HIV/AIDS is a disease of poverty, and thus efforts to reduce risk and vulnerability to HIV must be coupled with those to eliminate poverty and economically empower people and societies.

The MKQMA operates on extremely limited resources and relies upon FHI and GAC to financially support their programs. Although FHI and GAC provide funds for programs and to support HIV/AIDS orphans, there are still considerable unmet needs. For instance, GAC provides funds for orphans up to the junior secondary school level. Accordingly, there are no funds for children wishing to pursue senior secondary school or tertiary education, and the fees attached make it prohibitive for most children and their foster families. The queenmothers are often poor themselves and have only meagre incomes to support their own families. Furthermore, because they are responsible for the welfare of children and families in the community, they often must pay for clinical care for community members out of their own pocket (Group Meeting, 5 August 2004).

The MKQMA also does not have access to stable and predictable funding for their programs. Funding is contingent upon the capacity and support of donor agencies. Furthermore, funding is usually tied to specific programs, and there is little flexibility to create new programs or to divert funds for other program uses. The MKQMA must spend a great deal of time fundraising for their programs, which diverts already strained human resources. The MKQMA would like to scale up existing programs and add new programs but do not have the resources to do so. Manye Nartekie, the project manager, wants the MKQMA to develop a computer training centre in Lower Manya Krobo. She emphasizes that economic empowerment and skills training are essential to controlling the epidemic, enhancing the standard of living, and providing important growth and career opportunities for Krobos (Interview, 26 July 2004). Professor Amoa of the GAC acknowledged that the MKQMA needs access to longer-term financial support for developing and sustaining current programs, as well as further building organizational and community capacity (Interview, 17

August 2004). Dr. Anie of the GAC admitted that the MKQMA suffers from a "serious dearth in financial support" (Interview, 28 July 2004). The Chieftaincy, Governance and Development Project (2000) suggested that there was considerable sympathy from Ghanaians for queenmothers to access government funding. An endowment from government could provide the MKQMA with the needed resources and flexibility to develop new programs, scale up existing programs, and purchase important capital such as a desperately needed new resource centre to house their programs. The MKQMA has demonstrated their commitment and capability to build AIDS competence in Manya Krobo. Longer-term and sustainable funding, in addition to current support, must be secured to allow the MKQMA to sustain and expand AIDS competence in Manya Krobo. However, if the Government of Ghana is not in a position to provide needed funds, international donor agencies must look towards supporting AIDS-competence efforts such as those in Manya Krobo.

2. Health Infrastructure

Inadequate health infrastructure and access are serious constraints to delivering important VCT, PMTCT, ART, and other health services in Manya Krobo. Manya Krobo is served by two local hospitals – St. Martin de Porres Hospital and Atua Government Hospital. St. Martin de Porres Hospital houses forty-eight beds and Atua Hospital provides eighty-two beds. Thus, demand for services nearly always exceeds capacity. Furthermore, St. Martin de Porres Hospital is staffed by only one doctor and forty nurses. St. Martin de Porres Hospital does not receive any funding from the central government or the district assembly. Access to both hospitals is compromised by poor, unpaved roads that desperately need resurfacing. Dr. Nyarko from St. Martin de Porres indicates that adequate funding and human resources are major problems for both hospitals (Interview, 9 August 2004). Hospitals provide health services on a "cash-and-carry" basis, and thus patients and their families pay for services at the point of delivery. Given inadequate government funding and high poverty levels in Manya Krobo, hospitals and health clinics suffer from ongoing financial problems. Improved access is needed for VCT, PMTCT, ART, and other health services; however, financial constraints preclude or impede renovation or expansion of facilities.

3. Problems Specific to Rural Program Delivery

In Ghana, over 60 per cent of the population lives in rural areas (Seini 2003). This presents problems for program delivery because it is difficult to access rural populations with mass media campaigns (there is little or no television or radio reception in rural areas). For this reason, the Ghana Social Marketing Foundation developed and implemented the Rural HIV/AIDS Campaign, using mobile vans to deliver social marketing materials to rural areas. It is also difficult to organize rural populations for program delivery because of scattered and widespread settlements. Villages and homes in rural areas tend to be widely geographically dispersed. Queenmothers from rural Upper Manya Krobo cited problems with long distances to walk between homes and poor road systems to access homes and villages (Group Meetings. 5 and 9 August 2004). Queenmothers make home visits to discuss issues of HIV/AIDS and sexual and reproductive health, provide condoms, monitor health, and recommend VCT, PMTCT, ART, or other health services. Inadequate transportation and road systems serve as a major impediment to the delivery of awareness, prevention, health, and support services. Furthermore, when queenmothers discuss these issues, some people have indicated that they do not have the money for transportation to district hospitals. The two district hospitals (located in Lower Manya Krobo) are anywhere from thirty-five to seventy-five minutes by car from Upper Manya Krobo villages. This harks back to the issue of poverty; because the district does not have the resources to develop roads, queenmothers do not have the resources to purchase a vehicle and must use their own resources for taxis and local transportation, and people cannot afford the transportation costs to go to the hospitals to receive VCT, PMTCT, ART, or other health services. It is thus very difficult to deliver rural programming, particularly in impoverished areas such as Manya Krobo.

4. Orphans

The MKQMA successfully secured important food and education aid for four hundred HIV/AIDS orphans in Manya Krobo. However, the queenmothers have expressed concern about providing for the long-term health, education, and emotional needs for HIV/AIDS orphans (Group

Meetings, 2, 5, and 9 August 2004). Furthermore, because the GAC does not provide funding for orphans beyond junior secondary school , one of the major concerns expressed by queenmothers related to their ability to provide financial support for children who wish to pursue senior secondary and tertiary education and training (Group Meetings, 2 and 5 August 2004). Caring for increasing numbers of orphans without unduly straining already overextended family and social networks will be an ongoing challenge in Manya Krobo.

5. Queenmothers and Women's Economic and Social Empowerment and Equality

Despite advancements in women's economic and social empowerment, women continue to occupy subordinate positions in many traditional areas. Persistent cultural and gender norms preclude women from attaining and exercising equal social and economic rights. Women continue to be discriminated against and treated as unequal to men (Fayorsey 2003). Huber (1963) sums up a Krobo woman's social status as one marked by social and economic inferiority. Krobo women are not allowed to choose their own husbands and are expected to demonstrate respect and obedience towards their husbands. Krobo women relinquish their reproductive rights to their husbands who control the number and spacing of children. Krobo women assume the burden of all domestic work and polygamy is also approved under Krobo customary law (Huber 1963). While queenmothers admitted that many of these practices are phasing out, women continue to confront considerable social and economic disadvantage and inequality in Krobo society. However, the Manya Krobo Queen Mothers have continued to advocate for and achieve meaningful gains in social and political equality in terms of traditional political structures. Where traditional political structures and decision-making structures in the Krobo Kingdom and its administration were previously exclusively the domain of chiefs, the Queen Mothers were invited in 2003 to become sitting, and subsequently, voting members of the chiefs' traditional council. This provides them with considerable voice and agency in decision-making around development in the Krobo Kingdom. However, many queenmothers across Ghana and elsewhere in sub-Saharan Africa, are shut out of formal participation in the structures of political authority and decision-making. This continues

to be a major obstacle to the full and meaningful participation of women leaders in social and political organization in their communities.

Unlike chiefs, queenmothers in Ghana do not usually have palaces, access to royalties that accrue from the appropriation of resources of the traditional state, or access to allowances from government (Fayorsey 2003). Even where queenmothers have considerably more power, such as among the Asante queenmothers, Fayorsey (2003) argues that chiefs form enclaves of male autocracy to subjugate their female counterparts. Queenmothers *and* chiefs should continue to review and challenge the negative perceptions and traditional and social practices that circumscribe women's full social and economic inclusion, which consequently exposes them to increased risks of HIV. This is further discussed in the concluding section.

6. Involving Manya Krobo Men and Chiefs

Because women are more susceptible and vulnerable to HIV infection, and arguably face greater social and economic disadvantage than men, programming is increasingly "gendered" or focused on creating HIV/AIDS awareness, prevention, and empowerment strategies for women and female children. However, this can create an asymmetry whereby men's HIV/AIDS awareness, prevention, and support needs are not effectively addressed. It is important to include men in HIV/AIDS awareness and prevention programming – indeed they are a crucial half of the equation for reducing vulnerability to HIV infection. If males learn to behave responsibly in sexual relationships and respect the social, sexual, and economic rights of their partners, both male and female vulnerability to HIV infection will be reduced. Although women's empowerment is crucial to reducing vulnerability to HIV and elevating the status of women, men nonetheless constitute the other half of the primary method of HIV transmission in Ghana: heterosexual intercourse.

Manya Krobo men and chiefs should be encouraged to meaningfully engage in HIV/AIDS awareness, prevention, and support programming. The konor, Nene Sakite II, encourages and supports the efforts of the MKQMA, and regularly addresses his people on issues of HIV/AIDS (Interview: Dr. Kwame Essah, 27 July 2004). Mrs. Gifty Ofori contends that his support has been integral to the success of the MKQMA because it affirmed their credibility and responsibility to develop and deliver HIV/

AIDS awareness, prevention, and support programming (Interview: 28 July 2004). Due to prevailing cultural and gender norms, direct access to males by the queenmothers, especially chiefs, was not considered appropriate. While queenmothers address males during public gatherings, they target women, children and youth for programming. Involving and targeting men and chiefs in HIV/AIDS awareness, prevention, and support programming is the next stage in building AIDS competence in Manya Krobo.

7. Moving Towards Behavioural Change

Dr. Kwame Essah and Professor Sakyi Amoa contend that the MKQMA has substantially raised awareness of HIV in Manya Krobo (Interviews: 27 July and 17 August 2004). However, the next challenge facing Manya Krobo is translating awareness into action. Behavioural change implies increased utilization of condoms, voluntary counselling and testing to monitor one's status, and preventative health services (i.e., controlling and treating sexually transmitted infections). It requires people to apply their knowledge to sexual and social behaviours. Behavioural change remains a challenge in Manya Krobo, and thus social marketing campaigns and access to testing and preventative health services must be sustained and strengthened.

8. Local and National Representation on Decision-making Bodies

Queenmothers across Ghana have proven to be formidable and effective agents in the fight against HIV/AIDS in their communities. Despite their contributions, they continue to be excluded from participation on local, regional, and national decision-making bodies. Queenmothers are not represented at the National or Regional Houses of Chiefs, and only very recently have limited numbers of queenmothers had representation on traditional councils. Mrs. Valerie Sackey, former Director of Public Affairs under the Rawlings administration, stated that queenmothers have formed associations at the district, regional, and national levels to *inter alia* lobby for inclusion in National and Regional Houses of Chiefs, but suggests that there is "serious resistance to women joining the Houses of Chiefs" (Interview: 29 July 2004).

Because queenmothers cannot hold membership in the National House of Chiefs (NHC), they were inevitably excluded from participating in stakeholder discussions around the formulation of Ghana's national strategic framework. Prominent male traditional leaders drawn from the NHC and across Ghana were invited to participate on seven stakeholder committees in the formulation of the 2001–2005 national strategic framework. However, according to the list of participants, queenmothers were not represented on stakeholder committees (Government of Ghana 2001). Queenmothers make valuable contributions in their communities and deserve to have their voices heard and represented on national, regional, and local decision-making bodies. While the NHC has permitted their informal involvement, by inviting queenmothers to selected meetings,[10] formal integration is imperative to their full and equal representation on national, regional, and local decision-making bodies.

CONCLUSION

The case of the Manya Krobo Queen Mothers Association demonstrates the potential for involving female traditional leaders in the fight against HIV/AIDS. Queenmothers' traditional duties relate to the welfare and well-being of women, children, and families, which naturally extends to protecting them against the risks and impacts of HIV/AIDS. HIV/AIDS poses enormous challenges to communities, particularly rural, impoverished communities. AIDS competence provides a framework for grassroots community responses to HIV/AIDS. AIDS competence means that communities become empowered to develop and implement locally and culturally appropriate strategies to address their unique needs. Ultimately, AIDS-competent communities create "AIDS hardy" populations that are equipped to respond to the risks and impacts of HIV/AIDS. AIDS-competent communities are more likely to demonstrate perceived risk reduction of HIV infection, less HIV infection, more care and support for people living with or affected by HIV/AIDS, improved quality of life, and increased community autonomy.

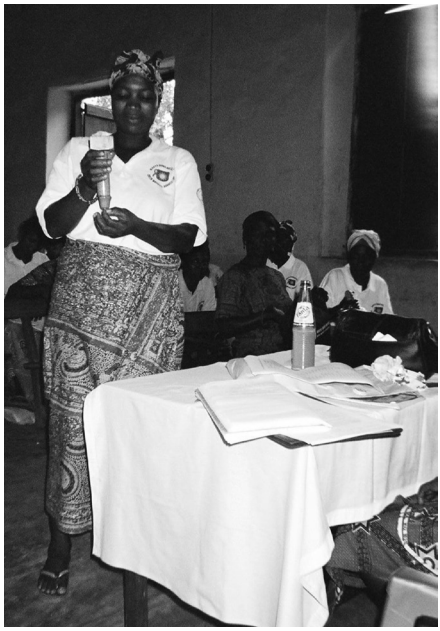
Manya Krobo Queen Mothers acted as change agents in the development of AIDS competence. Following recognition of HIV infection

in their communities, they sought and received HIV/AIDS awareness, prevention, and support training by establishing partnerships with non-governmental (FHI) and governmental (GAC) organizations. They then transferred their knowledge and training by developing and implementing widespread and targeted social marketing campaigns. They also provided education and skills training for targeted groups, including women, children and youth, and HIV/AIDS orphans. Furthermore, the queenmothers identified traditional and social practices that were inimical to reducing vulnerability to HIV infection. They mobilized resources and partnerships to provide care, support, and testing and treatment services for people living with or affected by HIV/AIDS. The data from this case study demonstrates that the actions of the MKQMA have contributed to building AIDS competence in Manya Krobo.

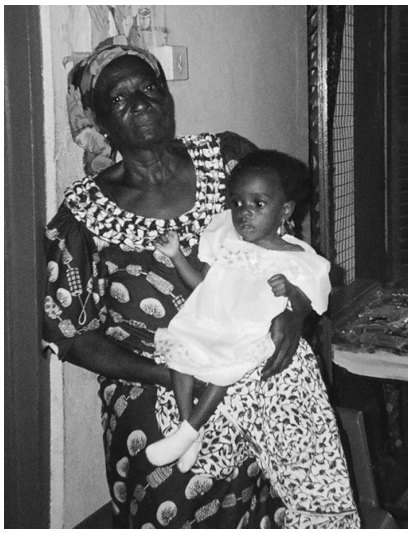
However, the sustainability and progression of AIDS competence is threatened by several constraints and challenges. High levels of poverty and unemployment, inadequate access to health and testing services, increasing numbers and needs of HIV/AIDS orphans, and gender inequality compromise or undermine efforts to build AIDS competence. To address these problems, increased levels of sustainable funding for capital and human resources and health and social needs is essential. Furthermore, there needs to be a greater involvement of men and chiefs in programming, as well as a full review of social and traditional practices that expose or increase vulnerability to HIV/AIDS. Queenmothers and women need to have equal representation on local, regional, and national decision-making bodies to ensure that their needs and perspectives are recognized and considered. Sustaining and scaling up AIDS competence will require a considerable and long-term investment of time, resources, and energies. Traditional leaders are willing to provide leadership and to develop and deliver low-cost/no-cost programs; however, technical and funding partnerships are essential to building and sustaining AIDS competence.

Manya Krobo schoolchildren. (Photo: Sherri Brown.)

Manya Krobo Queenmothers Association Resource Centre.
(Photo: Sherri Brown.)



Upper Manya Krobo Queenmother demonstrating condom use. (Photo: Sherri Brown.)



Manya Krobo woman with her foster child. (Photo: Sherri Brown.)

Manye Nartekie, Deputy Paramount Queenmother, and Sherri Brown. (Photo: Sherri Brown.)

Manya Krobo Chiefs and Queenmother. (Photo: Sherri Brown.)

Upper Manya Krobo Queenmothers. (Photo: Sherri Brown.)

Notes

1 Exact figures are not known. Sources: Interview, Manye Nartekie, 2 August 2004; Manya Krobo Queen Mothers Association (MKQMA), 2003. *Executive Summary of the Projects of the Manya Krobo Queenmothers Association*. MKQMA: Odumase-Krobo, Ghana.

2 I was not able to obtain the exact year when the Ghana Education Service and Manya Krobo District began providing English language instruction as part of core education curricula.

3 Descendants of the Basel missionaries made two visits to Odumase-Krobo in August 2004 while I was there conducting fieldwork. Chiefs, queenmothers and many community members warmly welcomed them and held a small durbar (festival) in their honour.

4 The Manya Krobo and Yilo Krobo districts in the Eastern Region are renowned for their distinctive bead handicraft. Krobos produce exquisitely crafted and colourfully painted powdered beads made from Bodom, Zagba, Ader, Koli, Olongo and other materials.

5 The 'paramountcy' of Manya Krobo refers to the paramount traditional leaders (male and female) – and comprises the paramount and deputy paramount chiefs and queenmothers. The paramountcy refers to these reigning leaders, and the royal houses from which these leaders descend.

6 Interview: Dr. Charles Nyarko, Chief Medical Officer at St. Martin de Porres Hospital, Manya Krobo district, Eastern Region, Ghana. Held 7 August 2004.

7 Based on figures from NACP/GHS (2003) and Sauvé et al. (2002).

8 DFID provides funding to FHI under the "Start" program. FHI manages and disburses these funds to local organizations, including the Manya Krobo Queen Mothers Association. Exact funding amounts could not be obtained from FHI.

9 From June 2004 to May 2005, the GAC would disburse a total of 300 million cedis in quarterly payments.

10 For example, Manye Nartekie addressed the NHC in March 2004 on the work of the MKQMA.

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LIST OF INTERVIEWS/MEETINGS

Date	Name and *Place of Interview*	Title and Organizational Affiliation	Type of Organization
26 July 2004	Esther Kpabitey (Manye Nartekie) *Odumase-Krobo*	Deputy Queenmother and Program Manager, Manya Krobo Queen Mothers Association	Traditional Leader Organization
27 July 2004	Dr. Kwame Essah *Accra*	Country Director, Family Health International	NGO
28 July 2004	Mrs. Gifty Ofori *Accra*	Programme Officer, Family Health International	NGO
28 July 2004	Dr. Sylvie Anie *Accra*	Director of Research, Policy, Monitoring and Evaluation, Ghana AIDS Commission	Para-Public
29 July 2004	Mrs. Valerie Sackey *Accra*	Former Director of Public Affairs, Office of the President, President J.J. Rawlings Administration	Government
29 July 2004	Mr. Duke Ofori-Atta *Accra*	AIDS Coordinator, Okyeman AIDS Foundation	Traditional Leader Organization
30 July 2004	Dr. Joseph A. Ayee *Legon, (University of Ghana)*	Dean, Faculty of Social Studies, University of Ghana-Legon	University
2 August 2004	Esther Kpabitey (Manye Nartekie) *Odumase-Krobo*	Deputy Queenmother and Program Manager, Manya Krobo Queen Mothers Association	Traditional Leader Organization
2 August 2004	Group Meeting *Odumase-Krobo*	Planned Parenthood Association of Ghana (PPAG) Peer Education Group Meeting	CBO
3 August 2004	Group Meeting *Odumase-Krobo*	Manya Krobo Local Undertakers Association	CBO
5 August 2004	Group Meeting *Otrokper, Upper Manya Krobo*	Queenmothers from Upper Manya Krobo-Otrokper	Traditional Leader Organization
5 August 2004	Manye Beatrice Kofi *Otrokper, Upper Manya Krobo*	Queenmother for Sekesua	Traditional Leader Organization

5 August 2004	Manye Otrokper *Otrokper, Upper Manya Krobo*	Queenmother for Otrokper	Traditional Leader Organization
5 August 2004	Monica Mawuger Tetteh *Otrokper, Upper Manya Krobo*	Queenmother for Breponso Ogome	Traditional Leader Organization
6 August 2004	Ms. Rebecca Anyan *Odumase-Krobo*	National Service Personnel, Assistant to Manya Krobo Queen Mothers Association	Traditional Leader Organization
6 August 2004	Group Meeting *Odumase-Krobo*	Manya Krobo Traditional Birth Attendants Association	CBO
6 August 2004	Ms. Maku Kodji *Odumase-Krobo*	President of the Manya Krobo Local Undertakers Association	CBO
6 August 2004	Ms. Comfort Naki Odonkor *Odumase-Krobo*	Vice-President of the Manya Krobo Local Undertakers Association	CBO
7 August 2004	Mrs. Comfort Ayertey *Odumase-Krobo*	Manya Krobo Traditional Birth Attendants Association	CBO
7 August 2004	Manye Maku-Kpong *Odumase-Krobo*	Queenmother for community of Kpong Manya Krobo Queen Mothers Association	Traditional Leader Organization
7 August 2004	Dr. Charles Nyarko *Odumase-Krobo*	Medical Officer, St. Martin de Porres Catholic Mission Hospital	Health Sector
8 August 2004	Esther Kpabitey (Manye Nartekie) *Odumase-Krobo*	Deputy Queenmother and Program Manager, Manya Krobo Queen Mothers Association	Traditional Leader Organization
9 August 2004	Group Meeting *Asesewa, Upper Manya Krobo*	Queenmothers from Upper Manya Krobo-Asesewa	Traditional Leader Organization
9 August 2004	Manye Gladys Teye *Asesewa, Upper Manya Krobo*	Queenmother for Asesewa	Traditional Leader Organization
17 August 2004	Professor Sakyi Awuku Amoa *Accra*	Director-General, Ghana AIDS Commission	Supra-Ministerial Government Organization
20 August 2004	Mr. Rudi Lokko *Accra*	Chief of Marketing Operations and Coordinator for External Business, Ghana Social Marketing Foundation	NGO