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Crossing the Border: Poverty, HIV and the Women of the Southern Ghana-Togo Corridor

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CROSSING THE BORDER:
POVERTY, HIV AND THE WOMEN OF THE
SOUTHERN GHANA-TOGO CORRIDOR

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ABSTRACT

This paper seeks to explore how geographic location, political economy and gender relations impact women living along the southern Ghana-Togo border. In this population, women who are financially dependent on men are often unable to maintain safe sex practices in both premarital and marital relationships, ultimately increasing their risk of contracting sexually transmitted diseases. Through participant observation and ethnographic interviews, this paper documents the past and present political, economic and social environment, focusing specifically on how these factors contribute to a cycle of poverty and HIV that constrains the lives of women in the border communities.

ACKNOWLEDGMENTS

I am forever indebted to all the people who have given me the tools, strength, and encouragement to complete this project. To my advisor, Dianna Shandy, who believed in my ideas and spent countless hours covering each of my drafts with her insights, comments, and corrections, all the while reassuring me that I (usually) knew what I was talking about. To Sonia Patten, who provided me with the books and course that have inspired my work and my future. To my Dad, who has never failed to be my favorite editor. To Julia, my best friend, who has tolerated me for so many months, and never failed as a roommate or last minute editor. To my family, who have fostered and encouraged my endless pursuit of knowledge. To Ben, who has always listened and provided immeasurable encouragement and love. To Colette, who accompanied me throughout my field research and with whom I enjoyed countless nights of *banku* and solitaire. To Sadat, Thomas, Valentina, Makafui, My Friend, Nelson, Nester, Eugenia, Eli, Sammy, Gregory, Helen and Rejoice, my Ghanaian family who always made me feel at home in Aflao. And finally, to Jane and all the women of the border, for providing me with their stories, time and smiles.

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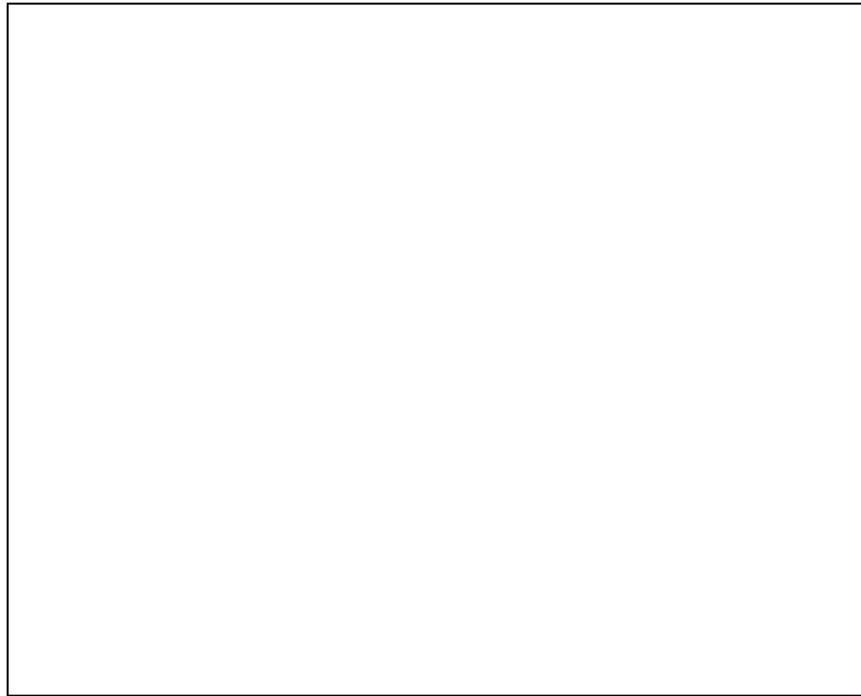
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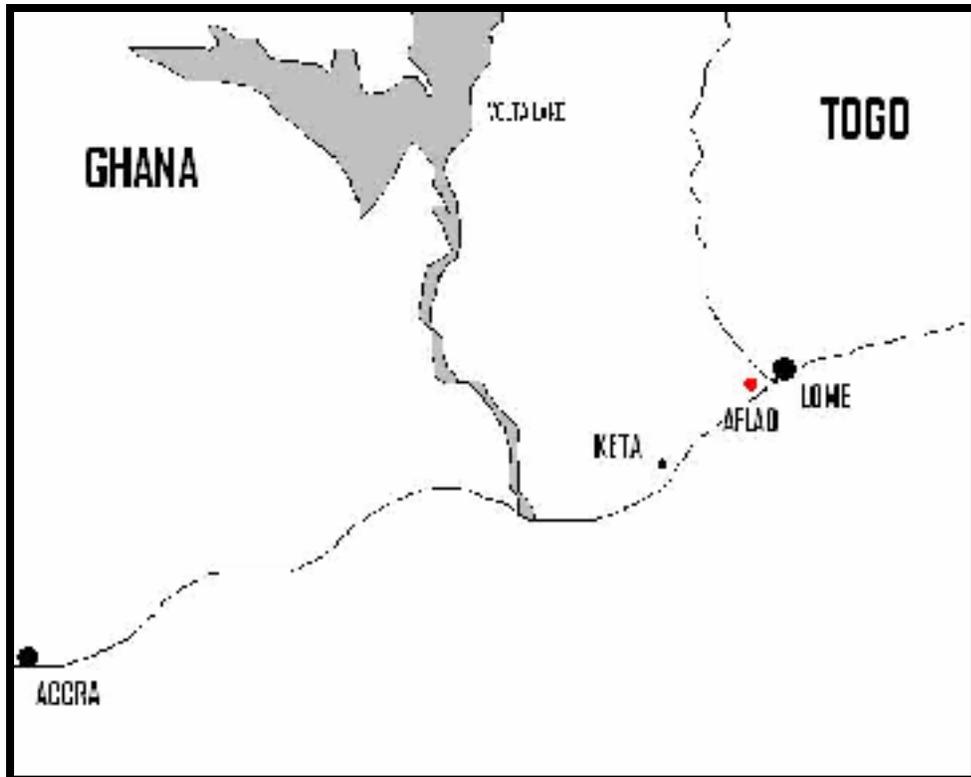
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MAP 1: *West Africa*

Please see:

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MAP 2: *Aflao, Ghana and surrounding region.*
(Map drawn by author)

CHAPTER I: INTRODUCTION

The billboard looms over a busy road in Ghana. “*Abstain ~ Be Faithful~ Condom Use. The choice is in your hands.*” A simple message, yet for many women an impossibility. The popular ABC HIV-prevention campaign has been disseminated to countries throughout Africa, each of which depends on international donor money that specify this strategy. Today, with more conservative funding, the abstinence portion of the ABC campaign has been increasingly emphasized. However, this prevention strategy does nothing for the majority of women living along the southern Ghana-Togo border, who cannot control the forces that place their lives at risk.

Women along the southern border of Ghana and Togo are faced with many difficulties as they struggle to ensure financial stability, navigate their way through a male dominated society, and protect themselves and their family from disease. With the onset of HIV and other sexually transmitted infections (STIs), women who appear to have attained security through marriage¹, are now faced with the possibility of contracting disease from their husbands. An atmosphere of mobility and desperate economic conditions has

¹ Among the Ewe who form the dominant ethnic group of the southern Ghana-Togo border, marriage is based on a patrilineal system. In addition, the region is characterized by an open polygynous system, in which it is culturally acceptable for men to marry more than one woman and pursue extramarital relationships without the intent of marriage. Some women also have extramarital relationships; however for women this is not openly accepted and according to G.K. Nukunya, is characterized by both religious and legal sanctions (Caldwell et al 1992:403). The implications of the social context of the southern Ghana-Togo border in relation to HIV are addressed in chapter IV.

left no age group or socioeconomic status untouched by HIV/AIDS.

Education efforts centered on abstinence before marriage, condoms, and faithfulness in monogamous relationships do not change the fate of married women, who are unable to ensure condom use or their husband's fidelity.

The purpose of this paper is to examine how the interaction between geographic location, gender relations, and political economy shapes the lives of women along the southern Ghana-Togo border. My research was focused on the manifestation of these interacting factors in the lives of HIV positive women, all of whom had limited access to education, and therefore depend on the informal economy². Throughout my field research it became increasingly clear that the political economy of the region is interacting with HIV in a vicious cycle in which women in poverty³ must put their lives at risk in order to survive. Those who become infected lose strength quickly in the stressful and stigma-ridden environment, ultimately preventing them from working to support increasing dietary and medical needs.

While poverty initially contributes to the risk of acquiring HIV, once a person is infected, it ultimately hastens the disease's impact on the body, preventing participation in income generating activities. Consequently, the

² The informal economy is defined as the exchange of goods and services that is not recorded by the government, and therefore outside of the control of regulatory agencies. This economy includes petty trading, commercial sex work, smuggling, and currency trafficking, in addition to unregistered seamstress or hairdressing shops.

³ Poverty is defined by the World Bank as living on less than 2 dollars a day; extreme poverty is defined as living on less than 1 dollar per day (World Bank). In the Volta Region of Ghana, 49.5% of the population was found to be living in poverty, in the Ketu district in particular, which includes Aflao and the surrounding communities, the poverty level was similarly estimated at 49.4% of the population (Coulombe 2005).

increased poverty of the children of those infected with HIV creates an intergenerational cycle of poverty and vulnerability to disease that seems to preclude any immediate or easy solution to the problem. This cycle is largely absent from the biomedical model of HIV, which focuses specifically on individual choice, and therefore ignores the interconnection between political economy and disease and the relationship between behavior and social conditions (Schoepf 2001: 339). However, despite HIV's seemingly unyielding control over infected women's lives, I will also describe how the women I interviewed use culturally specific strategies to mitigate the impact of the disease. This multi-factorial approach to the analysis of HIV among women along the southern Ghana-Togo border will form the basis for my recommendations for future HIV prevention and support efforts in the region.

THEORETICAL FRAMEWORK

Eric Wolf began a conversation about the interconnections between ideas and phenomena within the world in the introduction to his book *Europe and the People Without History*. He was writing against the misconception of culture as an “integrated and bounded system, set off against other equally bounded systems” (Wolf 2006: 368). Conversely, every phenomenon and every individual operates in a system of interconnections. This theoretical understanding of the world and society is illustrated through my own research on HIV/AIDS among women in Aflao, Lomé and the surrounding border communities. Their daily life was influenced in extraordinary ways by

events and historical processes occurring as close as within their own communities and as far as in Europe and the United States. The lack of access to education, employment opportunities and financial resources has become a fact of life for many, but its origin can be tied to the gender-segregation of economic opportunity, in addition to structural adjustment and the neo-colonial attributes of the World Bank and the International Monetary Fund.

An analysis of the difficulties faced by the women I interviewed along the Ghana-Togo border is not simple. Some aspects of the political economy that have facilitated these women's vulnerability to poverty have also increased the economic success of others. The governments of Ghana and Togo have often explained their decisions as based on perceived overall national benefit, despite the increased marginalization of certain populations. This was seen very clearly when the Akosombo Dam was constructed; Greater Accra benefited greatly from the energy production, while the Volta Region experienced flooding and coastal degradation.

Wolf emphasized the importance of considering the vast network of interconnections in both the extraordinary and the mundane. An important corollary of his argument, however, is to change the perception of those outside Europe and the western world as populations to whom things simply happen. Wolf argues that instead, "theoretically informed history and historically informed theory must be joined together to account for populations specifiable in time and space, both as outcomes of significant processes and as their carriers" (Wolf 2006: 379). In this sense, the people

living along the southern Ghana-Togo border are not simply at the mercy of forces outside of their control, they are using their own knowledge and agency to act within their communities, and therefore exert their own influence on the world in which they live.

The anthropologist Henrietta Moore has also focused some of her theoretical analysis on interconnections through her discussion of globalization and its influence on societies and individuals. In *Global Anxieties*, Moore discusses the global and the local acting on each other through “a complex set of interconnections and processes through which meanings, goods and people flow, coalesce and diverge” (Moore 2006: 448). Along the border, the actual flow of goods and people between Ghana and Togo makes interconnection a dominant reality in understanding the lives of local women. At the same time, the interconnections between concepts and meaning, realized not only across West African borders, but also in a larger global context can be seen in the way that the women and their communities interpret their illness.

The tumultuous political history of the region, from the days of the transatlantic slave trade onward has created an environment of constant movement and flux. With families split between Ghana and Togo during colonial division and re-division, there is an inherent complexity to national identification. The distinction of a border was originally forced upon the people of the Volta region; however over time it has been accepted as an economic opportunity and today the majority of people living on the border

depend on it economically. My conversations with Ghanaians in Accra, 230 km away from the border, revealed that they believed there to be a very clear distinction between themselves and the Togolese. However, when speaking with Ewe Ghanaians who lived along the border, the difference between the two countries was less perceptible.

Inherent in my own research is the idea of holism. Through their theoretical writings, Wolf and Moore discussed this idea; however its origin is more accurately placed in the work of Franz Boas in the early 20th century. In response to the comparative method and evolutionary thinking, Boas outlined the four-fields approach to anthropology, combining the branches of anthropological research in order to more fully understand the diversity of cultures that existed in the world. Through his emphasis on the importance of culture as integrated, Boas saw both local development and foreign influences as essential to the overall understanding of a cultural group. (Boas 2006b: 66) The idea of holism employed by Boas was one that emphasized a diverse methodological approach and awareness of both external and internal forces at work within a culture.

In 2001, Brooke G. Schoepf conducted a review of anthropological research and HIV. In this article, she discusses how the theory and practice of anthropologists contributes to the research process both nationally and internationally. Schoepf pays particular attention to how anthropologists have shown increasing consideration of the linkage between the “lifeworlds of sufferers to the global political economy” (Schoepf 2001:335).

I have formulated my research methods with this theory of interconnections and a “political economy-and-culture” approach (Schoepf 2001:337). As an infectious disease, HIV cannot be localized to a particular nation, community, or culture. Instead it must be considered in a globalized context, in order to understand the causes and effects attributable to its presence. In the atmosphere of infectious disease, the importance of interconnections becomes even more apparent in the realities faced by those infected.

METHODOLOGY

My interest in HIV began when I read Paul Farmer’s *AIDS and Accusation* during the summer of 2002. The book was over 10 years old; however the methodology and message contained within its pages inspired me to combine my pre-medical ambitions with an undergraduate degree in anthropology. As Farmer documents the history and culture of Haiti, he illustrates the suffering and blame that accompanied the arrival and transmission of HIV. His thorough analysis elucidates the underlying forces of poverty and racism that created an environment that was conducive to the spread of disease.

My anthropological studies at Macalester College included two courses in medical anthropology, introducing me to the work of Charles L. Briggs, Clara Mantini-Briggs, and Jessica Gregg. Through these medical anthropologists, I found inspiration for conducting my own research. My

long-standing interest in infectious disease and HIV influenced my decision to study abroad in sub-Saharan Africa. The Minnesota Studies in International Development (MSID) program through the University of Minnesota gave me the opportunity to not only study abroad in Ghana, but also to participate in an internship with a local organization.

I arrived in Ghana in January of 2006 and spent the first seven weeks living with a host family and attending classes with professors from the University of Ghana, Legon. In March, I moved on to Aflao, Ghana to begin my internship with Lolo-Agbé, a non-governmental organization (NGO) based in several communities throughout Ghana. Lolo-Agbé is an NGO that works with HIV/AIDS through education, outreach, and support of people living with HIV. Through my experiences working with the NGO, I was inspired to research the cultural, economic, and social context in which people along the Ghana-Togo border live with HIV.

Aflao, a city of approximately 38,927 people⁴, is located in the southeast corner of Ghana, extending into Togo. Aflao has the fourth highest population density in Ghana. Over half of the residents are female and 45% are under the age of 15 (GTZ 2003:9). The region's local economy features farming and fishing industries; however environmental degradation has led to increased reliance on the border economy. This economy is comprised of both a formal sector (e.g. customs officials, border guards, and registered shop

⁴ Ketu District Assembly, 2006 estimate.

owners), and a larger informal sector, characterized by taxi driving, petty trading, smuggling, commercial sex work and currency trafficking.

In 2006, Aflao's government hospital, Ketu District Hospital, reported an HIV prevalence of 11.7% in a sample population of 530 women attending the hospital for treatment. The Biostatistics Office estimates that the overall prevalence of HIV among all women in Aflao is approximately 8%. The high prevalence rate in Aflao is due to a number of factors; key among these is the population's location at the border between Ghana and Togo. Although both Ghana and Togo report national HIV prevalence rates below 4%, Lomé reported an HIV prevalence of approximately 8% among women attending antenatal clinics⁵, mirroring the HIV prevalence that is found in Aflao. The comparable HIV prevalence in Aflao and Lomé provides evidence for the high degree of mobility and sexual exchange that occurs across the border.

During my time with Lolo-Agbé, I examined the factors that have led to the spread of HIV among women living along the southern Ghana-Togo border. I have chosen to focus specifically on heterosexual transmission due to its dominance in the spread of HIV in this region. Therefore, my inclusion of children will be limited to their involvement in HIV prevention and education programs facilitated by Lolo-Agbé. According to the Ketu Biostatistics Office, data from Aflao shows that the overall prevalence within their community is declining. In Ghana, government funded education campaigns have significantly reduced the spread of HIV among youth.

⁵ UNAIDS 2003 estimate from 2006 AIDS Epidemic Update
http://www.unaids.org/en/HIV_data/epi2006

However, a reexamination of the numbers separated by age group and sex shows an increase in the number of women aged 25-59 testing positive for HIV in Aflao. The goal of my research was to discover what was making these women more susceptible to disease in an atmosphere of otherwise declining prevalence.

In order to better understand the circumstances in which these women were living, I worked with Lolo-Agbé from March through May of 2006. In addition to observing and assisting with Lolo-Agbé's community outreach and support programs, I conducted interviews with various people, all connected to the HIV epidemic in different ways. My interview process began with two counselors at the Ketu District Hospital, both lab technicians who also acted as HIV counselors in the Voluntary Counseling and Testing (VCT) center. I conducted two 30-minute interviews with each counselor. These interviews were followed by a 45-minute interview with the Paramount Chief and Queen Mother of Aflao. I was also able to conduct two 45-minute interviews with Dr. Mensah, a physician at Ketu District Hospital with extensive experience with HIV in Aflao. In addition, I interviewed 18 women living with HIV along the Ghana-Togo border. My interviews with the women took place at the Lolo-Agbé office in Aflao at a conference for women living with HIV that occurred during the week of April 24, 2006. The interviews were based on a standard set of questions⁶ and varied in length from 20 to 45 minutes. To

⁶ See Appendix I.

complete my field research I conducted two 30-minute interviews with Joseph, the project director of Lolo-Agbé Aflao.

I did not have access to a tape recorder, so I took detailed notes during the interviews. Additionally, after each interview I wrote my own observational notes to complement the informant's responses. All interviews were conducted in English, with the exception of the interviews with the Queen Mother and women living with HIV. For these interviews I relied on Sara, a counselor at Lolo-Agbé who translated between Ewe and English. All names used within this paper are pseudonyms to protect the identity of the informants.

At the conclusion of my time in Ghana I worked with the statistician at the Ketu District Hospital to get age-specific data for HIV-prevalence in the district. I also obtained a copy of *The Ghana-Togo Border Community HIV/AIDS response: Report on the HIV/AIDS Situation and Response in the Aflao Community*, which was compiled in 2003 by German Agency for Technical Cooperation (GTZ) and the JSA Consultants Ltd., a Ghanaian-based development research organization. This report briefly outlines some of the cultural and global factors that have contributed to HIV in the region. Also included is a summary of the NGOs and service organizations that work to prevent HIV in Aflao through education and provide support services for people living with HIV and their families.

I returned to the United States at the end of May and began extensive library research into the historiography of Ghana, with particular attention

to border issues. I looked at the history of the Ewe people living in Aflao and the border region, the influence of the transatlantic slave trade, colonization by European powers and the events since independence. My reading was focused on the socioeconomic, historical, cultural, and global factors that affected the daily lives of the women of southern Ghana-Togo border, creating an environment conducive to disease. This allowed me to see beyond the poverty of the women I interviewed to also appreciate the underlying forces and historical factors that created a system of economic desperation and inequality.

Several constraints have influenced my research. First, all interviews with HIV positive women required the assistance of an interpreter. This forced me to rely on another person to convey the details expressed by the informant, creating opportunity for summarization and therefore loss of the rich ethnographic detail that can come from the specific words that informants choose to express themselves. In addition, I was only able to conduct one interview with each woman, and therefore had a limited opportunity to uncover the details of their personal experiences. None of the women seemed openly mistrustful of my intentions; however as an outsider to the community my presence influenced the type of information they disclosed. Others may have withheld cultural and social implications of their disease that they believed I would not understand. On the other hand some may have been more open because I was an outsider and therefore not a threat to their reputation within their own communities.

Another limitation of my research was time, as I was only in Aflao for nine weeks. All field research was limited to this period; therefore, I rely on the work of others who have conducted research on HIV and the Ghana-Togo border. My research is also limited by my sample size of 18 women living with HIV. That said, from conversations with the Lolo-Agbé staff, counselors, and Dr. Mensah, I found that the experiences of the women I interviewed were consistent with their description of the average woman living along the southern Ghana-Togo border.

It is important to note that the women I interviewed are not representative of all women in the border population. The women I discuss in this paper have not received education beyond the primary level, have varying levels of literacy (English or French), and are fluent in the local Ewe dialect. They are individuals who participate in the informal economy, with the exception of one woman who had worked as a primary school teacher. I was unable to conduct interviews with women outside of the lower socioeconomic class⁷, thus many of the gender issues that I discuss are not necessarily applicable to all women. However, the risk of HIV in this environment transcends class due to the socialization of men and women regarding the importance of fertility (and therefore a lack of condom use), combined with acceptance of polygyny, which in the local context is characterized by its

⁷ Men and women who utilized the services provided by the NGO were predominately of the lower socioeconomic classes. Those of higher socioeconomic classes were not as reliant on the provision of food and support services offered by the NGO.

fluidity, allowing men to pursue extramarital relationships without the intention of marriage⁸.

Although the women I interviewed were from a lower socioeconomic class, none of them reported that they participated in the commercial sex industry. This was influenced by both time and access to these women, and by my own choice to focus on women who were not considered part of traditional risk group categories. The focus on women of one particular socioeconomic class was not a predetermined focus of my research; instead it was a consequence of which women chose to participate, who as it happened were all of similar economic backgrounds. This is not necessarily a surprise, since the current state of the political economy has left the majority of women in this region in poverty.

THEMATIC FRAMEWORK: SITUATING MY RESEARCH IN THE LITERATURE

The global study of HIV/AIDS is one that requires a multi-disciplinary approach, incorporating biological, economical, historical, geographical, social, and cultural considerations on the local and global scale. As a result, the literature produced on the HIV/AIDS epidemic has varied, some remaining specific to one discipline, others grasping the inherent complexity of the disease through a multi-faceted analysis. The following reviews the literature concerning HIV/AIDS in sub-Saharan Africa, where approximately 70% of all people infected with HIV/AIDS are living. I limit the review

⁸ Explained further in Chapter IV.

further to literature specifically related to my research into women and HIV along the southern Ghana-Togo border, and have divided it into sections that describe important themes of my research.

Schoepf produced a thorough literature review in 2001 detailing the important concepts and considerations taken by anthropological literature on the subject of HIV/AIDS. Using Schoepf's review and my own reading of the literature, I have identified four major topics concerning anthropological study and HIV. To frame this, however, I will begin with a brief introduction to the anthropology of infectious disease.

THE ANTHROPOLOGY OF INFECTIOUS DISEASE

Anthropological research in infectious disease is important because it provides valuable insight into the impact of infectious disease on populations throughout the past. Since HIV is a relatively new disease, this is especially important in foreshadowing its future impact on human societies. In a review of anthropology and infectious disease, Marcia C. Inhorn and Peter J. Brown write, "infectious disease problems are both biological and cultural, historical and contemporary, theoretical and practical" (1990:90). The connection between disease epidemiology and human behavior creates a space for anthropology to make important contributions to the study of infectious disease.

In 1958, Jacques M. May in *The Ecology of Human Disease*, began the discussion of the interaction between physical environment, disease

pathogens, human hosts and cultural practices, as a way to understand the impact of infectious disease (Inhorn and Brown 1990:95-6). Meredith Turshen developed this idea further in *The Political Ecology of Disease in Tanzania* (1986). Turshen is noteworthy for her discussion of economic, social and political factors causing and shaping disease, in contrast to the agent, host, and environment model that had been commonly used by academics (Inhorn and Brown 1990:97).

To conduct a more thorough review of the literature pertaining to infectious disease would take away from a discussion of the important issues specific to HIV. I have divided my discussion of literature regarding HIV into the following topics: gender, socioeconomic class and power, agency and vulnerability, stigma and risk, and history and interconnections. These four topics highlight the themes that materialized through my ethnographic research in Aflao. The contributions of scholars from anthropology and other disciplines are important in terms of framing my own contribution to the discussion.

GENDER, SOCIOECONOMIC CLASS AND POWER

In *Sex, Love, Money and AIDS: The Dynamics of Premarital Sexual Relationships in Ghana*, Augustine Ankomah writes of the phenomenon of “sexual exchange” resulting from the “severe imbalance in the allocation of resources” between men and women (1999: 294). Men, as a result of controlling financial resources, are able to maintain their places of power

and influence in society, leaving women in the subordinate role. Accordingly, in the context of the southern Ghana-Togo border, the majority of women have few opportunities to access money except through the informal economy and relationships with men⁹. Ankomah describes the paradox of this environment, where women who are dependent on men are faced with a choice of either unsafe sex or financial insecurity. To many, the “pressing economic needs for survival may be considered riskier than having unprotected sexual intercourse.” (Ankomah 1999: 304) However, with that choice, women are extremely vulnerable to contracting HIV.

Historically, those who are most vulnerable to HIV have been those who are already marginalized in society, which along the southern Ghana-Togo border are predominately women in poverty. In an analysis of HIV/AIDS in Ghana, Joseph R. Opong writes that the global problem of AIDS is expressed locally in ways that reflect the “spatial distribution and social networks of vulnerable social groups.” (1998: 438) Where poverty and inequality are present, HIV is able to thrive because the vulnerable are unable to ensure their own safety. Schoepf writes that although many know about the “danger of sexual transmission,” women are unable to avoid infection “because they cannot control the relations of power that put their lives at risk” (2001: 336). For the women of the southern Ghana-Togo border it was their inability to access education that has in turn increased their vulnerability to the cycle of poverty and disease. Men, who have historically had greater access

⁹ Despite men holding greater access to financial resources, the southern Ghana-Togo border region faces a general state of economic uncertainty, explained further in Chapter II.

to education and employment, are therefore less vulnerable to poverty than women. With greater economic resources, men gain a level of power over the women who depend on them for financial security.

Attempts at HIV/AIDS prevention and education campaigns have repeatedly ignored women's inability to change their behavior, which stems from this lack of access to education and employment and the resulting gender-power dynamics linked to economic status. Ann V. Akeroyd addresses this issue in her discussion of the "new gender agenda." Akeroyd writes, "behavior change must be initiated by the powerful, not cajoled or negotiated by the powerless" (2004:97). As vulnerable and subordinate members of society, women in poverty are not able to implement changes in their environment. Instead, it is the individuals that hold the power, those in the formal economy and government (typically men), who must see the impact of their policies and practices and enforce change. However, this re-appropriation of power and resources must be initiated by those who hold the power, creating obvious complications.

HISTORY AND INTERCONNECTIONS

The forces that place women at risk of poverty and therefore these gender-power dynamics are intimately connected to the political, economic, and social events of the past, and essential to understanding the way in which HIV as a sexually transmitted infectious disease will operate in the specific environment of the southern Ghana-Togo border. To understand why

women are in poverty and unable to protect themselves sexually requires a careful analysis of historical events that have altered the societal framework. For my historical analysis, I rely on others who have conducted research on the Ghana-Togo border and HIV, namely Paul Nugent, the director and professor of African Studies at the University of Edinburgh who has focused much of his research on the Ghana-Togo border region, and John Iliffe, a professor of African History at the University of Cambridge, who has documented the history of HIV in Africa.

John Iliffe focused on the historical aspects of HIV in *The African AIDS Epidemic: A History*. Iliffe addresses the history of HIV in Africa, from its beginnings in equatorial West Africa to its spread throughout the entire continent. A historical analysis is crucial to understanding the pattern of the epidemic. According to Iliffe, “like industrial revolutions or nationalist movements, AIDS epidemics make sense only as a sequence” (Iliffe 2006:1). He notes that although poverty and gender relationships have proved vital to an understanding of HIV and its interaction with specific communities, the “fundamental” explanation for its wide-scale effects is time. As Iliffe writes, “Africa had the worst epidemic because it had the first epidemic established in the general population before anyone knew the disease existed” (2006:1).

The historical approach taken by Iliffe emulates the theory of interconnections stressed by anthropologists such as Eric Wolf. According to Schoepf, as a “disease of modernity and global populations movement,” AIDS has had a profound impact on communities “struggling under the burdens

of poverty, inequality, economic crisis, and war” (2001:336). To understand the HIV epidemic in sub-Saharan Africa, it is essential not only to understand its historical movement throughout the continent, but also the conditions that were present previous to its arrival, setting the stage for its proliferation. Schoepf writes, “in communities with deepening poverty, hunger, and deteriorating health infrastructure, the HIV virus battens on bodies weakened by malnutrition and infectious and parasitic disease, and social bodies weakened by inequality, debt, structural violence and war” (2001: 354).

According to Farmer, structural violence is a process in which “historically given (and often economically driven) processes and forces conspire to constrain individual agency” (Farmer 1999:79). Structural violence is manifested along the southern Ghana-Togo border through structural adjustment policies and international development projects that led to a rapid increase in population mobility (Herdt 1997 cited in Schoepf 2001:343). This environment of mobility created pathways for the spread of commercial sex work, gender violence, and STI/HIV transmission (Schoepf 2001:343).

Interestingly, before HIV even emerged as an international epidemic, Charles C. Hughes and John M. Hunter initiated this conversation through their discussion of the impact of development projects on the spread of infectious disease (1970, cited in Inhorn and Brown 1990:97). In the case of Ghana, this was clear in the construction of the Akosombo Dam, which through subsequent flooding increased the prevalence of water-born

disease in the surrounding areas. In addition, a secondary consequence of the construction of the dam can be seen in the environmental degradation of the coastal ecosystems. As a result of this degradation, the people of the coast, including those in the border region, have suffered an extreme loss of income-generating opportunities due to the destruction of the farming and fishing industries. Mobility has increased to make up for lost income, and as infectious diseases of the past, HIV/AIDS has spread along the routes of trade and migration (Setel et al 1999 cited in Schoepf 2001:343). The declining economy and rising prevalence of HIV highlights the cycle of poverty and disease that exists along the southern Ghana-Togo border.

The forces underlying poverty provide context for populations' vulnerability to disease. However, without an understanding of these social conditions, which are typically ignored by the biomedical model of HIV, a sustainable prevention and treatment plan will remain elusive. According to Schoepf, the same biological and social conditions that contribute to the spread of HIV also challenge the efficacy of HIV-education campaigns for prevention based on behavior change (Schoepf 2001: 336). Before behavior change can occur, the conditions in which people live must be addressed. In the context of Aflao and the southern Ghana-Togo border, many local residents and foreign researchers blame the transmission of HIV throughout communities on commercial sex workers and mobile laborers. However, such a deduction is far too simplistic. This ignores the realities of the economic and social forces that severely limit the income-generating opportunities

along the border, necessitating the commercial sex and migrant labor industries.

AGENCY AND VULNERABILITY

Paul Farmer has dedicated much of his writing to structural violence, which is dictated not by culture, but by historical and economic processes that make some populations more vulnerable than others. Similarly, Oppong highlights the “geography of HIV/AIDS infection” (Oppong 1998:438). Oppong connects HIV to vulnerability theory by linking the geographical distribution of infection to the distribution of vulnerable populations, e.g. women, and their social interaction patterns (Oppong 1998:438). Schoepf commented on this interpretation and its complexities in her review of AIDS research and anthropology. She writes, “as a characterization, vulnerability [theory] denies the agency of the oppressed and the empowerment that many derive from participation in social movements... At the same time it is easy to exaggerate the agency of very poor women and children (Schoepf 2001: 347)

The vulnerability and structural violence that characterize the lives of the women I interviewed in Aflao limits their ability to ensure their own protection, even with the knowledge of HIV and its transmission. Agency is problematic in this context because there is a need to recognize the magnitude of the forces working against these women; however at the same time to not deny them their ability to shape their environment. The idea of structural violence as defined by Farmer is therefore important, but it cannot be

considered absolute. I argue, instead, that agency, however constrained among these women living with HIV, is always present in their actions and interpretations of their disease. By attending meetings at local NGOs, hospitals and churches and developing extensive support networks, the women of the border who live with poverty and HIV combat the forces of power that as Manuh writes, “promote policies that do not question the status quo but reinforce the subordination of men over women in society and interpersonal relations” (Manuh 2007: 130).

STIGMA AND RISK

At the outset of the HIV/AIDS epidemic, epidemiologists and government agencies categorized specific populations as risk groups (Farmer 1988, Bolton 1992, cited in Schoepf 2001). This resulted in the present stigmatization of those who are considered members of these groups, in addition to the belief that anyone not included in these ‘risk groups’ is therefore not at risk (Parker 1987 Lyttleton 1996, cited in Schoepf 2001:338). This was evident in my interviews with women in Aflao who, before contracting HIV, did not consider themselves at risk in their presumed faithful premarital and marital relationships. They had been told that by staying faithful to their partner and never participating in promiscuous behavior, they would be protected against HIV infection. Only by becoming infected with HIV have many of the women I interviewed realized that HIV can happen to

anyone. Unfortunately, due to the stigmatization and risk-group based education that still occurs many women consider themselves free of risk.

Not only is the ‘risk-group’ rhetoric dangerous to the general population due to the resulting false sense of security, the stigmatization of those who do fall into these groups is a clear example of how those in power are able to deflect responsibility for the epidemic. The use of culture in AIDS research has historically served to “distance and subordinate” those who are considered ‘risk groups’ from those who define them (Glick-Schiller 1992: 237). Glick-Schiller described the tendency of those in power, e.g. government epidemiologists and biomedical researchers, to associate HIV infection with cultural tendencies, as opposed to the political economy in which they are living.

Akeroyd similarly addresses this issue. On the global scale, Africa is increasingly vulnerable due to its economic subordination by the globalized capitalist economy. On the local scale, women living in politically male dominated communities, characteristic of Ghana and Togo, are especially vulnerable. The vast majority of these women are not commercial sex workers, and therefore not typically included in risk group focused education campaigns. These realities imply that, instead of focusing on risk-groups, an understanding of the general state of vulnerability needs to be achieved. Akeroyd writes, “the more recent emphasis on vulnerability rather than risk analysis have helped explain why people can remain personally vulnerable to

HIV despite their knowledge of HIV/AIDS education messages” (2004: 89).

The current separation of anthropological and public health discourse on HIV/AIDS needs to be addressed. It is necessary for professionals in both fields to understand that culture is not the root of the HIV epidemic in Africa; rather it is the global hegemonic forces and patterns of structural violence that set the stage for its impact. It is only through this perspective that prevention efforts should be formulated, addressing the systems of power that make people vulnerable. This will in turn remove focus from the behavior of risk-populations to the environment in which these behaviors (e.g. commercial sex work) exist and how that environment limits both men and women economically.

THESIS SUMMARY

Through my own research I intend to add to the discussion of HIV in sub-Saharan Africa with an ethnographic account of the forces at work in women’s lives in Aflao and the surrounding border communities. Due to the overall low prevalence rate of HIV in West Africa compared to southern Africa, there has been limited research specific to these communities. As economic pressures increase migrant labor, international trade routes have become important in understanding the patterns of HIV transmission. My goal is to combine my biomedical and anthropological perspectives to address the interaction between HIV and political and socioeconomic factors and how

these interactions impact women's lives along the southern Ghana-Togo border.

In the spirit of holism, I have sought to capture as much detail as possible surrounding the lives of these women afflicted with HIV along the southern Ghana-Togo border. Accordingly, I have written my thesis with an introductory analysis of the forces at work within their communities followed by their personal stories and the common themes that pervade their lives as HIV positive women. By beginning with a historical analysis of the political economy of Ghana, with special attention to the border region, a more complete understanding of the environment surrounding the arrival of HIV can be gained. In addition these details will allow a clearer understanding of the complexities of the lives of the women I interviewed.

Through its historical analysis, Chapter II focuses predominately on the border region, documenting its role in the transatlantic slave trade, its designation through colonialism and the disputes between Ghana and Togo that have impacted the local communities' interaction with the border. I also describe how international lending institutions such as the World Bank and the International Monetary Fund have influenced the border region. Specifically, the Volta River Project in the 1960s and structural adjustment programs (SAP) in the 1980s have caused dramatic changes in the local economy. This chapter will also include an introduction to the history of HIV in West Africa and along the southern Ghana-Togo border.

With SAP, the borders in Africa have become more permeable; allowing goods and people to flow freely. Since the 1960s, the shifting West Africa economy has contributed to a large mobile labor population made up of people who travel long distances to seek work and economic security, facilitating the spread of infectious disease. In Chapter III, I address the implications of HIV as an infectious disease, highlighting its unique cultural and social impact. Through a case study of the local NGO Lolo-Agbé, I will show specifically how HIV interacts with the southern Ghana-Togo border population. The case study will focus on the programs, efforts, and experiences of Lolo-Agbé in order to understand what is being done on the local level to address the underlying poverty and gender disparities that interact with HIV in a vicious cycle.

HIV is not a disease that can be simply explained by prevalence rates, modes of transmission, or risk behavior. HIV is a disease that feeds on poverty and stigmatization. In order to understand these powerful concepts and how they surface within a specific community, an understanding of why and how poverty, HIV and stigmatization of the infected exists is essential. In the context of Aflao, education about HIV has been extremely focused and well funded. However the declining rate of HIV among teens is in deep contrast to the increasing rate among women aged 25-50. These women are not defined as risk groups; they are not prostitutes, they are not mobile workers. They are wives, mothers, teachers, seamstresses, hairdressers, farmers, and traders. Some are educated, others are not; however, through

their HIV they all have a shared experience that will affect every aspect of their lives until it finally takes their life away.

Chapter IV is taken from my interviews with some of these women living with HIV in the border communities. Their stories paint the picture of both the diversity of their experiences understanding and discovering their HIV status, as well as the universal feelings of stigmatization, an overwhelming need for money, and the coping strategies that allow them to continue fighting for their lives and the lives of their families. My interviews have specifically identified the increased vulnerability of women to HIV as result of the risk-group focused HIV-education campaigns. As a result, women who believe they are in faithful¹⁰ relationships are consequently unaware of the risks they incur through sex. The political economy of the region and unequal access to education and employment influence the lives of the women in ways that make them more vulnerable to poverty and disease. The interconnections between gender, poverty and disease facilitate the seemingly never-ending intergenerational struggle with HIV. Despite these factors, I will describe how the women along the border living with HIV have

¹⁰ As opposed to using the term monogamous throughout this paper, I use the term faithful/faithfulness to allow for the presence of polygyny, which is common among the Ewe people of the trans-Volta border region. Faithful polygyny, i.e. closed-system polygyny prominent in the northern regions of Ghana, is characterized by men who only have sexual intercourse with their wives, and by women who only have sexual intercourse with their husband. The concept of open system polygyny, explained further in Chapter IV, allows men to pursue extramarital relationships without necessitating the intent of marriage. This system facilitates the spread of sexually transmitted infections by increasing the number of sexual partners among both men and women.

exhibited agency through the various coping strategies they use to live with their disease on a daily basis.

In conclusion, the historical, political and economic framework provided at the outset of this paper will facilitate a deeper understanding of the lives and experiences of the women I interviewed. Through the analysis of the environment of the border and its impact on women's lives, I seek to make recommendations for future prevention and support efforts in this region that will address the inherent complexity of the interaction between the communities of the southern Ghana-Togo border and HIV.

CHAPTER II: A HISTORY

The purpose of this chapter is to create a historical framework that will facilitate an understanding of the social, political and economic environment of Aflao and the Ghana-Togo border region. These historical events are essential to understanding the context in which HIV arrived in the region, and the factors that allowed its proliferation. My historical research has relied predominately on secondary sources. Paul Nugent, in particular, has written extensively on the history of the Ghana-Togo border region, and so his work plays a central role in this section. In addition, Emmanuel K. Akyeampong's work on the economy of the Volta region in his book *Between the Sea and the Lagoon: An Eco-Social History of the Anlo of Southeastern Ghana, 1850 to Recent Times*, provides an excellent framework for understanding the history of the region and the impact of 'development projects' on the environment and local economy.

This historical framework will address the local history of the border region, including its role in the transatlantic slave trade, its origins in colonialism, and the disputes between Ghana and Togo post-independence that have shaped the local communities' relationship to the border. Recent global impacts on the border will be described in relation to structural adjustment policies and the international lending organizations, the International Monetary Fund (IMF) and the World Bank (WB) that have altered the economy of the region. Reliance on the border economy resulting from limitations on alternative income-generating opportunities has left the

populations in a precarious economic state due to residual tensions between Ghana and Togo governments. These local and international events will set the framework for an introduction to the history of HIV in West Africa, Ghana, and the border region.

TRANSATLANTIC SLAVE TRADE AND AFLAO

Despite the early arrival of the Portuguese along the coast of West Africa in the 15th century, it was not until the 18th century that the transatlantic slave trade extended to the eastern regions of the Gulf of Guinea. The transatlantic slave trade moved east after trade had begun to decline at other more established posts and by 1727 the English and Dutch were established in Aflao (Greene 1996:36-7). Soon after, the Bight of Benin, located just east of present-day Aflao and Lomé, became Africa's second largest slave trading zone, shipping 1.2 million slaves, 18% of the total leaving West Africa at the time (Klein 1999:63).

The slave trade originally relied on the capture of people living within 50 miles of the coast; however by the 18th and 19th centuries, around the time the trade reached Aflao, rising demand created a market for slaves that extended further into West Africa (Klein 1999: 71). The growing slave trade shaped the politics and land of West Africa by dominating all economic activity. The result was an increase in trade routes, the abandonment of farmland and an increase in raiding and power struggles (Klein 1999:72). The slave trade gave coastal communities such as those in Aflao the new ability

to gain vast amounts of wealth. The movement of other ethnic groups to the Ewe territory resulted in more strict marriage traditions, preventing women from expressing their choice in marriage as they had previously done (Greene 1996:20). The purpose of this was to ensure that the limited arable land that was available was kept within the original resident families (Greene 1996: 20). Greene described the growing practice of arranged marriage as “virtually universal”; however at the same time it was more constraining to women than men, who still maintained some level of choice (Greene 1996: 21). Increasing numbers of refugees fleeing the war conditions encouraged by the transatlantic slave trade put pressure on the limited farmland to accommodate the larger population. Competition for land and slaves increased as women took on increasingly subordinate roles, creating the political, economic and social environment that existed at the onset of colonialism.

COLONIALISM AND THE EWE

After the transatlantic slave trade was abolished and eventually discontinued, the age of European colonialism in Africa began. The division of Togoland between Britain and Germany in 1887, and later, France in 1914, had a profound effect on the ethnic identity of the Ewe people (Nugent 2002:117-8, Akyeampong 2001:189, Greene 1996:8). The Ewe speaking people were divided between different European colonial powers and consequently were influenced in distinct ways. German rule over Togoland was based on direct rule policies of enforced labor and border control,

while the British relied on indirect rule, which allowed chiefs to maintain some level of authority through the incorporation of the traditional power structures into the colonial administration. The French were similar to the Germans in that they employed the policies of direct rule by dissolving all traditional power structures, and replacing them with colonial appointments. The disparate influence of colonial powers inspired an ethnic solidarity among the Ewe people that still exists across the Ghana-Togo border today. This is in contrast to the transatlantic slave trade, which through its opportunities for wealth and attraction of people who did not originally reside on the coastal land, created an atmosphere of intense competition and recognition of ethnic difference as opposed to similarity. For example, Greene places land as the impetus for the development of *hlowo* (clans) in the 17th century. The purpose of the clans was to gain control of land for the benefit of fellow clan members. Those who arrived first from Notsie (located in modern day south central Togo) considered themselves ethnically distinct from those who arrived later in order to secure superior access to the limited land resources (Greene 2000: 32).

While ethnic identity was not a new phenomenon¹¹, the unification of all Ewe people was not necessarily considered by the various Ewe populations prior to colonialism. The imperialist agenda's differential impact on travel, trade, and the lives of the Ewe people inspired ethnic solidarity among the

¹¹ (Greene 2000:30) *In the mix: women and ethnicity among the Anlo-Ewe*. Greene argues that ethnic identities “existed well before the impact of European colonialism” (Greene 2000:29).

trans-Volta borderlands population (Nugent 2001:161, Greene 1996:143). The Ewe residing within French Togoland desired to be united with those in the Gold Coast and British Togoland to escape the harsh treatment of their colonial government, while those in the Gold Coast recognized their minority position within the colony, and with that feared that the government would not have incentive to meet their needs (Aligwekwe cited in Greene 1996: 146). If they succeeded in uniting the Ewe of French Togoland with those under British rule, the Ewe would be guaranteed more influence in the government due to their large numbers.

Despite the growing ethnic solidarity, the desire of many Ewe to reunite their people living in the Gold Coast, British Togoland, and French Togoland was hindered by the existence of other ethnic groups within the same regions. Many of the other groups were not interested in seeing the unification of the Ewe people because it would directly affect their lives and access to resources (Nugent 2002). The distinctions between ethnic groups had been fortified by the transatlantic slave trade, and now acted to inhibit the unification movement. Several Ewe groups attempted to persuade colonial powers to unite the Ewe people through tax boycotts and petition writing; however, their efforts were suppressed by the French, who perceived their actions as a direct threat to their power (Nugent 2002:150).

The British and French aimed to quell unification discourse in favor of integration with their respective territories. The British began this process by extending the political rights of the British Togoland to match those in

the Gold Coast. Unificationists objected to these measures for fear that it would ultimately make the unification of Togoland impossible (Nugent 2002: 180). In 1950, the Togoland Union, an association dedicated to uniting the two halves of Togoland, joined forces with other unificationist groups and decided to boycott the Gold Coast elections (Nugent 2002:181). However, the boycott backfired, because it allowed opponents of unification to gain power within the government, which was dominated by the Convention People's Party (CPP), headed by Kwame Nkrumah.

The CPP proclaimed a message of integration, that if British Togoland joined the Gold Coast in its quest for freedom from colonial rule, French Togoland would soon follow suit (Nugent 2002:182). The CPP gradually built support for their integration mission among the people. Nugent writes that the ideological alliance of the CPP with the British government stemmed from the fact that plans had already been drawn up for the creation of the Volta River Dam. The dam was attractive to the British due to its role in development through industrialization; to Nkrumah it was the key to modernization (Nugent 2002: 184). The project relied on the integration of British Togoland with the Gold Coast, and therefore relied on the pacification of the unification movement.

On March 6, 1957, a United Nations plebiscite vote marked the integration of British Togoland with the newly independent Ghana, under the leadership of Kwame Nkrumah. Although the Togoland unification movement was quieted by the plebiscite, opposition still existed, especially

in the Volta region (Nugent 2002:198). Those who remained vocal about their opposition were silenced through enforced exile. Others moved on and looked towards the CPP to improve their lives. For populations in the Volta Region, the promises of modernization offered by Nkrumah's government left many communities worse off after the Volta River Project, which submerged 738 villages and displaced approximately 80,000 people (Akyeampong 2002:170). The displaced people, most of whom had originally been opposed to the integration of British Togoland, with Ghana, were moved to alternative settlements scattered around the Volta Lake, which lacked electricity, running water, and adequate housing (Nugent 2002:217).

The marginalization of the Volta Region Ewe through colonialism and then independence is visible today through the lack of infrastructure that characterizes the southern Ghana-Togo border region¹². The road leading from Accra to Aflao is well maintained until it reaches the Volta River where there is a noticeable change with the appearance of poorly maintained paved and unpaved sections of road. The lack of government funding and the disruption of the Ewe people by the border have had serious ramifications for how HIV has impacted the border region.

¹² It is particularly interesting to note, however, that under the leadership of Jerry Rawlings in the 1980s, there were vast improvements in infrastructure in the Ewe region in particular, due in part to his initiation of the Structural Adjustment Program and ethnic ties to the Ewe people. His subsequent democratic election in 1992 came as a result of strong rural support, due to the infrastructural benefits incurred through his military regime (Bawumia 1998:70).

ENVIRONMENT AND ECONOMY: IMPACT OF THE VOLTA RIVER PROJECT

The economic environment of the coastal Volta Region changed considerably with independence and the Volta River Project. The construction of man-made deep-water harbors and the Akosombo hydroelectric dam led to significant erosion along the eastern coast of Ghana, where residents built their lives around a lagoon and maritime fishing industry (Akyeampong 2001:170). In addition to erosion, by slowing the pace of the Volta River, the dam also contributed to a proliferation of mosquitoes and water-borne disease. Dry conditions and decreased salinity have increased the presence of grass and mud pools (Akyeampong 2001). As a result, mosquito and snail (the schistosomiasis vector) populations are flourishing, while, for the same reasons, the predator fish populations are dwindling (Akyeampong 2001:173).

60 percent of the lower Volta population participated in the fishing industry, and therefore were drastically and adversely affected by the construction of the Akosombo Dam. The suffering fishing industry has contributed to increased labor migration¹³, which in turn contributed to the spread of disease throughout the region and West Africa. These problems were further exacerbated by the adoption of SAP policies in 1984, which forced even more workers out of the formal and public sector into the insecure fishing and farming industries and the migrant labor market.

¹³ Labor migration is characterized by rural to urban movement, in addition to movement across borders to mining and logging camps, or to urban centers throughout West Africa that are experiencing economic growth.

The drought of the 1970's and 1980's proved disastrous not only because the lack of water limited the power generated by the Akosombo Dam, but it also prevented the necessary water from reaching the coastal lagoons, decimating the wildlife populations essential to the surrounding communities' economic survival (Akyeampong 2001:172). The hardships endured by the people of the Volta Region were largely ignored due to the government's belief in the national benefits and modernization that would be incurred by the harnessing of hydroelectric power. As economic and environmental problems were continually disregarded, feelings of insignificance and isolation from the Ghanaian government among the Volta River populations were again revived.

The environmental impact of the Akosombo Dam had another serious long-lasting effect on the economy of southeastern Ghana because it led to the decline of Keta, the coastal community approximately 25 km west of Aflao, which was then the capital of the Volta Region (Akyeampong 2001:182-3). Due to coastal degradation, in 1968, the National Liberation Council (NLC) decided to move the regional capital from Keta to Ho. This not only implied the movement of the administrative offices and regional prominence away from Keta, but the high volume of trade characteristic of the capital would now occur in Ho. The Keta market, once a vital component of the southeastern Volta Region economy, has suffered markedly (Akyeampong 2001:184). With a decimated fishing and farming industry, degradation of coastal communities, increase in water borne diseases, and a loss of trade, the economy of the lower Volta region has suffered significantly, leaving its

populations severely impoverished. These factors have led to an increased reliance on the border for income-generating opportunities. However, due to the tension that still influences the relations between the governments of Ghana and Togo, the border economy is characterized by its own uncertainties.

BORDER DISPUTES

The relationship between independent Ghana and Togo was difficult from the beginning. The political events described here have resulted in economic insecurity among the local populations of the border region, contributing to their poverty, and therefore current risk of HIV infection. The Volta Region has been profoundly affected by the political tension between Ghana and Togo, which has repeatedly separated families who live on either side of the border. In addition, the border economy has suffered as a result of the prevention of border trade and the decimated farming and fishing industries that would have offset the impact of the border closures. The political instability that has marked much of Ghana and Togo's history as independent nations, therefore, has prevented their ability to react to the issues of poverty, and now disease, that are endemic, especially in the Volta and border region.

At the outset of independence, Nkrumah believed that with the withdrawal of the French from Togo, unification could take place with Ghana. However, in 1960, Sylvanus Olympio, leader of the newly independent

Togo, became suspicious of Nkrumah's goals of uniting Togo with Ghana as a threat to Togo's sovereignty. The governments grew distrustful of each other, suspecting toleration of dissident activity along the border. However, Nkrumah was adamant, and visited Lomé in 1960 in order to propose a relationship between Ghana and Togo that would be characterized by diplomatic relations, mutual defense and a common currency (Nugent 2002:204). Olympio took time to confer with Nigeria and Guinea before making a decision; however Ghana interpreted the delay as deliberate and implemented strict trade policies along the border. This ultimately failed because of the high volume of border movement and smuggling through unofficial routes, and therefore, the only market hurt by the imposed restrictions was the Ghanaian export economy (Nugent 2002:205).

In 1963, upon the assassination of Olympio, his opponent, Nicholas Grunitzky, assumed power in Togo. The Nkrumah government attempted friendly relations; however, as soon as Grunitzky's resolute opposition to unification was realized, the border became a source of high tension between the two governments (Nugent 2002:207). Initially the border restrictions were relaxed and the border was opened. However, by June of 1964 the border was closed again, and would not be reopened until the Togolese government agreed to raise duties on imported spirits in order to inhibit the contraband sale of alcohol across the border (Nugent 2002:207). A brief reopening of the border occurred in July 1965; however it was closed again by the end of the year. It was not until a few months after the February 24, 1966 military

coup that removed Nkrumah from power that the border was again reopened.

The 1969 elections illustrated a divide in opinion between greater Ghana and the Volta Region. Although the Progress Party (PP) was favored throughout most of the country, the Volta Region chose the National Alliance of Liberals (NAL) Party instead. Participation in the democratic process reflected the Volta region's desire to abandon the separationist sentiments of the past and look towards a future within Ghana (Nugent 2002:221). In spite of this, by voting for the NAL, which was represented by an Ewe, the Volta Region was still perceived by the PP as adhering to the Ewe unification and separation ideology, rendering the region vulnerable to increased discrimination (Nugent 2002:221). Following the advent of Kofi Busia's PP government, construction in the Volta Region decreased by 30%, length of new roads fell from 72 miles to 30 miles in one year and to 1.5 miles in the next year. The majority of civil service and police employees dismissed when the PP took control of the government were also predominately Ewe (Nugent 2002:221).

In addition to alienating the Ewe and Volta Region, the Busia government aggravated relations with Togo. The Aliens Compliance Order of 1969 decreed that all immigrants living in Ghana without documentation had two weeks to leave the country. The Togolese government, led by Gnassingbe Eyadéma, responded by closing the border to anyone who was not Togolese, which the Busia government followed by enacting stricter border travel and trade policies (Nugent 2002:223). The border tension was

pacified through the military coup of 1972 in Ghana, which replaced the Busia government in Ghana with the Supreme Military Council (SMC), a military government led by General I.K. Acheampong.

Acheampong and Eyadéma established a Permanent Joint Commission, designed to coordinate political, scientific, legal, social, and cultural policies between the two countries. The positive relations were short lived, inhibited by the November 1972 emergence of the National Liberation Movement of Western Togoland (TOLIMO), a secessionist group based in Lomé that rallied around the unfulfilled promises of integration (Nugent 2002:223). It was quickly discovered that TOLIMO was funded by Eyadéma, who soon publicly addressed Ghana and requested that Acheampong restore Togo to its original state, uniting both the former British and French Togoland (Nugent 2002:224). TOLIMO eventually lost its clout when Eyadéma halted funding in order to pacify the Ghana-Togo border crisis in 1977 and ensure continued access to the electricity provided by the Volta River Akosombo Dam.

A military coup in Ghana led by Jerry Rawlings ultimately resulted in another border closure in 1982, which according to Rawlings was implemented to prevent dissidents from Togo from crossing into Ghana (Berry 1995:237-240). General instability in both countries fostered the negative feelings and accusations between Ghana and Togo. In 1985, one year after the border had again reopened, Togo blamed bomb explosions in Lomé on the Ghanaian government, and in 1986 the border was again

closed. It was not until 1990 that relations between the two governments improved, and the border was reopened. However, in January of 1993, random attacks and killings of civilians in Lomé by President Eyadéma's army sent Togolese residents fleeing into Ghana. After attackers stormed his home in March, 1993, Eyadéma accused Rawlings of protecting the attackers and partially closed the border, requiring that all Togolese obtain a special permit for travel abroad to Ghana by road. 1994 featured an assassination attempt on Eyadéma, and again the Ghanaian government was accused of indirect involvement. Retaliatory attacks on Ghanaians posted at the border and Togolese refugee camps in Ghana followed. Relations began improving, and by November 1994 the Ghanaian ambassador was welcomed in Togo for the first time since the early 1980s. Although relations have steadily improved, tensions have remained as a result of several random acts of violence along the border in 1998 and 1999.

The tumultuous history of the border region has contributed to the poverty of the border populations, increasing the impact of HIV on the region by depriving individuals of the ability to protect themselves or treat the virus once infected. In the wake of severe environmental degradation from the Volta River Project, disruptions in border trade and mobility have inhibited many from maintaining adequate income to support their families. Poverty has become endemic in the region, and in 2005, Appiah-Kubi et al estimated that almost 40% of people in the Volta Region are living in poverty (2005:13).

From my fieldwork and experience living in Aflao, this figure is probably an underestimate for the border communities.

Currently, the border is only open from 6AM-10PM Monday through Saturday. Remnants of distrust between the Ghana and Togo governments have prevented the border from staying open 24 hours, 7 days a week like other West African borders. However, relations between the governments have improved dramatically, exemplified by the Ghanaian ambassador's statement that 'logistic problems' are the main cause of border closure, not distrust between Ghana and Togo¹⁴. In January of 2007, a 26 member Inter Border Facilitation Committee was set up to ensure free movement of people and goods between Ghana and Togo in order to remove obstacles that place travelers and border communities at risk of HIV.

STRUCTURAL ADJUSTMENT: HISTORY AND CONSEQUENCES

The spread of HIV throughout West Africa was seemingly unavoidable as a result of the highly mobile migrant labor force and increasing number of commercial sex workers (Oppong and Mensah 2004:72). However, the reasons underlying the existence of these two populations are essential to an explanation of the devastating impact of the disease on the Ghana-Togo border communities.

¹⁴ Ghana and Togo negotiate for contractual differences on water project. Electronic Document, <http://www.ghanatoday.com/index.php?option=news&task=viewarticle&sid=17653>

Between 1960 and 1973, newly independent African nations had enjoyed a period of economic growth as a result of the increasing prosperity of Western nations (Lurie et al 2004:205). The resource-rich West Africa was able to develop a healthy export economy of commodities to Western nations, boosting its own economy and autonomy. However, this period of growth and prosperity was quickly stifled with the oil crisis of the 1970s that resulted in a significant reduction in international trade.

As a result of the oil embargo of 1973, developing countries, including Ghana and Togo, suffered a severe economic recession as export costs increased (Lurie et al 2004:295). The young governments of Africa were not ready to handle the economic devastation that resulted and plunged into deep debt as they continued to import the necessary food, medicines, fuel, and raw materials for their country's survival (Lurie et al 2004:205, Sparr 1994:66). The decreased demand in Western nations for products from developing countries resulted in a significant devaluation of goods from countries like Ghana and Togo. With a sudden excess of imports over exports, developing countries consequently became dependent on foreign credit and loans. However, it was quickly realized that the unpredictable interest rates resulting from the even more unpredictable economy were too risky to accept (Lurie et al 2004:205).

A second oil crisis in 1979 followed by the international market recession in 1980 and 1981 forced highly indebted developing countries to seek aid from the international lending institutions, the World Bank (WB)

and the International Monetary Fund (IMF) (Lurie et al 2004:205). The result was the Structural Adjustment Program (SAP), which featured policies that developing countries were forced to accept in order to receive loans from the IMF or WB. The SAP was characterized by 4 main policies:

1. Devaluation of currency
2. Government reduction of budget deficit through cutting subsidies on basic foodstuffs, water, public transport, gasoline, and electricity or cut public services and layoff public employees.
3. Government increase/removal of limits on interest rates to discourage borrowing, curb inflation, and keep capital within the country.
4. Removal of price controls. (Sparr 1994:7)

After implementing these policies, countries were eligible for SAP loans, which seek to set prices on goods in accordance with the free market, minimize government involvement in the economy, and create a more open economy (Sparr 1994:7-8).

Ghana, which had initiated a relationship with the WB in the 1960's with the Akosombo Dam and Volta River Project, turned once again to the multilateral lending institution for assistance in 1983 (Manuh 1994:64). Other African nations followed the same path and by 1990 the majority of indebted sub-Saharan African countries were pursuing SAPs in order to alleviate their debt (Lurie et al 2004:206). Simultaneously, HIV was quietly gaining a foothold on the continent, spreading from the epicenter of Western Equatorial Africa towards the north, south, east and west (Iliffe 2006:10).

Although the WB considers Ghana a SAP success, the impact of the policies on vulnerable groups such as the poor and women was not so positive (Manuh 1994: 66). As a result of SAP, life in developing countries changed dramatically. The expansion of transportation infrastructure, the declining sustainability of rural subsistence, increases in migration and urbanization, and reductions in spending on health and social services contributed to sexual risk behavior among populations receiving the loans (Lurie et al 2004:210, Schoepf 2001:343, Oppong and Mensah 2004:80). In the environment of the border, the implementation of SAP policies created the conditions necessary for the spread of infectious disease, including HIV (Oppong and Mensah 2004:81).

TRANSPORTATION INFRASTRUCTURE

The importance of export-driven economies to structural adjustment required the development of roads and transportation networks (Lurie et al 2004:208). These networks served to improve the connection between rural areas and urban export centers to increase the movement of goods from the interior of the country, outwards. Although roads and railways had originally been constructed throughout the period of colonialism, SAP policies further increased their reach (Nugent 2002:24, Lurie et al 2004:209). As a direct effect of this, a new labor force was introduced to the urban centers as rural residents sought out wage employment. Movement was increased not only for migrant workers moving to the cities, but also for the now employed truck

drivers who lived on the road, transporting goods throughout the country and region.

ECONOMIC CHANGES

The attraction of urban centers for rural residents lay in the reality that with SAP, the rural subsistence economy was no longer sustainable (Lurie et al 2004:208). As a consequence of the elimination of tariffs and taxation on foreign imports, increased foreign competition caused a significant decline in the demand for local product. Large-scale export agriculture, mining and logging also contributed to the marginalization of subsistence farmers and women, who are not traditionally employed by these sectors (Manuh 1994: 67).

The decreasing number of income generating opportunities for the general population made the cheaper foreign foodstuffs more affordable for the average family, further exacerbating the rural farmers' struggle to survive, while decreasing the self-sufficiency of developing countries that became increasingly dependent on foreign imports. With introduction of transportation networks, more individuals migrated to the cities to work for money to send back home to their families.

In Aflao, the unsustainable rural subsistence economy was paired with an already devastated fishing and agriculture industry along the coast (Akyeampong 2001:170,178, GTZ 2003:11). A large proportion of the population has been affected by these environmental changes and forced to

pursue the border economy or relocate to urban centers, e.g. Lomé, to search for work. My time in Aflao revealed the severe over population of informal professions along the border as a result of urban migration. When people stand on the side of the road to hail a taxi, three or four pull over to compete for the business. Small provisions, sewing and hairdresser shops are lined up one after the other surrounded by the local petty traders and food sellers who carry their wares on their heads. With the large informal sector population, the inherent gender segregation is clearly visible. Women work along the roadside, either in shops or as petty traders, while the men drove the taxis and tro-tros (minibus transport), and sold the meat. In addition, the border supports currency trafficking and smuggling, both of which profit from the differences in prices and exchange rates between Ghana and Togo. However, due to increased government surveillance and pervasive fencing, participants in these informal economic activities have to find more discreet routes, north of Aflao. For those who could not find adequate income in the border economy, Lomé offers some reprieve as a large capital city.

RAPID URBANIZATION

The increased migration of rural residents to export centers led to rapid urbanization. Male migrant workers who leave their families in the rural regions often find new partners in the city (Lurie et al 2004:209). Uneducated, or unable to access formal sector waged employment, women either remain dependent on their migrant husbands, or migrate themselves

in search of work. After traveling to urban centers, many women find that opportunities are still limited, and participate in the informal economy, e.g. petty trading or commercial sex industry, in order to support their families (Lurie et al 2004:209). Those women who stay at home are frequently unable to ensure safe sex practices and condom use due to their reliance on their husband for economic support (Ankomah 1999:304, Lurie et al 2004:209).

In Aflao and the border region, the police and customs officials join the migrant labor force, truck drivers and commercial sex workers as government identified high-risk populations (GTZ 2003:20). Studies in Ghana have shown that among junior-police officers, comprising 75% of the total police force, AIDS-related illnesses are the leading causes of death (Oppong and Mensah 2004:79). Negotiations at the border for permission to cross exacerbate this trend further by increasing the length of interaction time between customs officials and people moving between Ghana and Togo. As a consequence of the residual tensions and suspicions between the two governments, the Ghana-Togo border is one that is known for its volume of paperwork and detailed inquisitions into the purpose of those who cross it. In order to pass through the border hassle-free many traders perform sexual favors, and therefore avoid the difficulties faced by others who do not engage in sexual activity (GTZ 2003:15).

The border town is the direct link between Accra and Lomé and so a large mobile population moves through the border area daily. Aflao, although originally small, has dramatically increased in size due to the southeastern

Volta Region's increased reliance on the border economy. With border closure at 10 PM each night, many people are stranded on either side of the border as they wait for it to reopen in the morning. This encourages the commercial sex industry, which profits as a result of drivers and traders spending the night along the border.

CULTURAL IMPLICATIONS

My interview with the Paramount Chief of Aflao revealed that the increasing population and rapid urbanization of Aflao as a border town is contributing to weakened traditional rule. Due to Britain's policy of indirect rule during colonialism, indigenous authorities became integral to the colonial hierarchy, acting as enforcers of traditional and customary institutions and practices (Buah 1980). With the end of colonialism, traditional governments remained, resolving local disputes and maintaining cultural practices, but playing a subordinate role to the national government. Today, in the post-SAP environment, the decreasing influence of the traditional authorities combined with a suffering economy is inhibiting the maintenance of cultural values throughout the community. For example, prostitution was previously a highly stigmatized profession that required women to move away from their homes in order to practice it. However, as the economic gains from commercial sex work have become more apparent, women are able to more freely participate. Families have even been known to encourage their daughters to pursue relationships with men in order to reap the financial benefits.

Despite the change in cultural values regarding commercial sex, pre-marital pregnancy is still a serious taboo. Men are obligated to pay for all the expenses incurred by the women they impregnate. In addition, the Paramount Chief noted that the men are required to marry the women; however with the rise in commercial sex work, this cultural guideline is harder to enforce. Even so, the threat of pre-marital pregnancy and the cultural sanctions that follow has caused a significant shift in sexual behavior. Birth control is used, including condoms, but these are typically only used during a woman's 'unsafe' period of ovulation (GTZ 2003:11). The behavioral changes are concerned only with preventing pregnancy, and therefore do nothing to prevent the transmission of STIs or HIV.

LOSS OF HEALTH AND SOCIAL SERVICES

The SAP-induced increase in transportation networks, environmental degradation and declining economy is taking place concurrently with reductions in government spending on health and social services. This creates an environment where, as risk behaviors increase, the resources that would combat risk behavior and treat HIV and STIs are simultaneously decreased. Through SAP, spending on health, education, and welfare was cut in order to accommodate the infrastructural needs of foreign investors such as export-driven crop production, mining, logging, and road construction (Manuh 1994:66-7).

Fees are now charged for previously free medical services in order to raise money for the government and further 'development'. However, as a result, those who are poor are unable to afford the medical services, and instead turn to a variety of resources, including indigenous medical practices and itinerant drug vendors (IDV), poorly trained health care providers who often administer medicine using un-sterile needles (Oppong Mensah 2004:77). Consequently, health professionals suffer a significant decrease in patients, and many either adopt a more secure private practice policy, or move out of Ghana to other African nations, Europe or America (Millen 2007).

Initially, the iatrogenic spread of HIV through the misuse of needles was further complicated by inadequate blood screening facilities (Oppong and Mensah 2004:77). As governments and health care providers became more aware of the risks attached to blood transfusions and un-sterilized medical devices, the rate of iatrogenic transmission out of all HIV infection decreased to 5% (GAC 2001a:6). UNAIDS and WHO recently reported that 100% of the blood units transfused in the last 12 months in Ghana have been adequately screened for HIV according to national/WHO guidelines¹⁵ (WHO 2006). However, the increased awareness and safe medical practices will do nothing unless they are paired with greater access to medical services throughout the population.

In addition to medical fees, the adoption of school fees has resulted in many families facing difficulty sending their children to school (GTZ

¹⁵ WHO/UNAIDS Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections August 2006.

2003:10). According to the GTZ survey along the border, when families experience economic difficulty, girls are frequently encouraged to pursue transactional or commercial sex (GTZ 2003:10). Petty trading at the border is one method of earning money; however according to interviews with the staff at Lolo-Agbé, girls have found more stability in developing relationships with older men who will provide them with their school fees. As a result, girls are encouraged to adopt high-risk behaviors in order to gain an education and increase their access to a higher socio-economic status through stable employment in the formal economy. This pattern ultimately creates a paradox that as girls try to improve their lives they are more likely to engage in behavior that may prevent them from ever reaping the benefits of their education. Lynn M. Thomas writes,

The very fact of moving outside their homes and attending schools, often staffed by men, has offered girls and young women the possibility of joining broader and, in many cases, more promising and permissive social worlds. At the same time, such possibilities could leave them vulnerable to sexual predation and endanger familial reputations and investments. [Thomas 2007:57]

In the context of SAP, even those who completed their education faced uncertainties about whether there would be any work available. Cuts in the public employment budget as a result of SAP policies inhibits new graduates from attaining formal sector waged employment, leaving many to search for economic stability in the farming, fishing, informal construction, or trading sectors (Manuh 1994:67-8). Prior to SAP, educated women had been

employed with salaries and benefits as public employees. With SAP, many lost their employment and returned to the informal sector, which is characterized by insecurity and increasing competition.

HISTORY OF HIV IN WEST AFRICA AND GHANA

As a consequence of the economic and social environment created by SAP, which increased reliance on migrant labor and commercial sex work, it is not surprising that the onset of HIV-1 in West Africa was seen first in Abidjan, Cote d'Ivoire, which in the 1960s and 1970s experienced significant economic growth attracting people from all over West Africa. According to John Iliffe, the virus most likely appeared in West Africa around 1980, with the first diagnosed cases occurring in Abidjan in 1985 (Iliffe 2006:52). An analysis of the viral strains present in Abidjan indicated that the HIV-1 strain originated in Cameroon and Gabon, implying a diffusion that could have resulted from the migration of sex workers and their clients along the coast from Libreville to Abidjan (Iliffe 2006:52).

The attraction of Cote d'Ivoire to people throughout West Africa was a consequence of a 6.8 percent annual growth rate in the first two and a half decades since its independence (1965-1980). Ghana's economic decline in the 1960s coupled with Abidjan's economic stability meant that many Ghanaians migrated to Cote d'Ivoire (Iliffe 2006:52, Mensah 2001:445, Oppong and Mensah 2004:77). Among these migrants were Krobo women from the Eastern Region of Ghana. Scholars such as Iliffe and Porter have

documented that after arriving in Abidjan, most of the women could only find work as commercial sex workers, and as a result a large number contracted HIV (Iliffe 2006:53-4, Porter 1994 cited in Schoepf 2001:343). The diffusion of HIV beyond commercial sex workers and migrant laborers occurred along the major roads, which connected urban and rural communities throughout West Africa and beyond (Mensah 2001:445).

The initial reports of HIV prevalence in Ghana in 1987 claimed that there were 276 known cases of HIV: 242 of these were women, 199 were sex workers returning from Cote D'Ivoire, and 145 were from Ghana's Eastern region (Iliffe 2006:54). However, the resulting blame that was placed on the sex workers for the spread of HIV in Ghana is not necessarily appropriate. The women had been singled out for testing and therefore an incomplete sample produced an obvious bias in the results. Secondly, most sex workers were too sick to transmit the disease once they returned home (Iliffe 2006: 54). While HIV's arrival in Ghana is noteworthy, it is the political economy that facilitated its spread, the national and social response to the virus and its subsequent patterns of transmission that are important to its analysis today.

RESPONSE TO HIV

GHANAIAN GOVERNMENT

When HIV was first documented in Ghana in 1986 the response was primarily medical (GAC 2001a:9). Government efforts began when the

National Advisory Commission on AIDS was established in 1985 in order to advise the government on issues relations to HIV/AIDS, and in 1987, the National AIDS Control Program was created under the Ministry of Health in order to implement programs regarding HIV/AIDS in Ghana. In 1990, after a recommendation issued by the World Health Organization, the sentinel surveillance system was established in order to monitor the rates of HIV infection throughout the country. However, on the ground, little was being done to prevent the spread of HIV throughout the population. The programs, policies, and monitoring created the semblance of action and concern, but according to the Ghana AIDS Commission (GAC), it was not until 2000 when the prevalence of HIV was rapidly increasing did the government make a strategic effort regarding HIV/AIDS, 14 years after the first case was acknowledged. The lack of a timely and focused government response at the first sign of HIV infection allowed HIV to rapidly spread from the migrant labor force and commercial sex workers to the general population. Only later did political leaders and policy makers realize that HIV was more than a medical concern; it was ravaging populations, economies, and social structures across Africa, and it would do the same in Ghana.

A multi-sectoral approach has been implemented since 2001, incorporating the efforts of government offices, non-governmental organizations (NGOs), faith-based organizations (FBOs), and community-based organizations (CBOs) (GAC 2001a:16). Intervention and prevention programs are being implemented simultaneously at each level in order to

raise awareness about HIV/AIDS and promote behavior change. The National Strategic Framework (NSF), written in 2001 by the Ghana AIDS Commission in partnership with national and international organizations, outlined guidelines for government ministries, departments, and agencies, district assemblies, the private sector, NGOs, and the broader civil society to develop “specific HIV/AIDS strategic plans and activities as may be determined by their peculiar needs and circumstances.”¹⁶ The NSF outlines the background and history of HIV, the national response to HIV/AIDS, the goals and objectives of the plan, the methods of prevention of new infection, the care and support of people living with HIV/AIDS, the creation of a supportive legal, ethical, and policy environment for HIV/AIDS programs, followed by proposed implementation strategies and methods of monitoring and evaluation of progress.

Currently, Ghana is implementing a Monitoring and Evaluation Plan (M&E) in order to assess the national HIV situation and address the needs of the population effectively. Through the diverse range of organizations implementing HIV programs, the M&E plan is centered on gathering information in order to implement a more expanded, yet focused, national response to HIV/AIDS with the purpose of achieving the goals of the NSF¹⁷ (GAC 2001b). The government has acknowledged the need for a multi-sectoral approach to HIV/AIDS prevention, education, and support; however

¹⁶ Ghana HIV/AIDS Strategic Framework 2001-2005; Ghana AIDS Commission

¹⁷ National Monitoring and Evaluation Plan for HIV/AIDS 2001-2005

the coordination of each level from the CBOs to national government has not been fully attained. Despite Ghana's delayed response to HIV, the country's relative stability has allowed it to maintain consistent access to foreign aid, unlike its neighbor Togo, which as a result of political instabilities has been unable to adequately address its HIV/AIDS situation.

TOGOLESE GOVERNMENT

The political instability that characterizes Togo has made it difficult to implement government funded HIV prevention and support programs. Togo had been receiving aid from the Global Fund to Fight AIDS, TB and Malaria since their grant proposal was approved in 2003, and as of April 2006, the Global Fund reported that Togo had "successfully achieved significant Global Fund benchmarks" and were to receive approval for a second phase. However, in January of 2007, the Global Fund froze this grant money due to mismanagement and theft of earlier grants by Togolese officials. The implications of the loss of Global Fund money are serious because it will leave many Togolese without antiretroviral treatment (Wakabi 2007). For the Togolese border communities this is especially devastating because residents had enjoyed relatively easy access to subsidized medicine. Without the aid money from the Global Fund, this program is likely to end.

Currently, Togo is under the leadership of Faure Gnassingbé, the son of the late president Gnassingbé Eyadéma. Following his father's death in February 2005, Faure Gnassingbé was installed as president by Togo's

military and the border was temporarily closed. After international outcry forced a national election, Faure Gnassingbé was elected with 60% of the vote. The result was highly contested and has contributed to the instability that presently characterizes Togo. In 2003, the World Health Organization reported that the HIV prevalence rate in Togo was 3.2%; however among women attending antenatal clinics in Lomé, the prevalence was between 7 and 8% ¹⁸(UNAIDS 2006). According to the GTZ report, response to HIV along the border in Togo has been mostly limited to the efforts of local NGOs (GTZ 2003:8). The national response to HIV at the border has been lacking, and now with a loss of funding from international aid organizations like the Global Fund and World Bank, Togo's national response is severely constrained.

CONCLUSION

The historical events included within this chapter have contributed to the current political, economic, and social environment of the border region. The Ghanaian government's marginalization of the border region has resulted in a lack of infrastructure. Women are increasingly reliant on the informal sector as a consequence of the privatization-induced decline in public sector waged employment and decreased access to education. In the wake of SAP, the majority of women who were unable to access education have become dependent on work as seamstresses, hairdressers and petty traders, resulting in an overpopulation of those professions. Political instability in Togo has also

¹⁸ 2003 UNAIDS estimate

contributed to the border populations' economic insecurity, despite the presence of Lomé as an urban center. The inherent poverty that both Ghana and Togo are encountering along the border stems directly from the historical events described in this chapter. This environment has facilitated the spread of HIV by promoting survival strategies of mobility and women's reliance on men, both of which increase the population's vulnerability to HIV.

CHAPTER III: POLITICAL ECONOMY AND HIV

This chapter describes how sociocultural, political and economic factors interact with the epidemiology of HIV, shaping the way the virus affects the populations of the Ghana-Togo border. HIV is a disease that not only affects the person who is infected, but also their family and community. From the previous chapter it is clear that the history of the border, the tension between Ghana and Togo, SAP policies, gender disparities, and government and national responses to HIV have had a profound impact on the pattern of HIV transmission throughout the region. HIV is a unique infectious disease due to its clinical presentation and transmission, which in turn facilitate its far-reaching cultural and social impact. Through a case study of Lolo-Agbé, the NGO where I spent nine weeks as an intern, I will highlight how HIV interacts with these specific border communities, and what this local organization is doing to address the underlying poverty and gender disparities that feed into a vicious cycle with HIV.

THE IMPLICATIONS OF HIV

In Ghana, out of a total population of 22.1 million¹⁹, 3.5 million people suffered from malaria in 2003, killing 22% of all children under the age of five.²⁰ That same year, there were 310,000 reported cases of HIV, a remarkably smaller number than that of cases of malaria and other endemic infections. Therefore, singling out HIV/AIDS for analysis warrants

¹⁹ WHO, 2005 estimate

²⁰ WHO, 2003 estimate

explanation. Unlike malaria, those who contract HIV do not have the possibility of recovery. In addition, the majority of malarial deaths occur in children under the age of five; they are too young to be held socially responsible for their sickness. The majority of those who die from HIV/AIDS are adults, and therefore communities are more willing to blame the individual. The social implications resulting from transmission from one individual to another, most commonly through sex, are much higher than those for malaria, which is transmitted through a mosquito vector.

AIDS is also unlike other diseases because its clinical appearance is the result of secondary opportunistic infections, most of which have been endemic in the region for a long time. As a result, there is a common misconception that AIDS is an old illness, something that the community has been living with and surviving for many years. This idea is reflected in the local term *dikanaku*, 'grow lean and die', which is used to describe other illnesses, such as diarrheal diseases, and also categorizes the disease as a hopeless death sentence.

Believing the symptoms to be the result of a long-standing endemic disease, people will turn to a variety of therapeutic resources, which in the border region, includes itinerant drug vendors and fetish priests. Although the majority of the local population is Christian, indigenous belief systems endure. In addition, in the face of growing poverty, many people turn to traditional medicine because it is often cheaper than hospitals which feature costly fees for all services. In the context of HIV, reliance on fetish priests

complicates treatment. Dr. Mensah described patients who eventually came to him after initially seeking traditional medicinal therapy. The combination of herbal medicine and untreated HIV infection often leads to a rapid progression to AIDS. This is chiefly because antiretroviral treatment is delayed, allowing the virus to spread to a point where treatment may no longer be effective.

HIV is spread as a result of both biological and social conditions making both prevention and education difficult due to the necessity of behavior change. The modes of transmission, linked to bodily fluids such as blood, semen, vaginal fluids, and breast milk result in a highly stigmatized perception of those who are infected as polluted (Schoepf 2001:340). Those who are most susceptible to the disease are those who are already marginalized, which along the Ghana-Togo border include poor women. Where poverty and inequality are present, HIV is able to thrive because the vulnerable are unable to ensure their own safety. Schoepf writes, that although many know about the “danger of sexual transmission,” the women who are most vulnerable are unable to avoid infection “because they cannot control the relations of power that put their lives at risk” (2001:336).

As governmental and non-governmental organizations became aware of HIV’s presence in their countries and communities, a focus on ‘risk groups’ was enacted, targeting those who participated in commercial sex and migrant labor. Although initially necessary, this ‘risk group’ rhetoric has contributed to a false sense of security among the general population about their vulnerability to HIV. Consequently, the risk-group prevention tactic that

was intended to protect populations has instead increased their susceptibility. People in presumed faithful relationships, whether serial or long-term, monogamous or polygynous, are generally unaware of the risk of infection and so are less likely to protect themselves. Now, not only is there more work to be done in terms of reducing the prevalence of HIV among those who are belong in the various 'risk groups', but there also needs to be a concerted effort to inform the general public of the risks incurred through their faithful relationships.

Compared to other sub-Saharan countries such as Cote d'Ivoire and South Africa where the HIV prevalence is at 8.3 and 29.5%, respectively, Ghana's prevalence of 3.1% is quite low. This relatively low HIV prevalence has contributed to an additional false sense of security on the national level. However, the latency of the virus, which has an average duration of ten years, prevents government and community leaders from realizing the extent of the virus until it has already spread throughout the population. Consequently, the prevalence of HIV is likely underreported because many people are unknowingly infected and therefore also transmitting the virus. The number of unknown cases combined with an already increasing national prevalence may be sending Ghana towards a significant rise in HIV infections (Mensah 2001:446).

THE BORDER AND HIV

Borders present a unique challenge to disease prevention efforts by dividing populations between countries with different governments,

policies, and in the case of West Africa, different national languages. Despite the political divisions, the communities surrounding the Ghana-Togo border feature a remarkable amount of movement between the two countries.

Although a survey conducted by the Ghana Immigration Service indicated that at least 250 people crossed the border daily, a count at the border conducted by GTZ found that on three separate days of the week between 6 and 9 AM there were almost 1000 people crossing from Ghana into Togo (2003:9). The border is characterized by a high volume of mobility, connecting rural and urban centers through the movement of goods and people.

In West Africa, this high volume of human mobility, facilitated in part by economic fluctuations, was key to the initial spread of HIV. The transatlantic slave trade, colonialism and structural adjustment policies increased transportation infrastructure while simultaneously strengthening some economies and leaving others devastated. As described in the previous chapter, after 1970, Ghana's financial uncertainty increased, offset by the rapid development occurring in post-independence Cote d'Ivoire (Iliffe 2006:52, Mensah 2001:445). In order to find work, Ghanaian men and women left their homes for other West African cities. Women typically migrated west to Cote d'Ivoire, while men dominated the eastward migration path to Nigeria to participate in the male dominated oil and transportation industries (Anarfi 1995, cited in Mensah 2001:445). The roads linking cities and communities throughout West Africa served as a corridor for disease, spreading the HIV virus from urban centers to the surrounding

communities (Wood cited in Mensah 2001:445). The road leading into Aflao is especially central to this corridor of disease as it directly connects Accra and Lomé.

A DAY ON THE BORDER...

Arriving in Aflao on a Sunday afternoon after a bumpy 230 km drive, I was surprised by how quiet the supposedly chaotic border town actually was. The streets were open for the few people and vehicles to comfortably weave their way towards their respective destinations. Coming from the capital city of Accra, the calm atmosphere of Aflao was a welcome environment. However, at 6 o'clock on Monday morning, I was abruptly awoken by the sounds of people and speeding traffic. The once quiet town of Aflao had been transformed overnight into a busy, crowded urban environment. Kiosks that had appeared abandoned on Sunday were open and overflowing with fresh fruit, vegetables, meat, and basic provisions. Hawkers were moving up and down the road, yelling out to advertise their goods. Amongst the chaos of people and kiosks, taxis and tro-tros (minibus transport vehicles) rushed to and from the border. At the end of the day the border activity came to halt, leaving Aflao quiet again.

The Ghana-Togo border region is unique in that residual tension between the Ghanaian and Togolese governments, as described in the previous chapter, prevents the border from remaining open at all times. Currently the border opens at 6AM and closes at 10PM, Monday through

Saturday, and remains closed throughout the day on Sunday. A more trusting relationship is developing between the two countries, but unlike the Togo-Benin border, Ghana and Togo have not been able to establish a 24-hour open border policy.

As a result of the border closure, travelers and mobile workers are stranded each night on either side of the border as they wait until morning to resume their journey. Forced to spend the night in Aflao, travelers and mobile workers create a large market for commercial sex work. According to Joseph, the program manager at Lolo-Agbé, it is cheaper for migrant workers to spend the night with a commercial sex worker rather than arrange accommodations at a local hotel. However, commercial sex workers are not the only women profiting from the situation; other women will engage in transactional sex²¹ in order to obtain money. Without safer alternatives, sex becomes one option available to women living in the struggling economic atmosphere of Aflao. Due to its highly stigmatized nature, my informants never revealed their own participation; however in the present state of the economy, it is likely that some supplemented their income through transactional sex.

In the current climate of economic uncertainty and disease, the communities of the border are under going a significant period of change where traditional practices and gender roles are being called into question. The communities' place at a crossroads of geographical space situates them at another ideological crossroads. As Donna K. Flynn writes in *"We Are the*

²¹ In this paper, women who participate in transactional sex are not formally considered part of the commercial sex industry. Rather, sex acts only as a supplement to their already existing income.

Border": Identity, Exchange, and the State along the Bénin-Nigeria Border, “borderlands, both literal and figurative, are sited where political, cultural, and social identities converge, coexist, and sometimes conflict” (1997: 312). On the Abidjan-Lagos trade corridor, Aflao and the border communities are home to a large migrant population. The corridor connects people from all over West Africa, allowing the exchange of ideas between urban and rural communities throughout the region.

As a result of its proximity to Lomé, which features a large port and is the destination of many migrant workers, the communities of the border are also regularly exposed to foreign people and lifestyles from outside of West Africa. The Paramount Chief of Aflao struggles with what he perceives as the decreasing influence of traditional leaders as his community is inundated with what he calls *western* ideas of equality, sexuality, and economy. Despite this, in the context of HIV and growing poverty, women are becoming increasingly marginalized. The traditional gender-segregation of occupations and household responsibilities is no longer sustainable as it excludes women from viable income-generating opportunities. SAP has promoted the industries that typically employ men, leaving women to pursue the insecure border economy or rely on their relationships with men, therefore placing their lives at risk as they try to ensure immediate survival. Through recent increases in girls’ education and the sharing of ideas, changes towards gender equality are slowly occurring. This process is specifically addressed by Lolo-Agbé in Aflao and the communities of the border.

LOLO-AGBÉ: CASE STUDY OF AN NGO IN AFLAO

As an intern at Lolo-Agbé, my work was intimately connected with the border. A Ghanaian NGO, Lolo-Agbé is designed to link people of different educational, economic, and professional levels in order to share knowledge and experience and therefore improve lives. In Aflao, their focus is on support for people living with HIV/AIDS, school-based HIV/STI-education programs, and gender and reproductive health programs in the villages surrounding Aflao. Staffed entirely by local Ewe men and women who have a broad range of education levels, Lolo-Agbé has the unique benefit of understanding the challenges and opportunities available to the population they are serving. In that way, the organization is able to design its programs using a holistic approach, incorporating both preventative efforts directly related to HIV and STI education and general community education regarding gender and reproductive health.

Lolo-Agbé receives funding from World Education, American Jewish World Service, Village Infrastructural Project, Comic Relief, Plan Ghana, and the Ghana AIDS Commission. By attaining resources from a diverse group of donors, Lolo-Agbé ensures that if they lose money from one donor, their programs will not be devastated. Lolo-Agbé is also joined by several other NGOs and research organizations in the area that all work to provide support and HIV education services. Lolo-Agbé is fortunate to have developed a strong presence within the community; however not all governmental or non-governmental organizations can ensure local support or money for their

projects. Thus, coordinating the efforts of the many organizations located at the border has proved difficult.

Currently, and at the time of my internship, the Abidjan-Lagos Corridor Organization (ALCO) is operating at the border regions between West African countries. Partnering with international organizations such as the World Bank and UNAIDS, ALCO aims to increase access to STI and HIV/AIDS prevention services along the corridor, and to “serve presently underserved, vulnerable groups, particularly migrants and local populations living in the border towns.”²² Lolo-Agbé worked closely with ALCO in these efforts as they applied to Aflao and the Ghana-Togo border; however ALCO is a temporary project with an eventual end-date, leaving Lolo-Agbé and other local NGOs to handle HIV prevention and support services alone. With a permanent place in the community, Lolo-Agbé works closely with the Paramount Chief, prominent community members, government officials, and local hospital staff. In this way, despite limited economic resources, the organization works with community leaders in order to encourage long-term changes in perception and risk-behavior regarding HIV.

During my first week with Lolo-Agbé, I joined the staff on their weekly trip to Ketu District Hospital (KDH) to spend time with those suffering from HIV and meet with the counselors who work for the VCT center. As we walked through the various wards I spoke to several men and women, and was surprised to find that none were residents of Ghana; instead

²² ALCO Action Plan 2005; <http://www.corridor-sida.org/spip.php?rubrique70> 77

they had migrated from Togo, Benin, or Nigeria for medical treatment. Their reasons for traveling to Ghana for treatment varied. Some people who suffer from HIV/AIDS travel to KDH in order to gain a higher level of privacy than they would have received at their own community health services. Others come to KDH because the hospital has a better reputation for health services than others located in the surrounding border communities.

KDH is a very well kept district hospital, creating a welcoming atmosphere while providing high quality health services to its patients. In 2006, random surveillance testing of prenatal women yielded an HIV prevalence of 8%. In general, 62 out of 530 women tested positive in 2006, yielding a prevalence of almost 12%. Lolo-Agbé works with KDH by providing food to the growing number of HIV patients who have been admitted for treatment. Through this program, the organization is able to connect with those suffering from HIV, facilitating community awareness of their support and counseling services.

Located on the border, Lolo-Agbé directly serves both Togolese and Ghanaian men and women, in addition to immigrants from all over West Africa. Many families are split by the border, creating a need for the NGO to accommodate people from both Ghana and Togo, although it is a Ghanaian based organization. The division of the West African coast into several different countries over a small geographic area similarly contributes to the diversity of patients who visit the Aflao hospitals. The high level of mobility demonstrated by the number of KDH patients from surrounding West

African countries necessitates strong cross-border communication between governments and NGOs to develop more strategic and efficient support and prevention programs. While I interned with Lolo-Agbé, the staff was working to create stronger relationships with other NGOs in Aflao, as well as organizations in Togo and Benin.

There is still a general lack of communication between NGOs in Aflao, leading to misunderstandings and disorganization of efforts. The GTZ survey identified signs of mistrust between the various NGOs, hindering their ability to serve the local population. The lack of coordination between the various HIV support and prevention organizations on both the private and governmental level creates an amount of redundancy, and therefore ineffective use of funding. Even in times of increased coordination and communication, donated money is often granted to organizations for specific uses, e.g. condom use or education programs. For example, Lolo-Agbé had previously been responsible for distribution of condoms along the border; however another NGO set up a similar booth at the border, a situation that could have been avoided had the NGOs communicated about their respective projects and resources.

Despite the overlap of some services, Lolo-Agbé is unique in its support for people living with HIV/AIDS while other NGOs are predominately focused on Information, Education and Communication (IEC) programs. Through the HIV-support programs, Lolo-Agbé offers counseling, monetary support, and basic food supplies. However, most of the money

that Lolo-Agbé receives is from international donors, many of whom are not familiar with Ewe culture or the environment in which the NGO is operating. Conflicts arise when Lolo-Agbé is restricted from utilizing the grant money in a culturally appropriate way because it is not ‘cost-effective.’

My very first day working with the organization revealed the difficulty in translating donor money into culturally appropriate programs. As outsiders with the goal of cost-effectiveness, donors often did not appreciate that their money would not be successful unless its use was shaped by the local culture. In the morning, several of the staff members began gathering cooking oil, flour, gari (a cassava-based product), wheat, and beans into multiple large bags. The food was intended for HIV patients in the Aflao community. As we traveled to the home of Yao, a 47-year-old man from Aflao, who was suffering from advanced AIDS, I was surprised to discover that all of the food we had packed was intended for him and his entire extended family. My initial confusion was similar to that of international donors who attempted to guarantee that their donation is going to the people most in need, i.e. AIDS patients. In their, and my mind, so many more people living with HIV could receive the food aid if it was only given to the individual patients.

I quickly learned that there are several things wrong with this judgment. Culturally, the Ewe people are intimately connected to their extended families. Three generations of a family often live in a home together, sharing everything they have. Lolo-Agbé found that when they delivered only enough food for the person with HIV, it would be shared

anyway, leaving the patient without enough to stay healthy. After persuading the donors that more food must be given to ensure that the patient actually benefited, the amount of food delivered to each patient increased. In this way, through culturally appropriate implementation, the effectiveness of support programs like this one is dramatically improved.

Beyond the need for culturally appropriate donations, there is another factor that necessitates providing enough food for the entire family. Most of the HIV positive community members that Lolo-Agbé serves are young men and women who would otherwise be providing income for their extended families. As a consequence of their illness, they do not have enough strength to work, leaving their families without income they had come to rely on. In addition, if the family is caring for the person suffering from HIV, they spend more time at home, reducing the income generated by the family even more. As a result, the family is suffering from a remarkable reduction in financial resources, while spending more money to cover hospital fees. In this way, HIV is not a disease that is limited to the person it has infected, instead, as Iliffe writes, heterosexual AIDS is “a family disease,” whose impact falls “first and most heavily upon the household, with young adults as the chief victims” (2006:112). The strong family network that characterizes Ewe families is affected by HIV/AIDS in many ways, a consequence that needs to be considered when developing support programs for people living with the virus.

However, due to the highly stigmatized nature of HIV, it is impossible to develop a support strategy that will apply to every family in the border region. Afraid of abandonment, many people living with HIV will withhold their status from their extended families. Lolo-Agbé attempts to combat this by providing counseling services to all family members. This does not always work, and many people living with HIV suffer from their disease in secret. When the virus develops into active AIDS, family members may shun the infected, or hide them away from the community. Many of the families that I visited with had hidden their sick family members in order to avoid judgment by their communities. This prevented those suffering from HIV from receiving the health care and assistance they desperately needed.

One month before I arrived in Aflao, Sefako, a 36-year old woman living with HIV, was working with Lolo-Agbé in the local schools to educate students about HIV. While she worked with the NGO she received medication and was able to preserve her strength. With the conclusion of the school quarter Sefako spent her time at home with her father. In my first week with the organization, the director discovered that her father and stepmother were mistreating her, so the entire staff went to visit with the family. When we arrived we found her lying on a mat in a small concrete room separated from the rest of the house. Although previously strong, she had not eaten for a week and at this point was barely conscious. When the blanket that was covering her was removed I saw how ravaged her body had become. Every single bone in her body was jutting through her skin. I looked for any sign

of muscle or fat, but all that seemed to remain was skin and bones. I could not fathom how she was able to move, or was even still alive.

Sefako's family had brought her to KDH a week earlier, after she had lost a significant amount of body weight and refused food, but the nurses considered her a hopeless cause and declined treatment. Returning home, she spent another week too nauseous to eat. While a few of Lolo-Agbé's staff went to KDH to bring a nurse and IV fluids, Joseph, the head manager of Lolo-Agbé, reprimanded the family for their treatment of Sefako. In only four weeks, Sefako, already underweight, had lost 45 pounds of body weight. When the nurse arrived with the IV they were unable to successfully penetrate a vein. Unable to eat or receive IV fluids, Sefako died within a few days of our visit.

Through my internship with Lolo-Agbé, I quickly learned how intimately involved the family was in the health of people living with HIV/AIDS. In the case of Yao, the 47-year old man who received food from Lolo-Agbé, his family suffered a significant loss of income and sacrificed their time and energy in order to care for him. Consequently, the family was unable to secure enough income to buy food while paying Yao's hospital fees. For Sefako, her family's fear of stigmatization ultimately hastened her death. According to the staff of Lolo-Agbé, despite her role educating students in local schools, Sefako's own family hid her away to avoid community scrutiny, preventing her from accessing the treatment and support she desperately needed until it was too late.

Although they were not able to prevent Sefako's death, Lolo-Agbé is able to help many families by providing food and monetary support when the resources are available. With the growing prevalence of HIV, and the unrelenting stigmatization of those who are infected, the efforts of one organization will not be enough. Lolo-Agbé recognizes the need for a concerted effort between other NGOs, traditional leaders, and the local and national government; however convincing others of the urgency of the problem is taking time, time that most people living with HIV/AIDS cannot afford.

EPIDEMIOLOGIC CONSIDERATIONS

The initial demographic pattern of disease in Ghana was unique, with five females infected for every male (Oppong and Mensah 2004:76). This trend began to balance out and by 2001 it was predicted that it would reach a 1:1 ratio between females and males. However, according to Dr. Silas Quaye, Technical Surveillance Officer at the World Health Organization, Ghana, in 2005 data from the National AIDS Control Program (NACP) showed that two thirds of the reported AIDS cases were female, compared to one third male²³.

The high prevalence of HIV among women could be the result of several different factors. First, in a biological sense, women are more vulnerable to HIV infection than men due to the increased contact of seminal

²³ Reported female AIDS infection increasing more than male. Electronic Document, <http://www.ghanaweb.com/GhanaHomePage/health/artikel.php?ID=75610> 84

fluid with fragile mucous membranes during sexual intercourse. Power and gender roles also play into this fact as a result of the high prevalence of non-consensual sex, sex without condoms, and unknown sexual behaviors of the male partner²⁴. In addition, as the main income providers, men are often free to pursue relationships with more than one woman as long as they still provide for their original partner, a practice permitted by the local acceptance of polygyny (Ankomah 1999:297). However, if a woman were to pursue other men, she would risk losing the economic security provided by her partner.

Contributing to the high rate of HIV infection among women may also be the commercial sex industry, which the Lolo Agbé staff implied was growing due to limited income-generating opportunities. However, the high prevalence of HIV among women in Ghana may also be somewhat attributable to the education campaigns that targeted commercial sex workers, therefore increasing the number of commercial sex workers being tested. In addition, women's sexual debut has been noted to be earlier than that of men, increasing the risk of injury due to the immaturity of their genital anatomy.

Even with these hypotheses, there is no clear answer to why there are more women than men who are infected with HIV in Ghana. This pattern is especially unique because at the outset of other African HIV epidemics, the pattern was either close to 1:1 or featured a higher number of males over females. A vulnerability theory interpretation of the implications of poverty and disease states that “certain social and economic factors place some

²⁴ NIH: HIV infection in women fact sheet
<http://www.niaid.nih.gov/factsheets/womenhiv.htm>)

individuals and social groups in situations of increased vulnerability”, which in this case implies a higher risk HIV infection among women (Parker 1996, cited in Oppong 1998:438).

The vulnerability that Sefako and other women experience stems from their unequal access to education and therefore limited income-generating opportunities due to the male-domination of profitable labor industries such as mining and logging. Without access to work, women, whose powerlessness had originated from their lack of access to education or money, now depend financially on their husbands or fathers. This dependence makes it more difficult for women to defend their interests if they disagree with men because it will threaten their survival. In order to facilitate the development of equality between men and women, and therefore reduce the heightened risk of HIV infection among women, Lolo-Agbé has developed a program focused on gender and reproductive health education in the rural villages that surround Aflao. This program works to facilitate a more positive and pro-active community response to HIV, while empowering both men and women towards increased equality.

In order to address the gender inequality and how it is related to HIV transmission, Lolo-Agbé visits local villages and begins a conversation with the chiefs and opinion leaders. If the community leaders agree to the program, Lolo-Agbé trains several elected community members at their office. The program focuses on community and communication building exercises between men and women, reproductive health education, and an

exploration of possible income generating activities. The trained community members then return to their villages and lead the group activities and discussions. In this way Lolo-Agbé is able to share its knowledge with other communities without disturbing the existing hierarchy. Despite being local residents of the Volta region, the staff members of Lolo-Agbé are not members of all the communities they serve, and so by employing the help of specific community members the information is more widely accepted.

By providing the communities with both communication building workshops and income generating opportunities, Lolo-Agbé facilitates sustainable change in rural villages that previously relied almost completely on the money from men who migrated to urban centers for work. By fostering communication and equal distribution of household responsibilities between men and women while generating more economic opportunities in their own communities, Lolo-Agbé promotes changes that in turn make the community less vulnerable to HIV.

In addition to the village education programs, Lolo-Agbé works with ten of the primary and secondary schools located in the Ketu District. The program is similar to the village program in that specific students are selected to be trained at the Lolo-Agbé office, returning to their schools to lead peer group classes on six topics, ranging from HIV/AIDS to basic drug facts. The peer groups meet regularly to study each topic, and once the series is completed, the participating students graduate and are able to form a club. The purpose of the clubs is to work to educate other students through

puppet shows, quiz competitions, and testimonies from people living with HIV/AIDS. These programs are important in changing attitudes towards HIV and reducing the stigmatization of those infected with the virus by targeting youth, and therefore the future of the community.

Although the sessions are open to all children, regardless if they are in school or not, the children who attend them are predominately students, and therefore there is a population of youth that is not benefiting from the program. Most of the children who are unable to attend school are those whose family relies on their help in generating income. These children are therefore uneducated, and as a result experience a lack of empowerment, a situation predominately seen in young girls (Mbugua 2004:105). Through education come more opportunities for work, thus helping to prevent young girls' dependence on relationships with older men, therefore reducing their risk of HIV infection. However, due to the lack of economic opportunity available to educated girls in this region, in order to benefit from their education many have to migrate to urban centers to find work in the formal sector.

In a play conducted by Lolo-Agbé's HIV/AIDS school clubs entitled *AIDS is Real*, puppets tell a story of a girl who is encouraged to go out and find money in order to support herself. When the girl asks her parents how she is to find money when she has no skills and limited education, they say that she should do whatever she is able to do to generate income while subtly implying that she should find a man who can provide for her. The girl

moves to the capital city and finds a “sugar daddy”, who provides for her in exchange for sexual favors. She returns home after contracting HIV and becoming too sick to survive on her own. In the end the play emphasizes the importance of community support and a reduction in community stigmatization of HIV, while promoting alternative methods of generating income.

As the economy in Aflao and the surrounding communities continues to suffer as a result of environmental degradation, families are unable to provide for their children. As they grow older, girls who want to continue their education past primary or junior secondary school must find a way to support themselves, and with limited opportunity, many turn to transactional, exchange relationships as seen in the puppet show (Ankomah 1999:293). The inherent lack of education in the region can be traced to structural adjustment policies, which significantly reduced the government resources available for schools. At the same time, SAP policies reduced the income-generating opportunities available to the border communities, inhibiting their ability to afford the expensive education.

A gender gap in access to education remains throughout the southern border region, although progress is being made. Recently, in Ghana’s Ketu district, a secondary school became co-ed, creating the first local opportunity for Ghanaian girls to attend a higher level of schooling. In addition, in 2005, Ghana phased out basic education school fees, and enrollment has increased

by 16.6%²⁵. However in Togo, progress towards increasing the number of girls in school is slower due to a general lack of academic opportunity.

According to the World Association for Orphans Africa (WAO-Afrique), only 63% of children of primary school age in Togo had completed a primary level education in 2001²⁶. Enrollment in secondary school also dropped to 39% for boys, and 24% for girls. In 2000, a World Development Report given by the World Bank found that while 72% of men were literate, only 43% of women had the same level of education. The fact that the women I interviewed were unable to conduct the interviews in English or French provides evidence of their limited access to education. The lower levels of education in the border communities, however, do not impede Lolo-Agbé's programs outside of schools. With a local staff that is fluent in many Ewe dialects, Lolo-Agbé is still able to serve this population without difficulty in communication.

Lolo-Agbé has a very strong presence within its community allowing it to organize and implement its programs effectively. However, in order to reduce community vulnerability to HIV, a concerted effort needs to be made on the part of those in power to enact long-term social change. The difficulty is that those who are in power are typically men who are seemingly removed from the struggles that characterize daily life for the majority of people living in their communities. The local government's slow response is not

²⁵ Humanitarian news and analysis service of the UN Office for the Coordination of Humanitarian Affairs. 2006 Ghana: Surging Enrollment Presents Challenges. Electronic Document, <http://www.irinnews.org/report.aspx?reportid=61308>

²⁶ WAO-Afrique. 2007 Children in Togo. Electronic Document, <http://www.waoafrique.org/eng/context/causes.htm>

necessarily due to ignorance of HIV within the community. Rather, the long-term latency of the HIV virus, which leaves a large portion of those infected asymptomatic, and its infiltration of the most vulnerable and powerless, reveals the difficulty inherent in creating awareness of the urgency of the issue among policy makers.

Lolo-Agbé works to make the community leaders aware of the problem by visiting with the District Assembly and telling the stories of people like Sefako, who exemplify the consequences of limited education and economic opportunity for women, the relationship between poverty and disease, and the severe impact of stigmatization. By enacting a change in perception among the leaders, Lolo-Agbé is attempting to develop a conversation about HIV that emphasizes the entire population's risk of infection, thereby increasing awareness and support of prevention measures at all levels from the government to the communities. By increasing awareness of a general state of risk as opposed to identifying specific risk groups, the organization hopes to reduce the stigmatization of those with HIV.

My interviews with women living with HIV revealed the impact of the historical events described in chapter II and the political economy of disease described in this chapter. Lolo-Agbé works closely with these women through their prevention and support programs, which combat the unsustainability of the political, economic and social environment. The stories and experiences of women living with HIV in poverty provide valuable

insight into the reality of the virus in this context, and the immediate need for alleviation of economic and social inequality.

CHAPTER IV: WOMEN, POVERTY AND HIV

Yawa, a 32-year-old Togolese woman from a community just outside of Lomé, had always been told that women with HIV were women “who move from man to man,” something she had avoided. After collapsing in the market one afternoon, Yawa visited a local hospital where she was diagnosed with a fever and sent home. Over the next five months, Yawa’s fever persisted and developed into a rash that covered her entire body. Returning to the same hospital, she agreed to a test and was diagnosed with HIV. As a woman who had maintained what she felt was a healthy lifestyle and avoided behavior that she understood was associated with disease, the HIV diagnosis took her by surprise.

Yawa's problems began six years earlier when her husband died suddenly after suffering from a bleeding disorder. She later found out that the doctor had detected HIV and proceeded with treatment while keeping the information from her. After her husband’s death, Yawa moved into her cousin’s home and started preparing and selling cooked food to support herself. Later, when Yawa contracted several opportunistic infections and her cousin discovered her HIV status, he packed her bags and sent her away the same day. When I first met Yawa, she had been moving from house to house for four months, growing weaker every day. Caught in a vicious cycle, she no longer has the strength to continue making food to sell, and thus she is unable to afford the antiretroviral therapy that would allow her to gain strength and

return to work. Yawa is a powerful example of the vulnerability imposed by being a married West African woman in poverty. In reality, this vulnerability overrides the protection from HIV that could theoretically be gained through knowledge of HIV and its transmission.

Over the course of my nine weeks in Aflao with the NGO Lolo-Agbé, I conducted 18 interviews with women living with HIV. These women were all living along the Ghana-Togo border; however since the fear of stigmatization has led many women away from their homes when addressing their disease, my interview subjects were predominately from the Togo side, coming to Ghana for support and counseling from the NGO. This chapter is composed of some of their experiences, perceptions, and strategies against stigmatization and a disease that has changed the face of the border and their community. The following table summarizes known demographic information from each of the women.

Name	Age	Location	Occupation	Husband	Children
Mary	46	Aflao	Petty trading	Died 1997 (HIV+)	3 (all alive)
Helen	37	Aflao	Petty trading	Died (HIV+)	?
Adjua	36	Togo	Buys fish in Ghana sells in Togo	Died 2002 (HIV+)	3 (2 eldest alive, HIV-, 1 deceased HIV +)
Akosua	38	Togo	Petty trading	Died 2003 (HIV+)	1 (deceased)
Yawa	32	Togo, suburb Lomé	House chores, used to make/sell kenkey	Died 2000 (HIV+)	1 (alive)
Abla	?	Togo	Buys from Akosombo, sells in Togo	Died (HIV+)	2 (alive)
Yaa	?	Togo	Too weak to work, was hairdresser	Died 2002 (HIV+)	1 (deceased, HIV+)
Aku	50	Togo	Too weak to work, used to sell rice	Died 2004 (HIV+)	6 (all alive)
Afi	?	Togo	Sells fruit, was seamstress/teacher	Died 2003 (HIV+)	1 (deceased HIV+)

Ame	36	Togo	Sells sacks/house chores	Died 2002 (HIV+)	2 (all alive, HIV-)
Masa	34	Togo, suburb of Lomé	Petty trading	None, had fiancé	None
Ababuo	40	Togo	Sells bread	Divorced	3 (all alive)
Afafa	38	Togo	Petty trading, Sells soap	Divorced, ex-husband very sick	None
Afryea	50	Togo	Petty trading	Divorced (ex-husband sick)	5 children (4 dead, eldest alive)
Enyonyam	33	Togo	Sells used clothing	Divorced (ex-husband healthy)	1 (alive)
Esi	28	Lomé, Togo	Sells chewing sticks	None	None
Esinam	30	Lomé, Togo	Sells sponges and reduction salts	Divorced	1 (alive)
Sela	36	Lomé, Togo	No work, no money to buy charcoal to sell	Died 2005 (HIV+)	3 (all alive, HIV-)

Table 1. Selected demographic information of interviewed women living with HIV

Embedded in Yawa's experience are many of the themes this chapter seeks to explore: the consequences of risk-group rhetoric, the vulnerability imposed by marriage, the influence of the political economy and gender issues, and the effects of stigmatization. These themes are intimately interconnected and contribute to a cyclical pattern of poverty and disease that constrains the lives of women along the Ghana-Togo border. Despite the seemingly unrelenting control this cycle has over their lives, the women along the border have exhibited agency through the various coping strategies they employ in order to live with their disease on a daily basis.

CONSEQUENCES OF RISK-GROUP RHETORIC

The inadequacy of education concerning HIV was quickly apparent through my interviews with HIV positive women. After asking each

woman for her perception of HIV before and after she was aware of her own positive status, I found that despite knowledge of HIV and its modes of transmission, most of the women had been unaware of their own risk of infection. Before discovering their positive status, several women had been previously unconcerned with HIV, rarely considering it a possibility. Others believed that women with HIV were those who “move from man to man”. The education received by those women in purportedly faithful premarital and marital relationships focused on commitment and avoidance of promiscuous behavior, therefore fostering a false sense of security among the general population.

Overall, I found a high level of knowledge regarding HIV transmission and risk behavior among all of my informants. This was corroborated by the GTZ survey conducted along the border, which stated that more than 90% of respondents knew of at least one mode of HIV/AIDS transmission (GTZ 2003:13). However, despite this knowledge, these women still acquired HIV. In 2005, a USAID in depth report about HIV prevalence in Ghana stated that “though there is a high level of [prevention]-related knowledge in Ghana, there is little translation of that knowledge into behavior.” (Akwara 2005:32) This survey data corroborates the ethnographic data from my interviews; that although the population of the border is highly aware of HIV and its transmission, there is a lack of personal risk-awareness.

In a West African context, as already noted, government and NGO HIV education campaigns have identified commercial sex workers, border

officials, mobile workers, and youth as “risk-groups.” Although the campaigns have increased awareness and therefore reduced risk of transmission among those considered members of the risk-groups, they have also fostered a false sense of security among those who consider themselves outside of these groups. Specifically, married women who believe they are in faithful relationships, although aware of HIV and its transmission, are unaware of their own personal risk, and therefore are less likely to protect themselves. Consequently, the risk-group prevention tactic that was intended to protect populations has instead increased their susceptibility.

Information is lacking on Togo’s national campaign against HIV as a result of political instability; however the campaign initiated by Ghana’s government and the Ghana AIDS Commission in 2001 specifically defines two goals:

- 1) “intensifying actions and efforts targeted at high risk groups”, e.g. CSWs and border towns; and
 - 2) “increasing awareness of individual, community and institutional (including the public and private sectors) vulnerability and susceptibility”
- [GAC 2001a:12].

These two goals are included as central recommendations for the national response analysis; however from my interviews with women living with HIV, it was clear that the second goal, to increase general awareness of

vulnerability among the population, had not been effectively implemented along the border.

As a virus that takes an average of ten years to present itself as AIDS, HIV is able to infiltrate populations unnoticed. This makes it especially hard to estimate HIV prevalence because a large number of those infected are not yet symptomatic, and therefore undetectable. After contracting HIV and discovering their positive status, many women whom I spoke to discussed their realization that a person can be unknowingly infected for a long period of time. One woman, Akosua, a 38-year-old widow from Aflao, realized that if anyone wanted to marry her they would not know she is HIV positive. If a man would marry her, she worried that countless other men and women could inadvertently enter into marital relationships with partners who are already infected.

The most common misperception among the women I interviewed was that HIV was a disease that affected those who were unfaithful or promiscuous. It does seem logical from a public health perspective that the greater number of partners, the higher the risk of contracting HIV. However, several studies have demonstrated that among those infected, the relationship between number of partners and HIV infection is not evident. Researchers found that differences in sexual behavior did not correlate to differences in HIV incidence (Schoepf 2001:342-3). Paul Farmer recognized this in a small group of women living in Do Kay, Haiti. In a study including ten HIV positive women and ten HIV negative women, Farmer found that the chief

risk factor for HIV was not the number of partners; instead it was the professions of these partners that was significant (Farmer 1993:391). Similarly in my study, many of the women stressed their faithfulness and a minimal number of partners. Among the women I interviewed, many of their husbands were migrant laborers or truckers, which may have contributed to their susceptibility to HIV as it did among women in Do Kay.

The initial targeting of commercial sex workers, mobile laborers, and truckers by public health advocates in the government and NGOs emphasized this association of HIV and promiscuity. My interview with Esi, a 28-year-old unmarried woman from Lomé, revealed the consequences of identifying promiscuity as a risk behavior associated with HIV. Esi had originally believed that people contracted HIV as a result of unfaithfulness. Although unmarried, Esi was in a committed relationship with the first man she had ever been with sexually, and as a result did not feel at risk of HIV. It was not until discovering her own status that she realized that anyone could be infected with HIV, whether you are faithful to your partner or not. Esi's misperception of her own personal risk of infection contributed to her contraction of HIV by giving her a false sense of security. Unmarried with no children and shunned by her family, Esi struggles to survive with the small amount of money she earns selling chewing sticks.

Although Esi is not married, her vulnerability to HIV is surprisingly similar to the vulnerability experienced by married women living in the border communities.

MARRIAGE: THE NEW²⁷ RISK FACTOR

In a follow-up report written in response to the 2003 *Ghana Demographic and Health Survey*, Akwara *et al* found that “marital status was significantly associated with HIV serostatus for women,” even after controlling for other factors (Akwara 2005:31). Through my conversations with women living with HIV, in addition to those with Dr. Mensah at KDH, I found very similar circumstances. Marriage, which used to be a source of social and economic security and stability, is now a source of vulnerability.

Contributing to women’s vulnerability to HIV along the southern Ghana-Togo border is the public acceptance of polygyny. Polygyny is practiced among the Ewe people of Togo and Ghana’s Volta Region; however is very different from the Muslim polygynous practices found in the northern regions of Ghana. According to Kalipeni, polygamy, in all its forms, has been identified as a major impetus of disease proliferation (Oppong 1998: 438). However, in Ghana, the differences between polygynous practices in the northern and southern regions and the corresponding differences in HIV prevalence rates reveals that this assumption is unfounded. In the northern regions of Ghana, where polygyny is based on a closed system in which men and women remain faithful to their marital relationships, there is a much lower rate of HIV (Oppong 1998:438). In southeastern Ghana and Togo,

²⁷ Marriage is has always been a risk factor for men and women because it exposes both to unprotected sex; however only recently has it been identified as an HIV risk-factor, in the same way as commercial sex work and intravenous drug use.

where HIV is much more prevalent, polygyny is characterized by an open and flexible system in which men and women pursue extramarital relationships without the intent of marriage. As evidenced by Ghana, although polygamous behavior has been historically implicated in the spread of HIV, in actuality it is the type of polygamous system, rather than its presence, that is indicative of increased risk of HIV. Despite the increased risk of the open polygynous system, marriage is still viewed by the local population as a source of economic and social security.

Most (16) of the women I interviewed had been married; many were widowed, some divorced. While my sample size is relatively small, my interviews with the women revealed a startlingly common scenario whereby the husband fell sick and died two to four years before the woman, prompted by symptoms, discovered her own HIV positive status. The most likely explanation for this sequence of events is that the husband transmitted HIV to his wife. Through my conversations with women living with HIV, in addition to those with Dr. Mensah at Ketu District Hospital, I found very similar circumstances.

Married and economically secure, women become dependent on their husbands, and are either unaware of their risk of HIV infection due to their own faithfulness, or unable to negotiate safe sex practices. After contracting the virus through their marital relationships, women eventually have to care for their husbands who fall sick with various opportunistic infections. This results in a significant loss of income, because not only is the husband

unable to work, the wife must take care of him, preventing her from pursuing income-generating opportunities such as farming or petty trading. In addition, many women must borrow money in order to care for their husbands.

This common scenario highlights the “intergenerational cycle of deprivation and poverty” described by Geeta R. Gupta in her presentation at the 2006 International AIDS Conference. Women serve as the primary caretakers for those who are HIV positive, preventing them from participating in the trading or farming activities that sustains their families (Gupta 2006:1). As a result, children must abandon their studies to provide extra labor and economic support to their families. The children, without education, are therefore unable to break out of the poverty that plagued their parents, and thus are more vulnerable to early marriage and sexual behavior that will place them at high risk of contracting HIV (Singh and Samara 1996:148). Upon the husband’s death, women are left with debt, funeral costs, and possibly isolation from their families and communities as they are blamed for their husband’s sickness.

Through my interviews I also discovered a lack of communication²⁸ between husbands and wives, even in the context of HIV, which placed married women at greater risk of infection. Through marriage, women are not

²⁸ According to Anastasia J. Gage, polygynous relationships feature decreased husband-wife interaction and therefore less communication regarding family planning (1995:266). In addition, Boye *et al* found that polygyny is often associated with low status of women and increased gender inequality (Gage 1995:266). According to my interviews with Lolo-Agbé staff, the Paramount Chief, and Queen Mother, communication between husbands and wives, whether polygynous or monogamous, was limited in all respects, the implications of which are seen through HIV transmission between husbands and wives.

only vulnerable as a result of financial dependence and cultural perceptions regarding children and condom use, but also as a result of the unwillingness of their husbands to reveal their status and protect them from the same fate. The reluctance of men to reveal their HIV status is most likely a consequence of the stigmatization of those who are infected. As a virus that weakens the body, it is especially contradictory the image of strength valued by men. The lack of communication was not necessarily universal among the women I interviewed- many actually discovered that their relationships became stronger and closer as a result of their mutual HIV infection. However, three of the 16 married (includes those widowed/divorced) revealed their ignorance of their husband's illness in our interviews, highlighting a significant problem in communication between spouses, increasing their vulnerability to HIV transmission.

Helen, a 37-year-old woman from Aflao, first discovered Lolo-Agbé when her husband directed her to the office to pick up medicine. Despite her visits to the office, it took quite a while for Helen to realize what Lolo-Agbé was, and why her husband needed the medicine. He never revealed his HIV status to her, resulting in Helen's vulnerability to multiple transmissions of the virus. Similarly, Sela, a 36-year-old woman from Lomé discovered that her husband had withheld his HIV status from her while he was alive. After his death, Sela found that not only was he HIV positive, but that his family was aware of his infection. Even then, the family kept his status a secret. Sela decided to get tested only because she noticed that her husband grew

extremely lean before he died, a hallmark symptom of other HIV positive people in her community, the result of which revealed that her husband had infected her with the virus. Even with this realization, it is unlikely that Sela could have prevented her HIV infection due to her financial dependence on her husband, which prevented her from ensuring safe sex practices.

POLITICAL ECONOMY AND GENDER ISSUES ON THE BORDER

As described in the previous two chapters, the political economy of the southern Ghana-Togo border region prevents women from accessing the same education and employment opportunities available to men. As caretakers for their families and home, women have limited time to pursue income-generating opportunities. Without education, those opportunities that are available are limited to the uncertain informal economy.

Although girls' education is increasing throughout the border region, for the women I interviewed those opportunities were not present when they were growing up. Educational level has long been associated with socioeconomic class; higher education determines access to stable employment in the formal economy. For all of the women I interviewed and the majority of women along the southern Ghana-Togo border, education beyond the most basic level is atypical. For those living in Togo, school fees preclude families who are unable to afford the cost, which, due to the political instability and unstable fishing and farming economies, is a growing problem. In Ghana, school fees were phased out in 2005, increasing access to

education dramatically throughout the country. However, similar to Togo, the declining fishing and farming industries leaves families struggling to survive, necessitating children's participation in income generating activities, therefore preventing their attendance at school. A secondary school was recently converted to a co-ed institution, creating the first opportunity for girls to attend school past the primary and junior secondary levels in the local area. However, for the women and girls who did not have this opportunity when they were younger, their options for rising out of poverty are severely limited.

The link between lack of education, poverty and disease creates an intergenerational struggle, in which women who suffer from this cycle will bear children who will be similarly influenced until changes are made that allows them to access education and therefore greater income-generating opportunities. Boys historically have had greater access to education, evidenced by the unequal gender distribution in schools in addition to the greater number of boys secondary schools in Ghana's Ketu District. This imbalance generates the gender power dynamic that fosters women's dependence on men for financial resources. Even for men and women who achieve equal levels of education, the formal and informal economy are dominated by professions that are traditionally held by men, inhibiting women's access.

Many women access resources through marital and premarital relationships with men. It is important to note that although these women are not participating in commercial sex work, sexual exchange is implicit in relationships with men to an extent that denial of sex by a woman is often

grounds for termination of the relationship (Ankomah 1999:301). Although the relationships are founded on much more than sexual exchange, the socialization of men and women regarding the importance of fertility and reproduction limits women's ability to exert control over her sexual activity (Ampofo 2001:198).

The GTZ report found that childbirth in marriage was of such extreme importance that marriages that did not produce children were either dissolved or the man was allowed to marry another woman (GTZ 2003:10). The importance of children even limits women's behavior after discovering their HIV status. According to Baffour K. Takyi, health belief models typically used in HIV education campaigns naively assume that people will take action to protect their health if they perceive their risk, and therefore condom use will increase (2000: 16). However, Takyi notes that instead, HIV/AIDS may produce an opposite effect due to the importance of children in West African society. Women who fear they will become infected with HIV may be inclined to ensure they have children, and therefore have unprotected sex. The threat of dying childless, a reality faced by many of the women I interviewed, is so powerful that women may avoid condoms and therefore protection, in order to guarantee children (Takyi 2000:16).

With the increasing acceptance of pre-marital sexual relationships, changes in behavior regarding contraception are also occurring because while pregnancy in marriage is considered a necessary component, as mentioned in Chapter II, pre-marital pregnancy is still a taboo. Thus, condom use has

increased among youth who are participating in premarital sexual relationships to avoid the cultural cost of premarital pregnancy. However, condom use is still typically limited to a woman's period of ovulation, and so men and women frequently expose themselves to sexually transmitted infections during sexual intercourse outside of that time (GTZ 2003:11).

In his article *Sex, Love, Money and AIDS: The Dynamics of Premarital Sexual Relationships in Ghana*, Augustine Ankomah explained that in both premarital and marital relationships men "consider themselves as the main source of economic and physical power" and consequently "they are able to demand and almost always do obtain sexual favors" (1999: 301-2). Therefore, in order to access the economic resources held by men, women enter into these implicitly sexual relationships, which serve to transfer resources from men who hold positions of power to women whose opportunities are very limited (Ankomah 1999: 294).

This gender-power dynamic can be seen in women's reduced bargaining capability in sexual interactions. Even with increased awareness of the risks associated with sexual intercourse, women are not only limited in preventing sex but also in ensuring safe sex practices in their relationships for fear of losing their partners. Condoms are not commonly used in presumed faithful premarital or marital relationships because of their association with commercial sex workers and others who have multiple sexual partners. According to Dr. Mensah, if condoms are suggested by either partner, issues of trust and infidelity intervene, making condom use unlikely. Financial

dependence on men creates a paradox in which women are forced to choose economic security through relationships with men, but by doing so incur significant risk of contracting sexually transmitted infections. In this way, the women ensure their survival over the short term through material gain, compromising their ability to practice safe sex and maintain their health. This common scenario illustrates the inherent cycle of poverty and disease that characterizes the lives of these women.

Although women's engagement in risk behavior can be explained as a consequence of poverty, gender-power dynamics, or the importance of children, men's participation in risk behavior is more problematic, and highlights the inadequacy of education-based HIV prevention campaigns. The GTZ survey found that 80% of mobile persons interviewed indicated that unprotected sex is the most likely means of infection; however only 40% stated that they used a condom the last time they had sexual intercourse, and only 40% of those who used condoms did so to prevent HIV/STIs (GTZ 2003). The survey hypothesizes that the large population of commercial sex workers, delays in the customs clearing process, absence of work place HIV/AIDS programs, and lack of condom availability contribute to the increased risk behavior of men along the border (GTZ 2003). In addition, several studies throughout sub-Saharan Africa have indicated that men report a higher mean number of partners than women (Hunter 1993:65). Carael *et al* found that men were at least twice as likely to report having a casual sex partner in the past year than women (Hunter 1993:65-6). It is likely that

the fluid nature of polygyny along the border, importance of fertility and childbirth in marriage, and hesitancy to accept condom use contributes to the lack of personal risk awareness among both men and women. The consequent false sense of security among the general population contributes to the continual stigmatization of those who are infected with HIV by fostering the assumption that those who carry the virus are somehow participating in behavior that is different, unclean or promiscuous.

STIGMATIZATION

Compared to other infectious diseases such as malaria or tuberculosis, the consequences of an HIV infection are unique. In part, due to its transmission through bodily fluids such as semen, vaginal fluid, and blood, the stigmatization that accompanies HIV leaves those who contract it without the extended family support network that forms the foundation of society in Aflao among the dominant Ewe population. The severity of stigmatization was illustrated in my interview with Ame, a 36-year-old Togolese Ewe woman, who shared her status with her family, only to be rejected and left with nothing. Without a husband or family, she supported herself and her two children by selling sacks in the local market; however as she became weakened with AIDS, she no longer had the energy to work. Ame turned to her church where, instead of offering support, the pastor used her as an example of the 'ills' of society. Shunned by most in her community, Ame fortunately received help from her godparents. When she visits her own

family, they refuse to give her food, and if they are cooking, they do not invite her to join. This is a radical change from the generous and inviting nature that characterizes Ewe families, leaving Ame to manage her devastating disease without the support network she has always known.

In addition to the disruption of familial support networks as a result of stigmatization, the poverty that pervades the border communities limits people's ability to help, even if they are willing. Men also experience stigmatization as a result of HIV; however from the perspective of the women I interviewed, it was not as severe. My interview with Mary, a 46-year-old woman originally from Aflao, revealed the disproportionate impact of stigmatization on men and women.

Mary was living in Nigeria when her husband fell sick with HIV. She cared for him while raising their three children and working to support the family. Eventually, he became too sick for her to care for him alone so they returned to his family's village outside of Lagos. Her husband's family blamed Mary for his sickness and accused her of using sorcery to infect him. They refused to consider that he had contracted HIV from another woman. Even though Mary contracted HIV from her husband, his family condemned her as a "loose woman" and accused her of having contracted the virus by having sex with other men. During her husband's illness, Mary remained with him, despite his family's demands that she leave. Upon his death, she left Nigeria and came home to Aflao.

Mary's case illustrates well the point that being shunned by one's family and community as a result of stigma associated with HIV is a double-edged sword. While the HIV positive can be deprived of certain resources, they can also be freed from the family bond that ties them to one place. In some cases, this enables women to travel elsewhere to stay with other relatives or friends who may welcome them, either because they are accepting or ignorant of their condition. In Mary's case, this move was a permanent move. Others travel temporarily to hospitals or to the communities of extended family members to regain strength before returning home. However, this movement is not without risk as it creates stress and therefore increases the probability of contracting additional opportunistic infections. Mary suffered from several episodes of herpes zoster and was severely weakened after her move. Through the help of counseling and antiretroviral therapy, she has regained her strength, and therefore is benefiting from her move from Nigeria to a more accepting environment in Aflao.

The loss of family support leaves women in desperate need of money as their health declines, inhibiting them from pursuing opportunities for income. With inadequate employment opportunities for women along the border, a difficult situation is made impossible as they struggle to maintain health and nutrition as HIV consumes their body. The limited resources women may acquire from petty trading must either pay for food or medicine, and rarely is there enough for both. Without money, it is not possible for women to keep a balanced diet while maintaining a steady regimen of

antiretroviral treatment. Fortunately, women who live in Togo usually have relatively easy access to government-subsidized medicine when international aid money is present. On the other side of the border, however, women in Aflao must travel 230 km to Accra to get similarly affordable drugs²⁹. However, even in Lomé, the subsidized medicine is not always available, leaving women who cannot afford the higher priced drugs to manage their disease without antiretroviral therapy. As a result, the intermittent antiretroviral therapy contributes to viral resistance, preventing future management of the disease. Here again the cyclic pattern of poverty and disease is present: poverty associated with the political economy and gender contributes to HIV vulnerability, a disease which in turn prevents women from working, therefore deepening their poverty, which subsequently inhibits their ability to afford consistent antiretroviral therapy, the only way to regain strength to work again.

COPING STRATEGIES

In the environment that characterizes the Ghana-Togo border communities it is difficult to discern the agency of the women who fall victim to the cycle of poverty and disease. Schoepf addressed the complexity of this issue in her review of AIDS research in anthropology where she described the ease with which the agency of women can be both ignored or exaggerated

²⁹ In 2004, the Ghanaian government and Ghana AIDS Commission outlined the goal of increasing access to subsidized antiretroviral treatments throughout the country; however, according to Dr. Mensah at Ketu District Hospital, Aflao has yet to gain access to these drugs.

(Schoepf 2001:347). In my own research, HIV-positive women exhibited agency in subtle ways through their various coping strategies.

The immune system is intimately linked with psychological processes³⁰, and so with the high stress environment of stigmatization and poverty along the border, many people already live with reduced immune function. When faced with an HIV diagnosis, many of the women I interviewed felt hopeless and contemplated suicide. For these women living in poverty, HIV is a death sentence. Without money to control their infection level, there is little they can actually do to stop the virus' development into AIDS. This realization contributes to the high stress level experienced by women when they discover their positive status; thus in the presence of these emotions, HIV progresses rapidly. Coping strategies are extremely powerful in this environment because they help boost the immune system through reduction of stress experienced by HIV positive person, facilitating the body's defense against the virus. Counseling plays an integral role in providing men and women with new ways to frame their disease and experience when they discover their positive status. Through associations (HIV/AIDS support organizations) those living with HIV find a permanent place to share their emotions and experiences living with the virus.

As a consequence of the change in perception that has accompanied many women's discovery of their HIV infection, a re-categorization of the virus as a common illness occurs. This simple, yet profound, alteration of

³⁰ Jeffrey M. Leiphart. April, 1998. *Coping With Stress*. Electronic Document, <http://www.thebody.com/hivnews/newsline/apr98/stress.html>

meaning allows the women to live with their disease on a daily basis. After discovering her status, Akosua, a 38-year-old woman from Aflao, has realized that HIV can happen to anyone, similar to a headache. Through this re-categorization strategy, women perceive HIV as a sickness that can infect all people regardless of their profession or sexual behavior, challenging the risk-group rhetoric that had previously informed them otherwise. Some women even imagine that everyone has HIV, changing their disease from a personal affliction to a community one. By reframing the disease as a “sickness you go with”, Afryea, a 50-year-old woman from Lomé, has similarly transformed HIV from a debilitating disease to a manageable one.

Recategorization of the disease does not appear to be a strategy that is employed immediately after each woman discovers her status. The women who had only recently discovered their HIV infection were not yet able to reframe the disease that had suddenly taken control of their lives. Over time, with the help of counseling and support from other women living with HIV, many had found that re-categorization of HIV as a common illness was integral to their spiritual, mental, and therefore physical health.

The women find support for their re-categorization strategy through associations created by hospitals, churches, and NGOs. These associations create a space in which women with HIV are able to meet and discuss their experience with counselors and other HIV positive women in privacy. The difficulty of HIV emotionally and physically makes these associations especially meaningful because they provide a space in which women feel

free to speak out and handle thoughts and emotions that cannot be understood by those who are free of the disease.

The networks created inside these associations exist outside as well. Women will check up on each other by calling or visiting at their homes to ensure that they have food to eat, and to encourage each other to keep up their strength and will to live. Helen commented on the importance of Lolo-Agbé in her life because it provided her a place to meet other women in the community who were also suffering from HIV. Akosua³¹ described a similar experience at her association in Lomé, where she developed relationships with other women, creating an extensive support network. If any of the women in her group are unable to leave their homes or find food, the others work together to provide help. Many of these women do not have any other resources to turn to because they are widows and stigmatized by their own families.

Without the power to mitigate their risk of HIV infection through increases in education and economic opportunity, women use associations to connect with other women who have suffered similarly in the current social, political and economic environment. The creation of these networks inhibits the effects of stigmatization that otherwise insidiously prevent those who suffer from HIV from using their collective voice to inspire change. By working in the schools as Sefako did, or working to combat community stigmatization through their daily interactions, the HIV positive women

³¹ 38-year-old widow, Aflao

included in this paper are clearly not living at the complete mercy of outside forces and structural violence; rather they are using their own resources and ideas to promote change from the bottom up.

CONCLUSION

For the populations along the Ghana-Togo border, the threat of HIV is felt most acutely by the women who put their health at risk to achieve a certain level of economic and social security. As a result of risk-group focused education campaigns, many women assume protection from HIV through marriage and other purportedly faithful relationships, and consequently engage in unprotected sex. Other women are unable to ensure safe sex practices, despite the awareness of their risk of infection, as a result of their financial dependence on men and the association of promiscuity with condoms.

The growing prevalence of this virus among women in the border communities requires special attention from the government, traditional leaders and aid organizations. However, even without the help of those in power, despite the myriad political, social, and economic forces, the women included in this study shape their experience with HIV by working to reduce stigmatization and generate support through extensive social networks. Their agency is subtle due to the environment of structural violence that surrounds them; yet the women still are able to manipulate HIV's effect on their body through their re-categorization strategies. In addition, the presence of

NGOs, CBOs and FBOs provide evidence for the community's reaction, outside of the government, to HIV and the growing efforts to support those who are infected and prevent future spread of the epidemic. Here it can be seen that the people of the southern Ghana-Togo border, especially women with HIV from whom everything has been taken but their intellect, use their own knowledge and skills to act within their communities to promote a better future for those living with HIV.

CHAPTER V: CONCLUSION

Sitting in a large church in Aflao, I was surrounded by hundreds of local school children attending a quiz competition organized by a local NGO. Each school had chosen student representatives to answer questions about HIV transmission, symptoms, and prevention. A member of the ALCO Project was acting as M.C., asking the questions, fielding the responses, and attempting to control the excited crowd. “*How do you prevent HIV?*” His voice boomed out to students, who quickly yelled back an array of answers. He smiled and waited for the students to become quiet. “*It’s as simple as A B C, Abstain, Be faithful, use Condoms.*”

My field research revealed that for the majority of women living in Aflao and the surrounding border communities, HIV prevention is not simple. Especially paradoxical to the ABC HIV prevention strategy, for many of the women included in this paper, marriage, rather than reducing their susceptibility, instead increased their risk of infection. Most women living along the southern Ghana-Togo border are unable to acquire sufficient income to support themselves due to a lack of access to education, faltering fishing and farming industries, and competition for resources in the informal sector. Thus, they must rely on men, who have greater access to both education and employment.

In premarital and marital relationships, women frequently become financially dependent on their partners, preventing them from ensuring

abstinence or safe sex practices. Condoms, which have a connotation of infidelity due to their association with promiscuity, are rarely used in purportedly faithful relationships. Even with knowledge of HIV and its modes of transmission, women in poverty are forced to choose between unsafe sex and economic insecurity. This situation is not considered by popular HIV prevention campaigns like ABC, which do not recognize the connection between individual behavior and the political, economic and social environment.

The mutually reinforcing cycle of HIV and poverty, which places each successive generation at increased risk, illustrates the importance of a holistic approach to HIV prevention and research that considers the myriad contributing factors. This cycle of poverty and HIV also interacts with gender by increasing women's vulnerability due to the endemic lack of education, limited income generating opportunities, and the socialization of men and women regarding fertility and reproduction.

The global and historical impacts on the current political and economic context of the region can be found in the transatlantic slave trade, colonialism, and structural adjustment. Locally, marginalization by the Ghanaian government, in addition to environmental degradation of the coast, has had profound implications on the communities of the border. The consequent general state of economic crisis along the southern Ghana-Togo border is even more pronounced for many women who face segregation into the uncertain informal sector. Despite the extent of these forces that constrain the lives

of women along the border, their agency as individuals is still present, seen in the way they re-categorize their disease as a common illness and create social networks which serve to combat stigmatization in the community and unite women in their common struggles against poverty, disease and inequality.

FUTURE RECOMMENDATIONS

The work of Lolo-Agbé described in this paper reveals the importance of a multi-faceted approach to HIV prevention and support that works outside of the popular prevention only ABC model. Through the village-based programs that promote community awareness of gender inequalities and reproductive health, Lolo-Agbé addresses the local source of the problems that increase women's vulnerability to HIV. In addition, the NGO promotes economic empowerment through livestock projects that prevent the need for migration to urban centers for work. Other organizations are inhibited from pursuing similar programs as a result of limited funding and less prominence within the border communities. Similar to other local NGOs, Lolo-Agbé incorporates prevention into its school-based programs; however it utilizes teachers and student peer leaders to deliver the message, increasing the efficacy.

The methods employed by Lolo-Agbé form the basis for my recommendations. Due to the proximity of Aflao to Togo and Benin, coordination between the three countries is especially necessary in order to

increase the efficacy of HIV prevention. As a border town adjacent to Lomé, Aflao is connected to myriad towns and cities along the Abidjan-Lagos trade corridor, which has been implicit in the transmission of HIV throughout West Africa. The issue at hand, however, is that the root of the problem actually lies in the global economy that limits the Ghanaian and Togolese government's ability to provide adequate social services to their citizens. The difficulty in enacting change at the global level, or even at the national level, is that those who are able to influence the political economy would not directly benefit from combating the status quo. With that said, the status quo is not sustainable, and therefore, it is beneficial for policy makers to alleviate poverty and work towards equality in order to prevent disease and promote peace.

In terms of public health, the social environment of the southern Ghana-Togo border, which is characterized by a flexible system of polygyny, undermines the efficacy of HIV prevention campaigns that are designed for societies based in monogamy. Prevention and support efforts need to be reformulated with an understanding of the cultural, social, political, and economic context of the target population. Without consideration of these factors, as seen among the women of the southern Ghana-Togo border, knowledge of HIV and its transmission will not translate into reduction of HIV prevalence or risk.

In conclusion, culturally appropriate strategies for HIV support and prevention must be created in the presence of increased communication and

coordination between communities, NGOs, the government, and international aid organizations. In addition to messages of personal choice that only work for those with power, prevention efforts should focus on the forces that put the communities of the border at risk, i.e. the local and global political economy, lack of education and social services, and inequality. In the immediate sense, poverty alleviation, reproductive health education, and active support of those suffering from HIV are all intimately linked to effective prevention.

The changes that must come at the global level are essential to prevent the cycle of poverty and disease that constrains the lives of women along the southern Ghana-Togo border. At the same time, the work of NGOs, like Lolo-Agbé, is invaluable for saving and improving the lives of countless people. Coordinated efforts must be made both locally among NGOs and the national governments, and globally, among western nations and lending institutions that construct the global political economy, impacting people living in poverty throughout the world.

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APPENDIX I: INTERVIEW QUESTIONS

Included in this appendix are the questions that formed the basis for my interviews with the women living with HIV along the southern Ghana-Togo border. Each interview varied (some women did not disclose their age or exact location); however most interviews followed this format.

Demographic Information:

1. Name
2. Age
3. Where are you from?
4. Married? Children?
 - Status of husband (alive, divorced, deceased...)
 - Number of children? Status of children (alive/deceased)?
5. Occupation (current/former)

HIV:

1. What were your initial symptoms?
2. Reason tested? When tested? Where tested?
3. Perceptions of HIV before test?
4. How did perception change after discovering your status?
5. Who did you share your status with?
 - What was their reaction?
6. What kind of support/treatment have you received/(are you receiving)?
7. What is your community's perception of HIV?
 - How does that affect you?
8. What do you think the government or community can do to support those with HIV?
9. What do you think can be done to prevent further HIV infection?