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ELDERLY WOMEN, COMMUNITY PARTICIPATION AND FAMILY CARE IN GHANA

Lessons from HIV Response and AIDS Orphan Care in Manya Krobo

DEBORAH ATOBRAH

ABSTRACT: The new paradigm for promoting quality of life of the elderly, referred to as active aging, embraces the continued participation of the elderly in social, cultural, religious, and civic affairs. Culture has been identified as a cross-cutting determinant in the active aging framework. Based on ethnographic research on traditional responses to HIV/AIDS in Manya Krobo, this paper illustrates how elderly Krobo women leveraged their cultural status to participate in family and community affairs, foster family sustenance, and contribute to health promotion and HIV response in their community. Community participation was however stressful for many of the participants because of inadequate support. The paper argues that while the social benefits accrued from elder people's participation could be a complementary argument for policy interventions on their behalf, there is a need to interrogate how such engagements are likely to affect their quality of life. The paper thus recommends support for the elderly as they engage in community and family affairs, so as to enhance their quality of life, which is the ultimate goal of the active aging paradigm.

Introduction

On June 24, 2015, 74-year-old Maame Serwaa of Kumasi convened scores of disgruntled elderly women and men in the Ashanti region, dressed in traditional mourning cloths of red and black, to demonstrate in protest of the persistent power outages, worsening socio-economic conditions, and

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a distressed National Health Insurance Scheme in Ghana. The elderly people, mostly women in their 70s and 80s, embarked on the *Emrewa Eesu* ("old women are crying") protest across the principal streets of Kumasi to present their petition to the mayor, Kojo Bonsu, for onward transmission to President John Mahama.[1] Undoubtedly, this reality defied the popular representation of elderly people as docile and passive. By expressing their voices and by their active engagement in their community they demonstrated their continued participation in social, cultural, economic, spiritual, and civic affairs, which is an important tenet of the active aging and successful aging frameworks (WHO, 2002; Rowe and Kahn, 1997).

While research on aging in Ghana has usually focused on the vulnerabilities and dependencies of the elderly (Apt, 2001; Aboderin and Beard, 2015; Mba, 2007; van der Geest, 1997; Oppong, 2006), the concepts of active aging and successful aging both shift strategic attention away from a needs-based approach to the assumption that participation in society is integral to the well-being and welfare of the elderly (WHO, 2002; Rowe and Kahn, 1997). In addition to enhancing their physical, social, and cognitive growth, elderly people's continued engagement with family, peers, community, and nation also provides aplatform for them to foster cooperation, interdependence, and intergenerational solidarity (Fisher and Specht, 2000; Rowe and Kahn, 1997). Ultimately, the goal of giving and receiving between the older and younger generation is to optimize the quality of life of both groups. As such it has been proposed that the elderly "participate in society according to their needs, desires and capacities, while they are provided with adequate protection, security and care when needed" (WHO, 2002, 12).

Culture has been identified as a crucial determinant of active aging. Aging takes place within the context of a network of significant others, and culture establishes the norms by which this network of people acceptably participates in their society. There is however a need to better understand the extent to which cultural provisions for old people's participation promote their well-being and ultimate quality of life. The nature of ethnic diversity, with its associated cultural diversity, calls for sufficient ethnographic insights on the cultural nuances and differences of community participation in later life.

It is against this backdrop that this paper aims to illustrate how elderly Krobo women leveraged their cultural status to foster their participation in family and community affairs in the wake of HIV/AIDS crises in Manya

1. http://allafrica.com/stories/201506261281.html

Krobo by promoting family sustenance, health promotion, and HIV response in their community. The paper further describes how the activities of the elderly women are likely to optimize their quality of life. It thus interrogates the continued capacity of culture, as a determinant of active aging, to support and protect the elderly as they participate in society.

Background (Culture and Participation for the Elderly)

The role theory espoused by Biddle (1986), proposes that social roles incorporate a set of rights, duties, expectations, norms, and behaviors that a person has to embrace and fulfill as a member of the categorized group. This theory has been found as a useful perspective for analyzing elderly people's participation, in that it illustrates how society sets roles for them as a socially categorized group (Roh et al., 2015). There may however be interdependence and reciprocal roles across categorized groups, such as exist within families and communities. Role theory thus identifies the cultural norms governing elderly people's engagement in their society (Huang and Yang, 2013).

The social roles of the elderly are highly diverse across cultures and societies, and they are noted to influence both patterns and outcomes of participations. Studies in more industrialized societies, for instance, demonstrate that most elderly retired school teachers volunteer as tutors in their community schools and museums because volunteering through formal institutions is a culturally accepted role for the elderly (Fischer and Specht, 2000). Gender roles (which are also influenced by culture) also influence the opportunities for elderly people's participation, just as outcomes in cognitive functioning and mortality levels are also linked to their participation in the society (Roh et al., 2015). The interaction between role theory, culture, and elderly people's participation in Africa is thus a significant contextual background for this paper.

In many African societies, seniority is one of the primary classifications for organizing societies, characterized by cultural privilege and status to elderly people (Oyewumi, 1997; Kuper, 1965). Elderly people were accorded optimal status because they were seen as closer to the ancestors, and were the repositories of wisdom, practical life experience, and knowledge (van der Geest, 2004; Fortes, 2013)—hence the Ga proverb, *Onukpa ni eda, efe okɔmfo,* to connote that "an older person knows more than a diviner."

In traditional Akan and Gã [illegible]tical systems, a chief's elders ought to always be grown men, although sometimes women served in the capacity of queen mother (Fortes, 2013). Among the Kwahu, Miescher (2007) describes the valorized title of an *opanyin,* which is an accomplished status of

senior masculinity conferred on elderly men who have distinguished themselves in serving their community and families. The concept of seniority thus did not only attract respect but created a platform for the elderly to meaningfully participate in family and community. Although van der Geest (2004) critiques the conceptualization and execution of respect for the elderly, he asserts that many of them become depressed when they feel sidelined and unable to transmit knowledge and advice to their society.

With respect to women, aging significantly transforms their secondary status by removing many culturally imposed menstrual taboos and restrictions, so that they are no longer construed as polluting (Brempong, 2006; Agyekum, 2002). Elderly women are often able to break the so-called gender ceiling to assume male symbolisms such as smoking a pipe and performing rituals reserved for men (Wood, 1999). In many southern Ghanaian societies older women were seen the repositories of knowledge and wisdom,[2] and among the Krobo the "old lady" originally referred to the deity Nana Kloweki, a model of a wise woman (Streegstra, 2009). Within lineages and communities, elderly matrikin have the responsibility of training and socializing young girls into womanhood, an attribute of most female initiation rites in sub-Saharan Africa (Kenyatta, 1938; Sarpong, 1977; Teyegagah, 1985; Steegstra, 2005).

The effects of the heavy burden of care placed on elderly women and grandmothers by HIV/AIDS in sub-Saharan Africa are nuanced (Foster and Williamson, 2000). A large-scale, cross-sectional study on the subject found a positive correlation between the AIDS mortality rate and the proportion of elderly individuals living alone without prime age adults, as well as of elderly individuals who had become sole caregivers for young children (Kautz et al., 2010). A study conducted on AIDS-related caregiving responsibilities and burden among the elderly in Uganda found that having a caregiving responsibility was not associated with poorer health status or quality of life. This was because about 70% and 63% of the caregivers received physical and financial support, respectively. For these cohorts, caregiving responsibilities were associated with better health status, greater satisfaction, and increased quality of life (Mugisha et al., 2013). Social norms about elderly people's family caregiving roles in these societies are likely to contribute to the positive association between caregiving and the well-being of the elderly. For instance, the special cultural role of grandmothering involves

2. They usually had the final say on important and complicated matters. Among many southern Ghanaian societies such as the Ashanti, Ga, and Krobo, the proverbial "we are going to ask the old lady" is used to signify that serious consultation had to be made on a matter (see Odametten, 2012; Boateng, 1992).

ensuring the survival and well-being of their grandchildren (Badasu, 2004; Oppong, 2006). Elderly mothers were also found to be highly involved in the care of their middle-aged children diagnosed with various chronic diseases in Accra (Atobrah, 2009). While the notion of women's double burden of productive and reproductive work is an undisputable fact in gender discourse, the lack of disaggregation of data by age cohort obscures elderly women's contribution to domestic and community sustenance. As more and more young and middle-aged women obtain formal education and increasingly engage in rigid formal work, much of their care burden is likely to be shifted to elderly women because care work remains feminized.

Having examined the broader contextual background of family and community participation of the elderly in African societies, a discussion the Krobo context is in order.

Elderly Women in the Krobo Family System and Community

Manya Krobo is one of the two major towns of the Adangme-speaking Krobo people of Ghana, which has also been the site worst affected by HIV/AIDS in Ghana. Although the Krobo are patrilineal in principle, many become affiliated only to their matrilineage because of customarily rigid and restrictive conditions for assuming paternity rights. Women and the matrilineage therefore become very influential kinfolk (Huber, 1963).

Krobo traditions do not accord paternity rights to a man who has not performed the full and elaborate marriage rites for the mother of the child. The child instead becomes a legitimate member of its matrilineage and its maternal grandfather assumes paternity of the child. This concept is termed *yoobi* (woman's child) and is very common due to the expensive marriage demands on a prospective husband (Huber, 1963). As generations of *yoobime* (pl.) succeed another, very few children had grandfathers to take on paternal responsibilities, thereby placing full parental responsibilities on mothers (Atobrah, 2006).

Over time, as more and more people became *yoobime*, the concept of *yoobi* not only empowered women by broadening their access to political succession and household headship, but also increased their responsibilities to cover the familial roles of fathers (Atobrah, 2006). For instance, mothers and their matrikin have had to bear the cost of *dipo*[3] rites, otherwise the

3. *Dipo* is an initiation rite for girls that is required for every Krobo female in order to make her a true Krobo (Huber, 1993).

responsibility of legitimate fathers. While this overburdens mothers and their elderly female relatives, they become indispensable to their families and are able to exude authority and influence within their families. Many women became de facto heads of households which ultimately gave them huge traditional and domestic responsibilities.

Historical accounts identify three important female positions in Krobo traditional polities: the queen mother, the stool priestess, and the sister(s) of the chief (Obeng-Asamoah, 1998). The institution of queen mother was introduced by Nene Emmanuel Mate-Kole in the late 1890s in his administrative reforms, in recognition of women's importance in state affairs. Since then, queen mothers have become empowered to the extent that after the death of Konor[4] Azu Mate-Kole, Manye Mamle Okleyoo, the paramount queen mother at the time, became the primary representative of the Manya-Krobo, until Nene Sackitey was installed in 1998 (Steegstra, 2009). Although originally queen mothers had limited traditional political roles because their stools had no spiritual or ancestral powers, their sphere of influence has greatly increased especially within the context of the HIV crisis in the area.

HIV/AIDS in Manya Krobo

While HIV infection rates in Ghana generally have been around 2%, peaking at 4.6% in 2001, the Manya Krobo district has always had the highest prevalence and infection rates, with its all-time highest prevalence rate of 18% in 1992. Over time, prevalence rates in Manya Krobo dropped annually to about 7.8% in 2000. Anti-retroviral therapy has effectively reduced AIDS morbidity and mortality, so that prevalence rates remain high in spite of falling incidence rates because people are living longer with AIDS (Ghana AIDS Commission, 2006; Family Health International/USAID, 2011). In any case, the impact of HIV/AIDS on the Krobo community has been severe afflicting virtually every household in the district (Atobrah, 2004).

The mass migration of women to Abidjan and their participation in commercial sex work have been characteristic of the etiology of HIV in Manya Krobo (Anarfi, 1993). Such connections deepened stigmatization of people living with AIDS (PLWA) and generated high numbers of orphans,[5] many of whom had no connections with their genitors (Atobrah, 2004). Soon

4. Konor is the title of the paramount chief of the Manya Krobo Traditional Area.
5. The term commonly used to refer to children who have lost either or both parents to AIDS.

after the first AIDS case was recorded in the district in 1986, the number of sick middle-aged returnees, mostly female, started increasing rapidly (Anarfi, 1993). In the early 1990s, the HIV/AIDS crisis in the district had become very brutal, typified by increasing numbers of chronically sick adults and children, deaths, and orphans (UNAIDS, 2001). Such a situation created the need for promoting awareness and knowledge, controlling the spread of infection, and increasing the care and support for patients and orphans in the community.

Since its formation in 2000, the Ghana AIDS Commission (GAC) has initiated and implemented programs in the district among indigenous people, particularly elderly women in the position of queen mothers and grandmothers.

In the rest of the paper, I describe how grandmothers and queen mothers participated in caring activities and HIV response within their families and the Manya Krobo traditional area.

Methodology

The paper utilizes data from a larger study on traditional responses to and care for HIV/AIDS orphans in Manya Krobo. Primary data was collected during ten months of ethnographic field-work in Manya Krobo in 2000 and 2001, at the height of the HIV epidemic. As an outsider[6] researching such a highly sensitive and stigmatized topic, it was crucial that every aspect of the process (such as entering the community, navigating gate-keeping systems, rapport building, and gaining the trust of research participants) be handled with tact and care (Bernard, 2011). After making exploratory trips to the community, I identified the queen mothers in the community (organized as the Manya Krobo Queen Mothers Association-MKQA) as gatekeepers, so far as HIV/AIDS in the community was concerned. An appointment was made to meet the leadership of the MKQA, introduce myself and my project to them, and "seek their permission" to conduct the study in the community.

Two categories of respondents were engaged in in-depth interviews and observations: elderly caregivers of PLWA and AIDS orphans, and traditional queen mothers of the Manya Krobo area. All the interviews were conducted by the author, in Ga or Twi. A key informant also doubled as a translator in cases where the participant did not speak either language fluently.

6. The researcher is a not a Krobo.

After visiting the community a few times, I figured out the taxi drivers in the community had information about households or people affected by HIV/AIDS, as they drive people in and out of hospitals and converse with them. I asked a taxi driver to connect me with the first household with AIDS orphans, after which I used snowball sampling to contact another nine households. Most caregivers in the community knew other AIDS-affected households because they meet each other at the hospitals.

In-depth interviews were held with caregivers of ten AIDS-afflicted households, focusing on the general care and well-being of infected family members and orphans. Each household was visited at least three times for interviews and observations on the coping strategies and challenges of households. At least one household was selected from each of the seven traditional divisions of Manya Krobo.

Two focus groups of ten randomly selected members of the Manya Krobo Queen Mothers Association (MKQA) were conducted to elicit data on AIDS-related activities of the queen mothers. The program director and two other active members of the association were interviewed at length.

The data was analyzed by first reading through all transcripts at least three times to identify the topical categories that emerged from the data (Lacey and Luff, 2001). Snippets of narratives that corresponded with the topical categories were compiled and memos were made on analytically significant narratives for discussion in the research output. The contents of the narratives were analyzed for the contribution, role, and response of the respondents to the HIV crisis in Manya Krobo.

Elderly Women as Primary Caregivers in AIDS-Affected Households

While elderly women have been the main providers of care in most sub-Saharan countries affected by AIDS (Kautz et al., 2010), those elderly women presented in this paper had certain peculiar characteristics which shaped their social roles and participation in caregiving and response to HIV.

Most of the infected women had no legitimate husbands, and orphans from nine of the ten households studied had no connections with their fathers or paternal relatives. In those cases, maternal grandmothers were primarily responsible for the care of orphans. The elderly women presented in this paper were all maternal grandmothers of AIDS-affected households and primary caregivers. Orphans in two of the households were also infected with HIV and had full-blown AIDS, and six households had already lost members to the disease. The youngest of the elderly

women was 62 years old and the oldest was 84. Most of them had only a few years of basic education, and only one elderly woman in this category had completed middle school.[7] None of the women had worked in the formal sector nor had any received a pension of any sort. Five of the women sold petty items such as bread, charcoal, brooms, and soap from their homes. Two elderly women sold their wares at the market. None of the women earned up to GH₵100 monthly. Two households received regular financial support from their relatives who live and work in Accra or Kumasi. Only one of the women had a husband at the time of the study. They all professed to be Christians, although none of them claimed to attend church regularly because of their care burdens. All the households resided in traditional family homes owned by their ancestors, and cohabited with other kin members in the same compound. As such, none of them paid rent.

The relevant issues involved in the elderly women's participation in care activities within their families are described next.

Elderly Women Participating in Family Care and Sustenance

At the early stages of the crisis, when knowledge of the disease was very low, many patients and their families attributed supernatural causation to it. They blamed their competitors in commercial sex work for cursing them, commonly expressed as *apomi tsupan*, *anyuami*, or *afiami tukpan*, all meaning "I have been cursed." Most elderly women in families felt responsible for helping patients seek spiritual healing at shrines and from herbalists, which became an important aspect of family caregiving as the disease and related deaths continued to increase. Almost all the elderly women in the study believed in supernatural causes of HIV and had visited a traditional healer with their infected relative for treatment.

By the early 2000s, when ART services in Ghana were scanty and when PLWA became chronically sick very quickly, opportunistic infections were more difficult to manage and patients became dependent on caregivers for support and assistance for basic personal activities like toileting, meal preparation, and sanitary care (Kwansa, 2013). Caring for patients with full-blown AIDS required time, altruism, and commitment from family members. This became more critical for aged women because of their social role as caregivers and because they were a source of safety and security for their grandchildren (Oppong, 2006).

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7. That is, equivalent to junior high school.

Daale, a 72-year-old woman at Odumase, is a *yoobi* and lives in a large compound house with some of her maternal relatives. Her 43-year-old daughter, Rebecca, who had been living in Abidjan for six years, returned home about a year earlier with her three children: 12-year-old twins and their 10-year-old brother. Rebecca was critically sick and had tested HIV seropositive. All three children had also tested positive for HIV and Rebecca said the man who fathered her children had died two years earlier in Abidjan.

Since her daughter's return, Daale has been in charge of the care for her sick daughter and grandchildren, particularly when they contract opportunistic infections and are very sick. On a typical day, Daale prepares the meals for her daughter and grandchildren, washes their clothes, and cleans whichever of them is too sick to take his or her bath. She cleans their vomit and assists them with toileting when they have diarrhea. She accompanies them to the hospital for their routine visits and when they are critically ill. According to her:

> What is good is that the children are not heavy; you see how they have lost weight, so lifting them to bath them or help them to go to toilet is not difficult. But I have to do everything alone, I am the only one . . . I cook every day because sometimes they get diarrhea when I buy food from outside for them. When any of them has diarrhea and it is very bad, I put a bucket in the room, place a plastic bag in it so she can do it [i.e., defecate] in it, then I dispose it later. . . . Almost every day, one of them is sick and I have to run up and down to get medicine or send her to the clinic.

Stress and Strain in Caring

Undoubtedly, several of the elderly women felt obligated to care for their family members affected by HIV/AIDS. They felt the whole community would accuse them if they failed to care sufficiently for their children and grandchildren. Sixty-eight-year old Josephine, who takes care of her three grandsons (13, 11, and 9 years old), articulates her caregiving role thus:

> Sometimes I hear people comment that when the women were prosperous in Abidjan, it was their mothers who benefited so now that they are sick, their mothers have to look after them and their children. If I don't look after them, then they will be on the streets because no one will take them . . . people will ask "where is their grandmother?" People will even say I am a wicked woman if I do not take care of these boys. Once [i.e. as long as] I am alive, it is my responsibility.

The grandmothers generally seem to lack the energy to work long and hard enough to generate enough resources for the up-keep of their orphaned

grandchildren, yet they have to carry the bulk of the burden of orphan care. Stigmatization and fear of cross infection seem to have also deterred other relatives and community members from supporting the grandmothers.

For instance, 72-year-old grandmother, Daale, thinks her relatives were hesitant to assist in caring for her sick daughter and grandchildren for fear of contracting the disease:

> Even I fear and worry sometimes that one day I will get this sickness and there will be no one to look after all of us. The sickness is bad so nobody wants to get close to catch it. Only your blood [i.e. close relatives] can touch you when you have it . . . nobody else. . . .
>
> I know I am very tired now, I have to rest, the other time I was sick, the nurse said I have BP [high blood pressure]. Sometimes I wish I could travel to the village and rest for a while but who am I going to leave these children and their mother with? Who else is there? There is no one, it has happened like that already.

Daale feels drained by the responsibility to care and provide for her family. She however seems quite strong emotionally and resolved to do her best for them.

Awo Mamle, a 65-year-old grandmother taking care of four of her late son's orphans gives the reason for this phenomenon:

> Although I have two other children who are alive, they also have their families to take care of. One lives in Kumasi, taking care of her three children single handedly. How can I ask her to take on these too? She claims business of late is bad and she doesn't make enough profit to cater for herself and her three children. She occasionally sends me some money when she has someone coming down but this is not much. The last time she sent money was about two and a half months ago and this was ¢110,000.[8] My son who is a driver in Ashiaman (near Tema) also has his own problems. He also has four children with three different women and claims he has to remit all these women at the end of every month. I don't believe this but what can I do. Every one claims he or she has his or her own problems, responsibilities and what not, and they have left the children on me.

Daale, who is the primary caregiver for her daughter and three grandchildren, sells charcoal at the local market. She indicates that her trading activities have been disrupted and she only sells on market days. She usually makes about GH₵10.00, not enough to maintain herself and her sick daughter and grandchildren. She seems very frustrated and distressed; she

8. About the price of 5 kilograms of rice.

believes, however, that she is the only one who can look after her family and will continue to do so until they are well:

> When we don't have any money, I take my personal clothes or beads and sell at the market. The human beings are more important than keeping the cloth in my suitcase.

The financial burden that such care imposes on elderly mothers and grandmothers has also risen because of the scanty employment opportunities in the district. Most middle-aged persons have migrated to big towns and cities in search of greener pastures. The elderly women therefore have to deprive themselves and exude fortitude in their strategizing for their families' welfare and well-being. It must be noted, however, that in certain isolated households, although the grandparents may be seen as the providers for the orphans, the former may be receiving various forms of material support from other children. Such is the case of Awenye Dede and her husband. They together have six adult children who all live in the town and make adequate provision for the upkeep of her orphaned grandchildren. According to Awenye Dede, "My children always make sure the children [orphans] have food to eat. They help me look after the children well. We don't have a problem." Support from other relatives to grandparents towards the upkeep of AIDS orphans is usually seen as "assistance" or "help" to the grandparent because the care of AIDS orphans is seen as the responsibility of grandparents. Thus Joanna Deo, a grandmother caring for her orphaned grandchildren, said: "My eldest daughter is the one who helps me take care of the children." It was, however, noted that two grandmothers who had some of their grown children living in the same house or town with them received an appreciable physical or practical support from these children towards the upkeep of their grandchildren. These adult children helped bath young orphans and helped with homework and with general supervision.

Role Conflict of Grandparents as Orphan Caregivers

The fact that older caregivers have passed the age of nurturing and caring for their own children poses a great deal of role strain on them and on the people they care for. Sixty-seven-year-old Gloria, caring for her orphaned grandchildren, disclosed:

> My orphaned grandchildren sometimes refer to me as their mother and at other times their grandmother. Even me myself I also get confused as to whether I should see myself as their mother or grandmother. The youngest of them is six years, her mother died like three years ago so she does not know her; I am the one she knows.

This feeling of confused identity probably stems from the different expectations women have of how their social responsibilities will change as they grow in life. For instance, Gloria further disclosed that, "I had hoped that my role as a grandmother would be to care for my grandchildren occasionally during school holiday." Instead, she finds herself saddled with the entire responsibility of raising six young children. Her expectations as grandmother have been completely overturned by HIV/AIDS. She thus declares that the old are now taking on the burden of caring for children under conditions of increasing personal impoverishment, causing problems for both generations.

Community Based Leadership Response by Elderly Queen Mothers

At the peak of the HIV epidemic in the district, the septuagenarian paramount queen mother, Manye Mamle Okleyoo, being overwhelmed by the plight, invited all queen mothers for a discussion on how they could respond to the health crisis and also promote development in the area. She initiated the Manya Krobo Queen Mothers Association (MKQA) in 1995, which was officially inaugurated in 1998. It embraced all traditional queen mothers, their assistants and elders from the traditional area, and some market queens. The majority of members were elderly women, over sixty years old. The association had the overarching objective of marshaling female traditional leaders and elders towards solving community problems and fostering development.

After its inauguration, the MKQA focused on HIV/AIDS-related activities and took the form of a non-governmental organization (NGO) to help it access relevant support for patients and orphans. Manye Mamle Okleyoo's assistant, Manye Nateki, became the program manager of the association. By 2000, the leadership of the MKQA had garnered collaborative support from the Ghana AIDS Commission (GAC) and Family Health International (FHI). Thereafter, several other organizations and key actors—such as the UNDP, the Newmont Mining company, and the Ministry of Health—have collaborated with the MKQA because it was well organized for community response, had traditional authority and a mandate from community members, and had prioritized HIV-related activities. Having received the authority of the paramountcy and the necessary training by the GAC and FHI, the queen mothers felt empowered to participate and respond to the menace that HIV/AIDS posed to their community, mainly through gate keeping, collaborating with NGOs, organizing public events, providing home visits and orphan care, and promoting cultural reforms.

The next section focusses on the MKQA's collaboration with FHI on its START program, and the Ghana AIDS Commission on orphan and vulnerable children support

Queen Mothers Keeping the Gates

As the epicenter of HIV infection in Ghana, Manya Krobo soon attracted the attention and interest of researchers, NGO workers, and other interventionists. Considering the vulnerability and gullibility caused by chronic illness, poverty, and the general lack of knowledge about the disease, the queen mothers found it necessary to shield the community from exploitation and the activities of ill-intentioned predators. The queen mothers thus asserted themselves as the authority that scrutinized and granted key actors access into the community. Once they ascertained the credibility of an agency or individual, they further assisted and coordinated with community members to ensure the successful carrying out of projects. The MKQA program manager describes their mandate thus:

> The Konor has given us the authority to be in charge of affairs so far as the disease (AIDS) is concerned. Many people want to come to this town and do what they like but we have to monitor things and make sure that we protect our people. We have to protect our people. . . . Because many of our people are illiterate, they jump into anything and people can cheat them. I have told them that if anyone comes to ask them questions about their illness, they should call me or one of the queen mothers. Some people can come into the community and promise them help but they may in the end take advantage of them.

Queen Mothers Collaborating on FHI's START Program

The START program, touted as one of FHI's success stories, is an initiative by FHI and its partners to work with local institutions to implement a comprehensive program of prevention, care, and treatment for PLWA and their immediate families. The program offered voluntary counseling and testing (VCT) services at the Atua and St. Martin's Hospitals, both in the Krobo area. The program also provided home-based care and referral services and supported care for orphans and vulnerable children (OVC). START was designed to build on the district's strong community support structures and the commitment of traditional community leaders in a resource-constrained setting. As such, the queen mothers were the main conduit through which the program was executed (FHI, 2011).

Due to the low level of public knowledge about HIV at the time, the starting point for the program was to educate queen mothers about the

basic facts of HIV/AIDS through training workshops. These equipped the women to generate awareness of the disease, confront superstitious beliefs and attitudes, promote HIV symptom management, and prevent and control mother-to-child transmission. The START program further provided resources to the queen mothers to visit PLWA and programs. The queen mothers found the training they have received from FHI very valuable:

> I could say I have attended more than ten workshops on AIDS. Sometimes when I share what I know in the community, people think I am [a] nurse but it is all because of the workshops we attend. (Manye Maku, Kpong Queen Mother)
>
> When we attend [the workshops] they give us small money for transport, and sometimes lunch, but we also get to learn so much. Formally we sent our children [meaning PLWA in the community] to all kinds of places because we thought it was a curse but since we had these workshops, we know where to direct them for treatment. We also advise the pregnant women in the community to get tested and to take the advice of the nurse serious so their babies don't get the disease. (Manye Makutso, Queen Mother of Susui)
>
> It was easy to get the queen mothers on board because so many people died in this town. All our sons and daughters are dying, who will bury us? So we had to do something about it. (Manye Nateki, Program Manager of MKQA)

The queen mothers, many of whom have very little formal education, seem to have learned a great deal about HIV from these workshops. The popular superstitious beliefs associated with the disease seem to have eroded because of the educational activities of the queen mothers.

Public Events

Community durbars, which are already enshrined in Krobo festival cultures, provided effective platforms for the queen mothers to address HIV-related matters. Since the inauguration of the MKQA in 1998, the queen mothers have annually presented at the festival, speaking publicly about the AIDS problem in the community, its prevention and control, and voluntary counseling and testing (VCT). As such, most of the programs and interventions which were initiated in the community by key actors—such as UNDP, GAC, and FHI—were all inaugurated with a durbar which attracted large sections of the community. The queen mothers were usually engaged for the preparatory work, organizing the logistics, and for mobilizing the people in their jurisdictions. In line with this, the FHI commends the participation of

the traditional leadership of the MKQA in organizing the inaugural durbar of the START program (FHI, 2011).

> On such platforms, we spoke openly about Abidjan and sikpayami [lit. "roamers," i.e. mobile sex workers], and advised mothers to discourage their daughters from migrating. We also advised them not to stigmatize. . . . I usually speak on the platform and talk about all these issues. (Manye Nateki, Program Manager of MKQA)

Home Visits

Home visits were one of the key activities of the queen mothers, who were assigned oversight responsibilities within their wards. Each of them was to visit and encourage community members who were had been diagnosed or were suspected of having HIV/AIDS. Through the home visits they advised them on VCT, ART, and management of opportunistic infections. They also supported them materially and financially:

> We use the training we have got to help our people, each of us know the sick people in our communities so we visit them and tell them to take their medicines regularly otherwise their sickness will be worse. We could ask the sister or mother who looks after the patient whether she is taking her medication. We also educate the caregivers. When I visit them in their homes, I tell them to eat warm food all the time so they don't get diarrhea, and lose weight. When I tell them that once they lose weight everyone will know they have this illness and it is not good, they take my advice serious. I tell them that once you look after yourself well, you will be fine. (Manye Maku, Queen Mother of Kpong)

Queen Mothers' Support for AIDS Orphans

With a GH₵25,000 funding from the Ghana AIDS Commission, the MKQA launched the "Every Child our Child" program, through which the association provided material and financial support for about 120 AIDS orphans selected from the district. At the time of the study the queen mothers had registered 586 orphans.[9] Because of the overwhelming numbers of orphans, the queen mothers had to strategize to identify and select the neediest orphans to receive this support. The leadership of the association, with support from the funding commission designed a package of support for each orphan. Caregivers of selected orphans received a supplementary allowance of GH₵10 to supplement her income-generating activity, and a monthly payment of GH 6 for general upkeep of the children. Caretakers

9. Providing a database for policy makers, planners, and funding agencies.

of these orphans could also submit receipts of medical expenses spent on orphans in order to receive reimbursement from the fund. The association also sewed school uniforms and provided basic school supplies for each of them.

Considering the inadequacy of the funds and the magnitude of the orphan crisis, members of the association agreed to take care of at least six orphans in their respective jurisdictions. Such care includes ensuring that the children are fed, clothed, and sheltered. Queen mothers were admonished to put orphans in their care into school if they were not already in school, and they were to do all these things with their own resources. Although not all queen mothers were able to bear the educational expenses because of their own financial constraints, the majority of them were dedicated to this obligation.

Queen Mothers Initiating Traditional Changes in Response to HIV/AIDS

Another proactive response of the queen mothers to the menace AIDS posed to their community was to revise traditions and customary practices that were seen to predispose the populace to HIV infection. The queen mothers, as key custodians of Krobo traditions, play significant roles in organizing *dipo* and other rites of passage. Based on the knowledge acquired from the several training workshops on HIV, the queen mothers introduced three particular changes to Krobo traditions.

First, HIV training was incorporated in the *dipo* rites. When the initiates are in confinement, the queen mothers themselves trained them on basic information on modes of transmission, mother to child transmission, symptoms, and treatment. Second, an aspect of the rituals, known as *yo sami* (opening of the sex door) was eliminated from the rite. Describing this ritual, Teyegagah (1985) recounts that during *dipo* the initiates are confined in a room. On a particular day during the confinement, the girls lie in the *dipo* room and a young male relative, dressed in white loin cloth with beads, is introduced into the room and an old lady momentarily sits three times upon each girl's buttocks. As this is being done, the old lady simultaneously repeats: *Mue ne neo wa nye mo nyumu se blo hae oo! Ne ofo bime fuu!*; meaning, "From now on the way to sex life is free to you, may you bear many children." With these words in mind it is likely that many initiates felt they had been given the license to free sex after *dipo* and therefore did not see anything wrong with risky sexual behavior. To promote responsible sexual behavior, the queen mothers unanimously called for the elimination of the *yo sami* part of the *dipo* rituals in 2002. Finally, the usage of a common blade for bodily incisions on initiates was stopped. The queen mothers

instructed each initiate to provide her own new blade for her incision to prevent the spread of infected blood among the girls.

Discussion

Traditional Krobo kinship structures and political systems seem to have effectively established the authority, norms, and legitimacy for elderly people's social roles, participation, and active engagement in their community. Such features conform to studies that propose that culture determines the acceptable fields and norms for elderly people's participation (WHO, 2002; Rowe and Kahn, 1997).

The responses of elderly Krobo women to HIV/AIDS defies the usual depictions of the elderly as weak and inactive members of society who have "retired" from contributing meaningfully to their society and community. Both the grandmothers and queen mothers seem to have braved the enormous challenge posed by the dreadful disease. They took ownership of their families and community and seem to have resolved to do all that lies within their strength and power to stall the ravaging damage of the dreadful disease.

In spite of their low level of formal education, the queen mothers utilized their social roles to effectively mobilize themselves and participate in community development (Biddle, 1986). They exuded strong organizational attributes of planning, organizing, and collaboration. Their strategies to mitigate the impact of AIDS on the community included delegation and collaboration with grandmothers and families in providing care and support. They served as liaisons for several NGOs, were responsible for mobilizing community members to attend workshops and durbars, made practical and logistic arrangements, and disseminated information to the community. In this regard, FHI's START program and its collaboration with the queen mothers were identified as a best practice, worthy of replication in other resource-poor countries.

As HIV/AIDS deepens the vulnerability of people who are already impoverished and are deprived in a number of ways, the queen mothers saw the need to safeguard the community and its members from exploitation. The queen mothers, as bearers of traditional authority over the community and its members, took ownership of the health crisis and became gatekeepers who screened "outsiders" who needed to "enter" the community because of HIV/AIDS. Researchers, policy makers, and practitioners who needed to do projects in the community had to get some kind of approval from the leadership of the association. Because their collaborative support was inevitable to the success of any program within the community, their

gatekeeping pursuits were effective and successful. By this they were able to garner and mobilize concerted efforts and resources for greater impact.

Both queen mothers and elderly mothers, most of whom were also grandmothers, became primary home caregivers for PLWA and AIDS orphans. They felt a sense of traditional responsibility and obligation to exhibit virtues of care and devotion to their families. Amidst scanty resources, personal weakness, and their own needs for care, they were resilient in providing care under stress and strain.

Elderly women (just like elderly men) contribute in diverse ways to social development and cohesion. Economists and sociologists in Ghana have paid very little attention to the contribution of elderly people to social cohesion. Furthermore, in arguing for women's work to be valorized, feminist researchers have often focused on women in their productive age group, thereby further obscuring the care and community roles of elderly women in various capacities.

The collective participation of the queen mothers seems to have boosted their confidence and given them a great sense of accomplishment. They accomplished much through their collective efforts and with the support of the NGOs with which they collaborated. The active aging framework for analyzing the well-being of elderly people highlights the importance of participation in society, and thus of those cultural norms that govern social engagement. The role and authority of the queen mothers in assisting with the HIV/AIDS crisis was enabled by the traditional political system. On the other had the grandmothers seem to have suffered immense stress and strain in caring, which was unlikely to have enhanced their quality of life. They had very little support from their relatives, the community, or NGOs. In spite of the numerous acclaimed benefits of elderly people's participation, the insufficient support, undue exertion, stress, and strain the experienced could be inimical to their quality of life.

Conclusion

This paper illustrates the social productive capabilities of elderly people in Manya Krobo in relation to high HIV/AIDS prevalence in the district. It highlights the role of culture as a determinant of their social roles and their engagement within their community and family. Socio-cultural norms and values accorded old people respect, authority, and responsibility because of their experience and status. They are thus able to marshal such cultural resources to influence and socialize members of the community and to build networks. It may thus be useful to involve and engage elderly people at the community level regarding interventions such as healthy lifestyle, sexual

exploitation, sanitation, and environmental preservation. Once they understand and embrace the agenda, they could become drivers of behavioral change. The paper argues that as elderly people participate in social and community development, they need to be supported in order to enhance their quality of life.

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