

"The beginning:" An analysis of the dynamics, vulnerabilities, and policies of the HIV/AIDS epidemic in Ghana

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Ghana, a small West African nation of 20-million people, is a strange nation by most definitions. Its economy has seen great swings since independence. Its political movements have gone from far-left to far-right and back again. It houses some of Africa's most underdeveloped regions, with people living on less than \$100 per year, as well as some of the continent's most wealthy and educated in downtown Accra. Its history with the modern plague of HIV/AIDS is also uniquely Ghanaian--complex and constantly changing. Since HIV/AIDS' emergence in 1986, Ghana has acted swiftly and the disease has remained under control. "The beginning" aptly describes Ghana's programs yet far: they have yet to be fully flexed and tested, and surely could use improvement.

As a nation of sub-Saharan Africa, Ghana by any account has fared well with HIV/AIDS. Whereas some of Eastern and Southern African nations record prevalence rates from 10-30%, Ghana has consistently estimated prevalence from 2-4% since the emergence of the disease. It has done well compared to even its successful West African peers, such as Nigeria or Cote d'Ivoire, where rates have been reported around 5%. Why has Ghana not suffered more? In comparing Ghana's HIV/AIDS situation with its neighbors in Eastern and Southern Africa, the question emerges about not only what Ghana has done correctly, but what historical preconditions to disease are lacking in Ghana.

This paper argues that the situation in Ghana is not due to an excellent response by the Ghanaian government, but rather that the government's response has in many ways failed. However, the epidemic has been kept at bay due to a lack of formalized migration and transportation, male circumcision, and a low prevalence of concurrent sexual relationships. The paper additionally argues that Ghana remains a very vulnerable state due to low civil

engagement, gender relations, and bureaucratic government programming. It concludes by recommending increase funding to HIV/AIDS prevention and treatment to maintain current prevalence levels.

The paper is organized into three sections: (1) history and dynamics, which provides narrative of Ghana's post-colonial struggles and attempts to explain Ghana's low HIV/AIDS prevalence, (2) vulnerability, which presents arguments as to why Ghana's epidemic could easily make large increases in the coming years, and (3) recommendation for future policy.

History and dynamics

Post-colonial Ghana: nationalism, socialism, and economic destruction

"Ghana," was the phrased used by British colonialists to describe what is now West Africa. In 1957, under the leadership of the progressive pan-Africanist Kwame Nkrumah, the Gold Cost, the Empire of Ashanti and the British Togoland merged as "Ghana" and declared independence. However, in 1966, Nkrumah was disposed by a coup, which many believe was backed by US CIA forces. The next 13 years were characterized by additional coups, corruption, and economic mismanagement. Public moral and opinions of the government were very low. In June of 1979, however, a young Flight Lieutenant, J.J. Rawlings, staged a successful coup. He was a popular politician--he spoke with charisma and heavily criticized the previous government's corruption. He spoke of bringing justice to the leaders of these movements, and through a "House Cleaning Exercise," summary trials and executions were held. People's

tribunals were created to "serve justice," and many of the past's corrupt business leaders were summarily executed. Individuals with more than \$1200 in their bank accounts had their accounts frozen. The economic situation worsened.

However, Rawlings held a belief in democracy, and handed the government to a democratically-elected president, Dr. Hilla Limann in 1979. Limann, who's government consistent almost entirely of civilian intellectuals, felt the main components of his leadership would be to restore Ghana's image abroad for long-term external investment, and stabilize the political situation. Charges were brought against the violent polices of the Rawlings government, causing much tension. Eventually, Limann removed many of Rawlings' men from the military. Rawlings staged a coup a retook power in 1981.

This period of rule, Rawlings declared, would be characterized by revolutionary socialism. Foreign-owned businesses were threatened with nationalization. Business exchange with foreign nations was criminalized. The economy quickly declined until 1983, its low point. Health and education infrastructure failed. Previously eradicated diseases (such as yellow fever and yaws) reemerged. Additionally, 1983 saw a devastating series of brush fires and drought. Ghana's share of the world's coca market fell from 35% in the 1970's to less than 10% in 1982. The average citizen was worse off in 1983 than in pre-independence 1956 (Dzorgbo 2001). By 1983, the economic downturn had lost Rawlings his popular support. He was forced to go to the World Bank and International Monetary Fund (IMF) and request assistance. (Brydon and Legge 1996)

In 1992, elections were held due to pressure from the World Bank and IMF for "good governance," and Rawlings was "elected" as president. He was succeeded by John Kufuor in

2000 under the first peaceful transition of democratic power since the nation's independence, who was succeeded by the current president, John Atta Mills.

Structural adjustment and the Economic Recovery Program

There has been much literature linking the Structural Adjustment Programs (SAPs) of the IMF and World Bank to the increase in HIV/AIDS prevalence rates in African nations (Lurie, Hintzen, and Lowe 2004). Ghana, however, shows little of this trend. Much evidence points to the success of the Economic Recovery Program, which was the moniker for Ghana's SAP (Dzorgbo 2001).

Relaxation of economic controls allowed for more trade with foreign businesses, and Ghanaians were able to receive money from the Ghanaian diaspora. Government practices focused on investment in the product sectors of the economy. Businesses, especially coca farming, flourished. By 1989, coca production had increased 88 percent of 1983 levels. The IMF and World Bank have featured Ghana as a success story, the "front-runner in adjustment" (Dzorgbo 2001).

However, many scholars claim otherwise. Faria (2008) posits that the social, educational, and health effects of adjustment increased poverty and inequity. Structural adjustment forced governments to divest from the public sphere. For many, this meant closing government schools and hospitals or introducing "user-fees" for service. In many rural areas, where the majority of the employment is in the informal sector, these services cannot be purchased. The number of doctors fell by one-half (Barnett and Whiteside 2002). However, many clinics are able to offer

services and medications that were not available before the adjustment (Brydon and Legee 1996). There is additional evidence that inequity increased. World Bank (1995) data shows the proportion of people classified as poor increasing from 43 percent in 1981 to 55 percent in 1997.

The emergence of HIV/AIDS in Ghana: gender and geographic diversity

HIV/AIDS was first discovered in Ghana in 1986, and is rumored to have come from a visiting German couple (Yankah 2004). Since its introduction to Ghana, it has proven to effect genders and sub-regions of the nation differently. As the first demographic data became available, the somewhat normal pattern of gender differences was swapped. Whereas in most of Eastern and Southern Africa, the beginnings of epidemics were characterized by high prevalence in males, Ghana showed a 5:1 ratio of infected females to males. Over time, by the end of the 20th century, the pattern had disappeared and Ghana's statistics had normalized to a 55:45 female to male ratio commonly found in other sub-Saharan nations (Oppong and Agyei-Mensah 2004).

Younger women also seemed to carry an unequal burden in the beginning stages of the epidemic. In 1998, 2.8 percent of the total AIDS cases were girls ages 15-19, whereas boys constituted only 0.7 percent in the same age group (Oppong and Agyei-Mensah 2004). This may be attributable to gender imbalance and an inability to negotiate contraception in younger relationships. Additionally, this may be due to an increase in the biosocial gap between menarche and marriage. Menarche in Ghanaian girls has declined from 14.5 years to 13 years, while average age at marriage has increased from 17.5 years to 19.1 years (Oppong and Agyei-Mensah 2004).

This time period of biosocial gap has been shown to be the period where girls are most vulnerable (Campbell 2003).

Prevalence greatly varied by geographic region as well. During the beginning of the epidemic, infections were found mostly in the Eastern region, and were found to move north into the Ashanti region during the early 1990's. In the late 1990's, however, prevalence increased in the north (Northern, Upper Eastern, and Upper Western regions). These patterns are strange seeing that these areas are largely rural, and most of the epidemiological patterns observed in other nations saw early concentrations of infection in urban centers. Various scholars explain these observations.

Anarfi (1990) argues that the Eastern region had higher prevalence because of returning sex workers from Cote d'Ivoire. Additionally, many of the women were of the Krobo ethnic group, who's culture may prevent them from other forms of work.

Increases in prevalence in the Ashanti region may also be attributable to sex workers. The Ashanti region underwent massive migration to and from Cote d'Ivoire and Nigeria during the Ghanaian economic crisis. Additionally, the region has historically been underserved by biomedical practitioners.

The north regions' increase in prevalence, in spite of a high rate of Islam, may be attributable to migration of young women, mostly sex workers, between Ghana and Burkina Faso due to Ghana's economic depression (Agyei-Mensah 2001).

Since the late 90's into the mid 2000's, the rural prevalence has declined in many areas, while urban prevalence has increased. By 2003, prevalence in urban areas was estimated to be

2.4 percent, while rural areas were estimated at 2.0 percent. Additionally, the northern areas, which hold the highest Muslim population, are now showing decreased rates. (UNAIDS 2008).

Government response

The government quickly responded, and established a National AIDS Control Program (NACP) in 1987 charged to "reduce new infections..establish a multi-sectoral and multidisciplinary institutional framework to coordinate program implementation" (Fobil and Soyiri 2006). The government generally viewed HIV/AIDS as a health problem, not a policy or social problem. Rawlings, who served as president until 2000, did not make any public comments on the disease until late 2000 (Patterson and Haven 2004).

However, due to pressure from UNAIDS, an additional body was created by Rawlings in 2000 called the Ghana AIDS Commission (GAC). It is located in the office of the president and is mandated to "direct all activities in the fight against the epidemic, and to provide effective leadership in the coordination of all programs and activities of all stakeholders" (Fobil and Soyiri 2006). GAC is supposed to function as an advisory and governing body, while NACP is meant to act as a method of enforcement and implementation.

The bodies have been acting under the Ghana Strategic Framework 2001-2005, which mandates that all sectors of government include an HIV/AIDS component (Fobil and Soyiri 2006).

Rawlings successor, John Kufuor, implemented a much more substantial program. He addressed HIV/AIDS in his opening parliamentary address, asking Ghanians to be open about

HIV/AIDS and sexuality. He worked closely with traditional leaders to develop culturally-sensitive prevention measures. In 2002, Ghana received a \$38 million grant from the Global Fund to create 20 additional testing centers, 20 additional centers for Prevention-of-Mother-to-Child transmission, and three antiretroviral care centers.

Treatment has remained low. Currently, only 15 percent of those infected are receiving the antiretroviral treatment needed for livelihood.

Low prevalence in Ghana: circumcision, migration, and concurrency

Male circumcision, a common practice in West African cultures compared to the cultures of Southern or Eastern Africa, is one of the largest determining factors of prevalence. Many studies have shown the decrease risk associated with the circumcised penis. Langerhans cells, an important component of human immunity, are not present in the human prepuce. Additionally, the warm, protected area of the prepuce can incubate organism growth and thus facilitate viral transmission (Moses 2000). According to the Ghana Demographic and Health Survey in 2003, 95 percent of males 15 to 59 years old were circumcised. One recent report (UNAIDS 2008) using three randomized samples found a 60% decrease in transmission for circumcised males. In Ghana, this has been proven true as well. Communities surveyed in Cote d'Ivoire and Ghana showed decreased risk associated with male circumcision (Moses 2000).

Another possible reason is the lacking of internal formal migration within Ghana and a poor transportation system. Mine work has been documented as a significant factor spreading infection in South Africa and bordering nations. Men leave rural areas to work in the mines, and

are infected by sex workers that work near the mines. Men then return from the concentrated urban mines to their rural homes to infect their partners (Campbell 2003). Mine work, however, is less developed in Ghana, providing less than 1 percent of the GDP in Ghana during the 1980's, mainly because of foreign divestment during the turbulent and socialist policies of Rawlings (Bermúdez-Lugo 2006 and Dzorgbo 2001).

Road transportation has also been identified as a key player in the movement of infection in Eastern and Southern Africa. However, in Ghana, transportation was underdeveloped. There are a few major roads, but much of the nation remains largely isolated (Clark 1994). The government of Ghana, recognizes the "dilemma of improving transport as an essential element of national development while protecting the health of transport workers and their families" (National AIDS Control Program 2001).

Another large factor determining prevalence rates is the amount of concurrent relationships individuals maintain. Epstein (2007) posits that this is the key determining factor, and that some African cultures find concurrent relationships acceptable. She writes that "long term overlapping relationships are far more dangerous than serial monogamy, because they link people into a giant network that creates a virtual superhighway for HIV" (2007). She claims that these sexual behaviors are deeply rooted in African cultures. However, these behaviors may be the product of a colonial past, where forced migration, especially to mining facilities, caused long-term distance from lovers. Evidence exists that concurrent relationships do occur. In Uganda, about 40 percent of men and 30 percent of women reported overlapping relationships (Epstein 2007). Surveys in other African nations provided similar results. In Tanzania, 18% of men reported concurrent relationships. In Lesotho, 55 percent; in Zambia, 22 percent. In Ghana, these

numbers are more modest, with eight-ten percent of men and one percent of women reporting multiple partners in the last 24 months (UNAIDS 2008-2).

However, many critics of the so-called "concurrency hypothesis" argue that it unduly places blame on African culture, and represents colonialist images of "exotic" African sexuality. (Faria 2008). Additionally, there is evidence to support that correlations drawn between concurrency and prevalence are not universally valid. For example, Peru reports that 23 percent of males have had multiple partners with the past two years, although has consistently reported prevalence rates below one percent (UNAIDS 2008-2).

Vulnerability

Ghana, although being able to maintain low HIV/AIDS prevalence rates, has many factors that contribute to its vulnerability, mainly its lack of advocacy through civil engagement, bureaucracy, challenges of structural adjustment, and gender inequality. Without changing the policies that mold this environment, Ghana will remain susceptible to an increase in prevalence.

Lack of civic engagement

Because of the authoritarian nature of many of Ghana's past regimes, many scholars (Dzorgbo 2001, Brydon and Legge 1996), and Rawlings himself, have argued that a "culture of silence" is pervasive in Ghana. During the violence of the authoritarian regimes, citizens became fearful of their government and preferred to remain quiet than risk become an enemy of the state.

This concept has important implications for the HIV/AIDS pandemic. Citizen participation in government is essential to health policy. Activist organizations such as the AIDS Coalition to Unleash Power played a key role in shaping the United State's HIV/AIDS policy (Patterson and Haven 2004).

Civil organizations addressing HIV/AIDS are especially lacking in Ghana (Paterson and Haven 2004). This could be due to the closeted nature of many HIV-positive individuals, and an unwillingness to be associated with those who are openly HIV-positive, especially considering the relatively high rate of stigma in Ghanian society (Poku 2004). A history lacking in stable democracy and civil-disobedience may form a political context that does not encourage activism or government pressure.

Bureaucracy and failures of the national response

National health plans can be large, complicated, and slow-moving. Ghana's anti-HIV/AIDS programs exhibit all of these characteristics. First, there is a large amount of institutional overlap. For example, the two governing bodies for HIV/AIDS policy, the NACP and the GAC, have very vaguely different roles -- one is roughly "coordination," while one is roughly "implementation." It is very hard to coordinate without being able to implement, or implement without being able to coordinate. Thus, the functionality of the two programs is very similar, and much time is wasted unproductively infighting about roles (Fobil 2006).

Furthermore, there has been a dearth of political commitment to fighting the epidemic. Although superficial political will and rhetoric remain high on a national level, most leaders seem prone to pass the task of funding of the programs to foreign donors (Fobil 2006).

Corruption is rampant in Ghanaian government, and the HIV/AIDS sector is not unaffected. In 2003, 62 percent of citizens reported that some government officials were corrupt. A traditional system of patronage is seen in government, and the vague and multi-leveled HIV/AIDS response facilitates patronage. In June of 2003, some GAC members were charged with embezzling money (Patterson and Haven 2004).

Lastly, the government's approach is narrowly focused and does not address larger contextual issues that create environments that promote risky sexual behavior. Unemployment, sex work, and gender issues have gone seemingly unnoticed.

Adjustment: economic success, social failure

Many of the issues which allowed Ghana to avoid high HIV transmission may be reversed by structural adjustment. For example, the ERP has increased investments in roads and road transportation, recently allocating as much as 25 percent of the federal budget to road assistance. Increased road accessibility will make movement easier and may provide an increased risk of transmission. Additionally, Ghana is quickly becoming more urbanized. Between 1984 and 2002, there was a 12 percent increase in the population living in urban areas (Eed 2005).

Additionally, the mining sector of Ghana's economy has been steadily growing. An increase in percent of GDP from 1.3 percent in 1991 to over 5 percent in 2006. The majority (95 percent) of this mining is gold mining (Omayra Bermúdez-Lugo 2006). The economic policies which push mining development may create risky environments for the men who work at these centers and the sex workers who visit them (Campbell 2003).

As mentioned above, SAP's destruction of the public healthcare system leaves the nation additionally vulnerable, especially for the poor who cannot afford clinic's user fees. Furthermore, since HIV/AIDS is less of a pressing problem for many, it is often ignored in favor of addressing more urgent needs, such as hunger or acute infections. Government sources do not place HIV/AIDS on the forefront, but warn it may distract healthcare from other important needs: One report reads: "The increasing need for funds to expend on AIDS care threatens to divert spending from other important health care needs." This focus on prevention as opposed to treatment as a "cost-effective measure" has been greatly criticized in recent literature (Farmer 1999). Programs that ignore treatment "do not adequately acknowledge the structural constraints of poverty and gendered inequality that continue to reduce the ability of individuals to engage in safer sexual behaviors" (Faria 2008). Ghana, with a 15 percent treatment rate, has surely failed on this account (UNAIDS 2008).

Gender: lacking the contextual view

Many scholars have recognized the gendered nature of the HIV/AIDS crisis in Africa. Ghana is no exception. Faria (2008) completes a detailed analysis of rhetoric in Ghanaian HIV/AIDS education campaigns. She concludes:

"Women are increasingly found to have higher rate of infection with females contracting the disease at a younger age... These patterns of infection are closely tied to gender inequality, the social and cultural assignments of values, beliefs and behaviors, roles and responsibilities to women and the gendered nature of political and economic entitlements."

She found that even when analyzing some of the traditionally matrilineal societies, patriarchal values of Christian and Muslim societies played a role in shaping thoughts and behavior. The ad campaigns used by public health authorities largely look at sexual behavior as a matter of personal choice and ignore the contextual constraints placed on women. Women were depicted as pure, innocent, and responsible for their own behavior. The campaigns additionally focus on the choices and possibilities of behavior for women, ignoring the male side of the problem. The gender bias found in the public health campaigns and throughout Ghanaian society make Ghana more vulnerable to increase infection rates.

Policy recommendations

There are a series of policy possibilities that may work to decrease Ghana's vulnerability. First, programs that account for the social failures of economic adjustments are necessary. In healthcare provision, lack of user fees has been shown to be an effective measure towards

increasing population's general health, especially in rural settings where trade in the formal economy is minimal (Farmer 1999). Additionally, recent interventions show that treatment of complex diseases, such as HIV/AIDS and TB, is possible in resource-poor settings and has incredible benefits such as reduced stigma, economic productivity, and prevention through decreased viral load (Faria 2008). Treatment and prevention programs should take into account the gender inequality found in Ghana and focus on relieving the historical and contextual constraints to healthy sexual behavior.

Economic development, including improvements in the business, mining, and transportation sectors, should be recognized as possible modes for increased transmission and the Ghanaian government should plan accordingly.

Governmental overlap and systems of patronage should be fixed through a clarification process of the documents which mandate the Ghanaian response. The GAC and NACP should be combined. Campaigns against stigma and in favor of civic engagement are needed.

Conclusion: Moving forward from "the beginning"

Although the Ghanaian epidemic has retained low rates of infection, the historical factors which mandate that level may be changing through adjustment. Government programs should prepare for increases in prevalence through the methods discussed above, leaving "the beginning" stages of the Ghanaian response.

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