

# AN INHERENT BURDEN KINSHIP, MIGRATION AND HIV/AIDS AMONG THE AKAN OF GHANA

· PERPETUAL CRENSIL ·

## ABSTRACT

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The connection between rural-urban migration, risky survival activities and HIV infections in sub-Saharan African societies has been central among the social and cultural factors associated with the high rates of HIV/AIDS in the continent. But the underlying role of kinship in this relationship has been less documented. This article discusses the connection of kinship in rural-urban migration and HIV infections among the matrilineal Akan of Ghana. There is a pressure on people to migrate from their villages to urban areas where they are expected to be successful and remit to other kin members back home. When people become infected, the burden then turns to lie on kin members to care for the AIDS patients. The article concludes that the family pressures reflected in the stories of many AIDS patients in Akan society are too huge to ignore. It suggests that interpersonal dialogues as campaign strategies should target both individuals and family members in households.

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Keywords: kinship obligations, migration, HIV/AIDS, Akan of Ghana

### *Introduction*

In a study of rural-urban migration and ethnic identity in Obo, a small Ghanaian town, Philip Bartle (1978) lays bare how migration and the search for a better life are intricately tied to kinship relations and moral obligation among the Akan. Migration for economic purposes is inherent to the Akan social system and is often part of the survival strategy in the matrilineage. People are encouraged by words and practical help to migrate. In their individual movements from the rural settings to the urban areas, such migrants are safeguarded largely by their personal ties of kinship. They are expected to be successful in the city and help kin members back in the village with remittances (Bartle 1978). Such migrations are essential to the making of the social worlds of both migrants' home villages and their new homes in the urban areas.<sup>1</sup>

Migration from rural to urban areas in Ghana has long been a strategy to improve living conditions. Rural-urban migration in the country probably started in the late nineteenth century during colonialism, when the building of such facilities as the railway line from the capital Accra to the second largest city, Kumasi, about 400 kilometres further north, attracted migrant workers to major towns dotted along the railroad (Middleton 1979). The boom in the cocoa industry, Ghana's major export crop, from the 1940s was another contributing factor since it turned many towns into large market centres and people migrated to such places largely for trading activities.<sup>2</sup> The social organization of the Akan is based

predominantly on matrilineal descent from an apical ancestress through the mother's line to the new generation. Made up of such subgroups as Ashanti, Fanti, Kwawu, Akwapim, Akyem and Bono (Brong), the Akan occupy the coastal south and forest zone of Ghana in West Africa and constitute about 44% of the nation's population of 20 million. Since descent is recognised through mothers from whose (menstrual) blood the individual is perceived to take his or her existence, members of a lineage (*abusua*) conceive themselves to have a metaphorical 'one blood' (*mogya koro*). A number of corporate lineages (*mmusua*), expressed as 'houses' (*efie*, sing. *ofie*), constitute every town or village in Akan society. Mutual support and cooperation are crucial for survival in the Akan matrilineal group, a tendency Meyer Fortes (1969 [1950]) describes as "prescriptive altruism". Deriving from relations in which respect and reciprocity are central features in family and household unity, there is a moral obligation to be there for members in times of need. The tendency for people to depend on others for help, and be similarly depended on, throughout their lives is a strong feature of the kinship or lineage organisation. M. J. Field (1960: 30) noted long ago that people who become successful "attract a retinue of partially or totally inadequate hangers on", whom she refers to as "economic passengers".

Most migration studies often focus on finding work or a source of income to improve one's financial situation. Such an approach focuses on the migrant as an individual actor who is following primarily personal purposes (Fleischer 2007). Mainstream analysis often overlooks intra-household dynamics that critically influence people's decision to migrate from the village to the urban areas for better living conditions. Individual persons' actions cannot be understood in isolation; they belong to households and the responses in many aspects of their lives, such as economic needs, cannot be understood in relation to the individual alone.

The connection between rural-urban migration, risky survival activities and HIV infections in sub-Saharan African societies has been well documented. Studies of the relationship between migration and high-risk sexual behaviour in Kenya (see Brockerhoff and Biddlecom 1999) and Zimbabwe (see Coffee et al. 2005) have found that the epidemic occurs geographically in areas with a high concentration of male migrant labour, and particularly among males and females who have high levels of heterosexual activity. In Uganda in the 1980s, labour reserves, as core developed areas with high rates of circulating migration for work, had quite a high incidence of AIDS cases (Hunt 1989: 362). Some authors argue that rural-urban migration in Africa leads to the removal of lineage controls over sexual behaviour, often placing a person in an environment conducive to high-risk activity (e.g. Smith 2001; Anarfi 1993). Examining sexuality, migration and AIDS in Ghana, John K. Anarfi (1993) argues that migration removes family restrictions on many young people who may not have the privacy for fulfilled sexual relations in the family homes in the villages. Sexual fulfilment is enhanced in the urban areas and this builds a tendency in the youth to abuse the social freedom from sexual restrictions (Anarfi 1993). He concludes that an appropriate policy for the control of the spread of AIDS in Ghana should be one which combines educational programs with strategies for removing the factors which compel young people to migrate. Similar findings of lack of village controls in urban centres and HIV infections have been recorded in Kenya (see Brockerhoff and Biddleton 1999). Thus, the migration of usually young unmarried adults from presumably 'conservative' rural environments to more sexually permissive African cities and towns is regarded as partly responsible for the high HIV levels in the continent.

Anthropologists who have studied migration and the risk of HIV have tended to focus on such broad structural and cultural variables as poverty, migration, gender and sexuality. Many studies of the social and cultural ramifications of HIV and AIDS also situate them mainly around the individual in regards to sexual networking, premarital and extramarital sex, and low condom use as the main arguments for HIV risks. But there are embedded variables in these broad structural arguments which often seem to be glossed over and remain largely unexamined. One such area is the role of kinship in migration and HIV infections. Of course, it is not easy to make inquiries into people's sexuality, one of the most private aspects of their lives. To connect it to kinship organisation and remain innocuous seems sensitive and tricky since AIDS is a highly-stigmatizing disease associated with what is largely seen as people's 'immoral' lifestyles. To avoid stigmatization, even words deemed politically and morally incorrect are being avoided, which has affected AIDS and its metaphors in a way that such earlier descriptions as 'AIDS victim' or 'AIDS carrier' have given way to 'AIDS patient' or 'persons living with HIV' respectively. A recent study of migration and AIDS in two Africa countries (see Ansell and Blerk 2004) focuses on how households or families affected by HIV/AIDS use children's migration, generally between households of the extended family, as a means of supporting the survival of both children and other relatives. This is a welcome study devoted to how HIV/AIDS affect migration, the social structure, and kinship organisation in Lesotho and Malawi.

In this article, I focus on how migration as a major feature in the search for better conditions of life in Akan society is tied to kinship and HIV, and how this further burdens other kin members who care for AIDS patients. I ground my approach in this article on Douglas Webb's (1997) point that broad structural explanations cannot account fully for the variability found at the local level and that there are many embedded variables, such as the kinship role in HIV infections, which need to be examined further. This article suggests an approach that grounds the risk of becoming HIV infected in the very nature of kinship (lineage) organization of Akan society. There is a high value attached to unity and cohesion in the matrilineal Akan group and members are expected to help the less fortunate ones. Helping in this way is a positive sign but these expectations can become a burden tied to HIV infections and in giving care to AIDS patients. The material here is from my doctoral research, fieldwork from February 2003 to March 2004 on HIV/AIDS, folk illness explanations, and the search for therapy in everyday lives among the Akan of Ghana. It is based mainly on qualitative methods of participant observation and in-depth interviews with many AIDS patients, four of whose case stories I use here to show how kinship morality and obligation put a burden on people to migrate, and how that is tied to HIV infections and care of AIDS patients. The term 'burden' is to be understood in everyday usage as the duty or responsibility that causes worry or difficulty, hard work, or stress.

### *Migration and AIDS in Ghana*

The first official cases of HIV-positive persons in Ghana were recorded in March 1986, among sex workers who had returned from neighbouring Cote d'Ivoire. Four years later, however, the rate of HIV-positive persons who had lived outside Ghana had decreased from 89 percent in late 1986 to 56 percent in 1990. As K. Anarfi (1993) has pointed out, this implied that the disease had moved from the introductory stage to the level of internal

circulation. Migration and HIV infections are still recorded; at the internal circulation level people infected with HIV are usually young and many have a history of travel (cf. Radstake 1997). The populations most affected with increasing rates of infection in the early stages of the AIDS epidemic in sub-Saharan Africa were in the urban areas. This continues to be the overall picture, portraying the spread of HIV/AIDS in sub-Saharan Africa in a diffusion pattern where most urban areas have higher incidence than the more rural areas. In Ghana, cities, mining towns and trading centres continue to show higher HIV prevalence rates than rural areas. Koforidua, the capital of Ghana's Eastern Region and a bustling town, was leading in HIV prevalence in 2002/2003.

In sub-Saharan Africa as a whole, there is a concentration of HIV/AIDS in southern Africa with a sliding gradient to eastern, central, and then western Africa (Yeboah 2007: 1130). The nexus of southern and eastern Africa has been called the 'AIDS belt'. Estimates of prevalence in some African countries in 2006 were as high as 33.4% in Swaziland, 24.1% in Botswana, 23% in Lesotho, 20.1% in Zimbabwe, 18.8% in South Africa, 6.1% in Kenya, 5.4% in Cameroon, 3.9% in Nigeria, and 3% in Ghana (UNAIDS 2007). It is believed that more than 350,000 people in Ghana (in a population of about 20 million) were living with HIV in 2007 (Yeboah 2007: 1130). The most vulnerable group is the fifteen to forty-nine year old age category with a prevalence rate of 7.0 percent, a sector which also forms the bulk of the country's labour force. These statistics are startling considering the abject poverty in which most people live in Africa and the inability of governments to provide safety nets for citizens (Yeboah 2007). Urban growth, migration, and high rates of HIV infection are experienced in almost all countries in the continent (Brockhoff and Biddlecom 1999).

Human mobility is considered a key risk factor for infection and the spread of HIV/AIDS. The association between migration of people from mostly rural areas to urban centres and the number of HIV infections has long been made in many poor societies. Paul Farmer's (1992) study in Haiti is one of the earliest on HIV and AIDS in a poor society which records many instances of poverty having driven people to seek better fortunes in urban areas where they later became infected. In Africa, migration has long been associated with the spread and epidemiology of infectious diseases (Hunt 1989). With regard to HIV, initial stages of the epidemic in sub-Saharan Africa showed that cases of infection in rural areas could be traced to those who had been in urban centres. Truck drivers who travel long distances are often associated with the transmission and spread of HIV because of their high degree of mobility (Orubuloye et al. 1993). As noted above, migration is indeed viewed as a strong catalyst to the spread of HIV in sub-Saharan Africa, where heterosexual contact and low use of condoms dominate the discourse on risk factors. In a study of the role of high-risk occupations in the spread of AIDS in Nigeria, Orubuloye and others (1993) found much sexual networking and low use of condoms among truck drivers and itinerant market women. A recent study of life in rural areas and work in urban settings in Malawi (Smith and Watkins 2005) showed that even though many Malawians are changing behaviours that are perceived as risky, sexual networking is still highly prevalent.

There have been quite significant successes regarding public awareness of the disease. State responses to HIV/AIDS are a critical part of reducing the death and devastation of the virus (Yeboah 2007). Uganda's success in reducing its HIV rate from about 20 percent in the 1980s to around 6.7 percent in recent years has been partly attributed to state action

to educate its citizens about the epidemic. In Ghana, educational campaigns about HIV/AIDS have done much to sensitize many people about the disease, its modes of transmission, and risks of infection. AIDS has no cure, and the emphasis on responses to it has been on prevention. People are being advised to lead healthy sexual lifestyles by practising 'safe' sex, grounded in the 'three commandments' widely known as the ABC method—Abstain from sex, Be mutually faithful to partners and Condomize. From the beginning of the HIV/AIDS crisis, non-governmental organisations (NGOs), community-based organizations (CBOs) and other civil society organizations have played an important role with community outreach campaigns to make people aware of the dangers about the epidemic. And yet, people migrating and leading lives that put them at risk for infections are still often recorded.

Migration can influence risk through exposure to high prevalence areas and people adopting risky sexual behaviour. In ten cases of patients' life stories, the majority had a history of travel from their rural origins to an urban area where they became infected. Eight out of the ten patients had travelled from the village to urban areas for paid work or trading activities. In the urban centres, all eight patients had engaged in sex with multiple partners or in unregulated sexual practices. Most of them were quite young, in their early 20s and 30s. The eight patients comprised five women and three men. In their stories, the women mostly resorted to sexual favours in order to survive and be able to help others in their families. In contrast, the men were promiscuous when they became quite successful financially after some time in the city. The remaining two, married women, were infected by partners who were suspected of becoming infected when they lived abroad or in an urban area in Ghana.

#### *Migration, kinship altruism, and burden*

**Case 1:** A young woman (27) was forced to enter into a number of relationships for money to help provide for her mother's four other children. She had moved from her village to Koforidua, some kilometres away in the Eastern Region of Ghana, in order to trade and make some money to support the others back in the village. The young woman did not make much, and she took male friends who gave her money in exchange for sex. She herself acknowledged that her lifestyle was what is seen in Akan society as waywardness. However, she argues that she had not 'done' it for her sake alone. She claims that her family members have benefited too because they were able to put up a few more huts in their household compound and bought household equipment that made life much easier for the whole family.

The young woman's case aptly shows the role of kinship obligations in people's lives and how they are related to HIV infection. Her support for the upbringing of others expresses the matrilineage's encompassing nature and individual members' chance to help and be helped. The holistic nature of the matrilineage is such that while the welfare of the individual is promoted, the common good of the group is emphasized. In a study of household characteristics in this research, migrants who were traders or wage earners in the urban centre of Nkawkaw gave monthly or occasional financial support to kin members back home in the village; only a few respondents did not remit to other relatives.

TABLE: Remittances by migrants in Nkawkaw

	Monthly/occasional remittances	No remittances	No answer	Total
Respondents	12	5	33	50
Percentage	24 %	10 %	66 %	100 %

The table above shows that twelve out of a total of fifty respondents (or 24%) gave monthly or occasional remittances; only five respondents (10%) did not give such support. The bulk of the respondents (thirty-three, representing 66%) did not give any answer in the survey questionnaire, which should not, however, be taken to mean that they do not remit to relatives back in the village. Rather, it shows a pertinent Akan value; the obligation to help others is almost a matter of course and to mention it could be seen as bragging about it, which is usually frowned on.

Refusing to help others in the family is often seen as not being generous or being apathetic to the group's welfare, which can sometimes produce bitterness and strife. From today's perspective it may be tempting to dismiss the idea of kinship altruism. Structural changes have occurred and individualism is gradually taking hold in many aspects of life in Akan society. People are becoming increasingly individualistic and many try to make it in life on their own, which undoubtedly minimizes the importance of kinship ties. The Akan are very much aware of the need to pursue individual goals, which they characterize with the well-known proverb that the family/lineage group is like a forest: *Abusua te se kwae, se wogyina akyiri a wo hu no se eb omu; wo pini ho a ena wo hu se dua biara si ne sibe*. This roughly translates as 'The family is like a forest; when standing afar it looks together but when you get closer you see that each tree stands in its own place.' This idea notwithstanding, extended family systems and strong kin and lineage relations remain important among the Akan, since they provide an inherent sense of belonging, solidarity, and protection. But they also involve expectations, obligations and responsibilities in the enactment of roles and duties. Thus, these relations provide a crucial mechanism in social control.

Not everyone sends money back home to the village when they feel they cannot make enough for themselves (cf. Bartle 1978). But many are those who strive to succeed and be able to support relatives left behind in the village because matrilineal kinship expectations persist strongly; people who migrate to urban areas due to economic needs pursue individual goals with 'helping the family back home' still on their minds because there are always 'economic passengers' left behind in the village. In this sense, an inherent burden associated with the Akan lineage system is the constant presence of the group's values in the lives of individual members, which constitutes a conceptual struggle between individualism and holism.

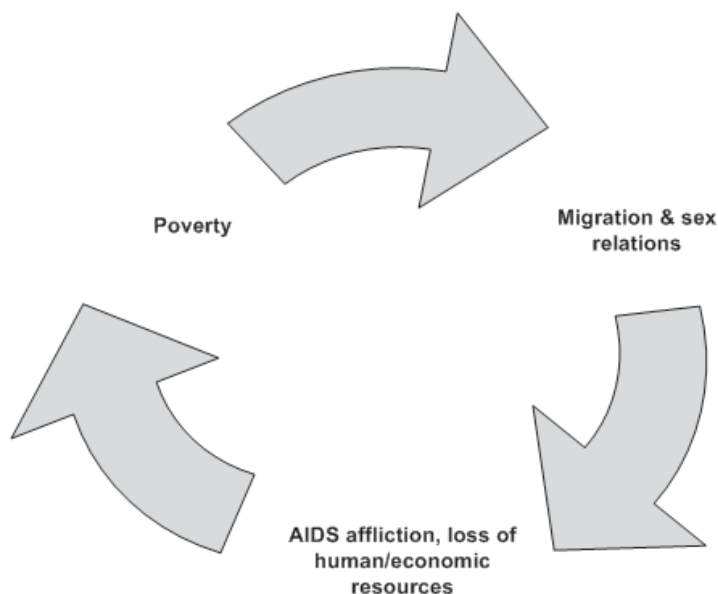
#### *Poverty, avoiding village life and ambiguities*

**Case 2:** When KB (26) completed elementary schooling at the age of eighteen years in 1995, he vowed not to remain in his home village for farming and the "village life" of hardships. He wanted to have a good standard of living and he moved from his village in the Kwawu area in the Eastern Region of Ghana to Accra, the country's capital city about two hundred kilometres south. Luckily, he found

a job as a shop assistant in Accra. From his earnings, he sent remittances back to the home in the village to supplement the household income. He worked and gave support this way for more than four years until he was diagnosed as HIV-positive, became ill with AIDS and moved back to the village.

This young man's story shows how the dynamics of the decision to migrate from the rural area to an urban environment can be strongly influenced by poverty and harsh village conditions. In one of the earliest studies of internal migration in Ghana, J. C. Caldwell (1968) found that young adults always dominate migratory movement from rural areas to urban places for economic purposes. Young men and women have always constituted a significant proportion of migrants. Given the high rates of unemployment in the villages, migrating young people look for alternatives in the urban centres. In order to understand the hardships in countryside, there is the need to consider the trends in the political economy of Ghana, the level of development, and labour migration. There are no employment opportunities in the villages except farming and subsistence consumption. The need for surplus wealth often necessitates migrating to urban areas for labour and commercial activities and foreign investment creates opportunities in and around cities, inducing rural workers to move to urban areas. Thus, the harsh economic conditions or unemployment and lack of opportunities in the villages push people to migrate to the cities. The quest for wealth and prosperity in Akan society is widespread and starts early in life. To become rich and live in affluence signifies a very successful life and is the goal of many people, although there is the worry these days that many young people are becoming increasingly avaricious.

Although there seem to be no specific figures on youthful rural-urban migration for labour and other commercial purposes in Akan society, it is believed that every year hundreds of people do move from their villages to the cities to find work. Poverty is widespread in Akan society and the rural areas of Ghana generally<sup>3</sup> and starts a vicious cycle. A graphic representation of such a trend would be:



Migrants in Akan society today are mostly the youth who complete early schooling but are faced with a lack of opportunities in the villages. Land is abundant and inalienable in Akan society. The nature of land tenure system in the rural areas is such that both men and women can easily acquire portions from family or lineage lands for cultivation. However, the subsistence mode of mainly hoe cultivation is unattractive because it does not make much money.<sup>4</sup> Superficially the combined effects of the lack of opportunities to earn cash, the boredom of rural life, the desire for possessions and new experiences, and the capacity to send remittances to kin members back home provide a strong incentive to migrate.

The model of the AIDS epidemic in Africa relies on an understanding of patterns of development in parts of the various African countries. In southern, eastern, and central Africa, for instance, the epidemic occurs geographically in areas where labour is concentrated (Hunt 1989). In the early stages of the South African epidemic, migration appeared to fuel HIV spread through geographic connectedness between locations with substantial differences in prevalence rates, such as migrant work sites and their rural homes (Coffee et al. 2007). The cities and other urban centres in Ghana provide paid work or trading activities. Migrating to such places has always been part of the strategies aimed at balancing competing needs and limited resources in the interest of preserving or improving the livelihood, consumption, health and social status of not only the individual but other kin members. Coping strategies are thus for individual and collective well-being. In the cities such migrants are expected to be successful and help others in the family back in the village. They become positioned individuals who help to provide for others. Consequently, older kin members in the villages usually encourage the youth to go to the cities to find work. Working in the urban areas and visiting home occasionally for funerals or festivals have become a symbol of status in many kin groups in Akan villages.

Individual successes in wealth or fame are almost equated with the honour of the lineage/family. Nevertheless, parents and other older people worry that the youth will copy what is seen as the corrupt life in the cities. The worry is over the lifestyles of people when they reside outside their home villages and are less under the scrutiny of kin members. Mothers of grown-up children working in Accra, Kumasi, and other urban centres were worried about their married sons' infidelity or the lifestyles of their daughters' husbands or prospective partners. A sixty-year-old woman in a village near Nkawkaw was worried about her married son who works as a teacher at Obuasi, a small gold-mining town in Ghana. "I know my son likes women too much", she said.

#### *Urban life, sex, and HIV infection*

**Case 3:** M.E. was a young woman who had dropped out of school at the age of seventeen. She had moved from her village to Tema, a bustling harbour town about 150 kilometres east in southern Ghana. She earned some money working with a woman in fishmonger business and was able to send some money back to her home village to support the upkeep of her four younger siblings. But she soon left Tema to find 'better prospects' in Accra, the capital city of Ghana some twenty kilometres west. In Accra, according to informants, "she changed men like she changed her clothes." After a few years, she was back in the village, ill and weak. An aunt of hers helped to take her to the hospital where she was diagnosed as HIV-positive.



This young woman's case indicates how many youngsters who move to the cities engage in sexual activities and become vulnerable to HIV infections. Much of the literature on HIV and AIDS in sub-Saharan African societies points to high incidences of sexual relationships, from multiple regular partnerships to non-regular, casual relationships among vulnerable groups such as sex workers and the youth in urban areas (Caldwell et al. 1989). Urban life in Ghana is often viewed as potentially dangerous in that it can corrupt the youth in two ways. First, successful people in the city are thought to easily fall prey to frivolous pleasures and fast life. People easily indulge in alcohol consumption, unscrupulous sexual relationships, and drugs. Recent media reports indicate that the sale and use of marijuana (locally called *wee* or *ntampɔ*), other dangerous narcotics, and alcohol consumption are on the increase among the youth in the urban areas. As in Malawi (Englund 2002), rapid political and economic transformations in Ghana in the 1990s account for the promise urban centres appear to hold for many people. As a consequence, the cities and towns in Ghana have become bustling market centres where vendors and various service providers are very visible. Urbanization in Ghana has moved at a fast pace since the 1970s, propelled by small-business trading rather than by industrialization. Many youths have become petty traders engaged in street vending with such items as dog chains, electrical gadgets, clocks and wrist watches.<sup>5</sup> The second factor is a more serious problem with migrants who do not find jobs or the many more who have no form of regular income. It is little wonder that high rates of armed robbery, pick-pocketing and other crimes in Ghana today are thought to be the result of the increasing number of unemployed youths in the urban areas.

During the 1980s, AIDS responses focused primarily on risk—the probability of a person becoming HIV infected—and risk reduction. Simon Watney (1989: 67) has reminded us that to think in terms of 'high-risk behaviours' re-emphasizes modes of transmission that are also retributive and, following Watney who suggests that instead of 'risk', we should be talking of 'vulnerability', I would like to take this idea a little further. The onus of Watney's argument is that people do not merely engage in risky behaviour but rather that societal factors render some people vulnerable to HIV infections. His concern is understandable in respect of the blame games, politicization, racist, nationalist, class, gender and sexual orientation undertones that have surrounded AIDS from its recognition almost three decades now. However, one can also argue that vulnerability is often the result of risky situations.

For some time now, the focus of attention in the responses to AIDS has been shifting from risk reduction to considerations of how vulnerable some people are to HIV infections. Individual risk is perceived to be influenced by societal factors that increase vulnerability to HIV infection of certain individuals and sections of society more than others (UNAIDS/FAO 1999). Vulnerability theory in health studies suggests that adverse life situation such as poverty, hunger and disease does not affect social groups evenly. For instance, while all human beings are biologically at risk for HIV infection, certain social and economic factors put some individuals and social groups at greater risk than others (Parker 1996; Oppong 1998). Economic desires and unemployment drive vulnerable groups of people into risky survival activities, although paradoxically people who become successful in the urban places may take to carefree lifestyles that are equally risky. Such instances trigger support for the view that behavioural interventions based on reasoned persuasion in the HIV/AIDS campaigns are insufficient to produce risk-reducing behaviour change.

When people migrate in Akan society they mainly seek out kin members, the friends of their kin members, or their own friends with whom they associate in the host location (cf. Bartle 1978). However, they usually move out after some time to be on their own. Under no strict surveillance, they are then free to engage in pre-marital sex (Anarfi 1993). Some girls target rich men for relationships even if they are other women's husbands. The wish is to have a child and gain the man's commitment for its upkeep, if not a possible marriage. The common assumption is that such attitudes trigger the high rates of pre-marital and extra-marital sex. Unfortunately, such practices are common and are virtually viewed as a normal way of life.

Sexual networking is highly prevalent in the urban areas of Ghana. Casual relationships are generally not respected and yet they are common. Both males and females may have more than one sexual partner and a lot of sexual activities occur among the youth and others such as porters at transport stations, traders and hawkers (Anarfi and Antwi 1995). Women's attraction to men for economic gain is seen as a necessary evil (Nabila and Fayorsey 1996). Gender inequality, particularly the low socioeconomic status of women and their vulnerability in terms of sexuality, is perceived to have increased HIV prevalence rates generally in Ghana. Existing data show that women are infected with HIV in significantly greater numbers than men. The rate of HIV in women aged 20 to 29 is higher than in men of the same age group. According to current figures from the United Nations Programme for HIV/AIDS (UNAIDS), of the approximately 350,000 people infected with HIV in Ghana, around 180,000 are women (UNAIDS/WHO 2007). Indigent young women become particularly vulnerable as a consequence of gender inequality and poverty and they may become sex workers or, as it usually happens, they resort to sexual favours for money to survive. For many young women, economic or educational motivations to migrate may necessitate reliance on men, usually older men, for more financial resources (Caldwell et al. 1989). Others without education, marketable skills or knowledge of any income-generating opportunities resort to informal or formal transactional sex as the means readily available for money for self-support and in order to send remittances to relatives in the village (Anarfi 1993). Some girls visit hotels or go to a man's home for paid sex (Anarfi and Antwi 1995).

The risk of HIV infection rises due to such factors as the high prevalence rates in urban areas, the number of sexual partners and encounters, the probability of encountering HIV-infected sexual partners, and other risky sexual lifestyles. However, although cultural restrictions against sexuality are no longer strictly enforced, the very nature of the social organisation of the Akan puts a brake on some excesses. The absence of family pressure and a general breakdown of traditional structures in the urban areas are cited for the risks of HIV infection (e.g. Anarfi 1993). Such issues about rampant and dangerous sexual relationships in the urban areas of Ghana and other African societies somehow justify the point by Caldwell and others (1989) that the failure to attach any moral value to sexual activity accounts for the high prevalence of HIV in the continent. But the criticism (e.g., Ahlberg 1994) against Caldwell and his collaborators for not taking into consideration African societal taboos and prohibitions about sexuality which have become outmoded today because colonialism and Christianity viewed such native customs as superstitious is equally plausible.

For instance, in Akan society many traditions, customs and beliefs prohibited premarital sex. In the past puberty rites (*bragoro*), for example, were performed after menarche by the

matrilineal kin members, supervised by elderly women, to mark a girl's entry into physical maturity—where she was ready to become a wife and a mother (Sarpong 1977). Betrothals (*asiwa awaree*), where a girl was promised usually to an older future husband, were common, and aimed to minimise premarital sex or promiscuity on the part of the girl. Marriage (*awaree*) is important to produce children and it also brings respect to both men and women. Although sex outside marriage was common in the past, it was largely frowned on if it was not meant for procreation. A society which values high fertility, nevertheless, recognized birth within marriage or in an approved cohabitation. Thus, sexual relations and pregnancy occurred in socially recognized relationships. But most of the traditional practices are not accorded the same significance as previously, owing to the combined impact of the teachings of Christianity, Western education and urbanization (Sarpong 1977).

*Back to village with AIDS: kinship and the burden of care*

**Case 4:** A twenty-eight-year-old woman suspected that she was infected in early 1990 at Koforidua where she worked after completing school in her hometown, a village about fifty kilometres northwest. As a paid worker she sent remittances back home for the upkeep of her own child, as well as her sister and her child. She claimed she had been unlucky in her relationships with men. After her infection she moved back to her home village in 2003 and was cared for mostly by members of her matrilineal group. Her biological mother was dead but there were other kin members to care for the patient. Her mother's brother (*wɔfa*) and his wife provided financial support and other logistics but the bulk of practical care, such as massaging the patient and helping her to eat, was undertaken by the patient's eighty-year-old classificatory grandmother (her grandmother's sister).

Beneath the care the elderly woman felt a huge sense of frustration. She felt that she was too weak herself to be taxed with caring for her weak patient. This was such a problem to the octogenarian that one day she expressed the wish that the patient would die quickly to alleviate the burden of care placed on her.

Although the old woman's comment on the plight of the young dying woman, her 'grandchild', may at first hearing sound inhuman, such utterances provide clear indications of the burden borne by such care givers. The frustration they go through may trigger cruel-sounding comments about their afflicted relatives. I have discussed elsewhere (Crentsil 2007) the trend whereby people who have become infected in urban areas move back to their villages to receive care from kin members. The nature of care-giving in Akan society is such that mothers, aunts, and female cousins usually provide the bulk of practical care in day-to-day activities like massaging, bathing, and feeding the AIDS patient at home while men usually provide the financial aspect of such support. As women, they are also those on whom the bulk of household chores fall. Thus, there is a feminization of AIDS care that further burdens women.

Such care-giving by non-professional people at home, which constitutes informal care, differs from home-based care as advocated by the World Health Organisation (WHO). The WHO recognizes that home visits are important as part of an integrated programme which offers the patient and his or her family health services in the home. Consequently, the world health body highly supports community and home-based care for AIDS patients in developing countries. Home-based care involves health workers of hospitals where AIDS-

afflicted persons are out-patients in which a health team will visit the home of a patient and make inquiries about the patient's general condition. At Nkawkaw, for instance, a health team from the Holy Family Catholic Hospital visits patients every other Wednesday in the various villages and towns in the Kwawu area. Members of the team inquire about the sick person's condition and medicines received after counselling sessions at the hospital every other Thursday. They sit for some time with the patient and discuss practical or emotional problems affecting the sick person and his or her family members.

Informal care (that is, by non professionals) and home-based care are necessary because hospital care is not always available or accessible in Ghana. Care by relatives is also enhanced since patients who are diagnosed as HIV-positive become out-patients of the hospital. No patient is hospitalised; in-patients are only hospitalised when they have developed worsening AIDS-related conditions. This model gives rise to a number of issues associated with the practical care provided by women in the home. Normative assumptions in traditional societies categorize men as 'breadwinners'; women's roles as carers for the family and the sick are unpaid. Gender theorists, social scientists, and others in health studies continue to question why women's substantial work in the informal sector generally, and care-giving in particular, is undervalued. A joint report by the UNAIDS, UNFPA, and UNIFEM, posted in the website of UNFPA, bemoans the fact that poverty reduction strategies and national AIDS plans seldom take women's care-giving into account. Care-giving "remains unpaid and therefore undervalued in economic terms", the report points out (UNAIDS, UNFPA and UNIFEM 2004: ch.4<sup>6</sup>).

The practical burden aside, care-giving lends itself to moral evaluation, extending the motivation to care for a sick relative beyond notions of kinship amity in Akan society. Highly psychological, it concerns the fear of gossip or castigation from other people and forces relatives to care for a sick kin member even against inclination. One woman who was resentful when her brother, an AIDS patient, complained about the care given to him, said the patient would have been left to his fate but for fear of criticism from people. Health and illness being both social and medical issues in Akan cosmology, they are of concern to kin members and the community. Consequently, not caring for a sick kin member is seen as an affront. In the ten cases observed closely in this study, all were cared for by kin members, especially by mothers, but one patient was later abandoned.

#### *HIV/AIDS and contradictions in Akan kinship morality*

There is an increasing burden on women linked to contemporary uncertainty about their roles as reproducers of the matrilineage. How can they know if the men they meet in the urban areas and socialize with are infected? How can they be sure that their husbands working in the cities do not engage in unprotected sex and risk being infected? And yet the matrilineal group must grow—an ideology which in itself threatens the campaign on condom use. There is indeed a low condom culture in Ghana.

The frustration associated with care-giving, disappointments and disagreements, stigmatization and abandonment of AIDS patients and orphans who are taken in by orphanages, suspicions or accusations of witchcraft by kin members as the cause of patients' affliction, all indicate rancour and an inherent burden on others. What is perhaps more frustrating and inherently burdensome is caring for a chronically-ill person. Since caring

for a sick person can be a very stressful task, more so with AIDS patients who mostly become so weak that they must rely on their carers in order to move about, many carers become visibly frustrated. But, as I have already indicated, to refuse to care for a sick relative is almost seen as anathema in Akan society, no matter what the reason(s). Thus such carers are virtually caught between the devil and the deep blue sea.

In sum, there is the burden created by 'the pulls of matrilineal descent', to use Mary Douglas's words, which contributes to the risk of HIV infection in the first place, and then there is the burden on other people in the care of (or non-care of) the AIDS patients. Hence, if poverty becomes a vicious cycle, so does burden, expressed in the guise of reciprocal obligation on the individual. In expectation of becoming successful and being able to support others, people often migrate to the urban areas for work. Their survival activities, HIV infections and affliction with AIDS in turn put a burden on others to care for the patients.

#### *Migration, kinship obligation, and HIV*

Economic needs, kinship obligations and expectations, migration to the cities, and risky survival activities that render vulnerability to HIV infections are intricately connected. The effect of migration on the spread of HIV/AIDS in Akan society is significant. The role of kinship obligations and expectations, in socio-economic aspects of sexual behaviour (especially by young women) as a strategy to support the individual and other relatives in the village is equally significant and needs to be studied further. This also concerns poverty, political economic issues and gender inequality.

There are unduly burdensome expectations of people who migrate to the cities to be successful for the honour of the family or lineage, which forces many young people into risky survival activities that also increases the risk of contracting HIV. Family pressures (in the guise of reciprocal moral obligations) that recur in the stories of AIDS patients in Akan society are too salient to ignore in the campaigns on the disease. Household campaigns about this could be introduced to the existing strategies of HIV prevention.

Poverty and lack of working facilities in the rural areas, which necessitate moving to the cities and risking HIV infections, point to one important consideration: there is the need to improve conditions in the rural areas to encourage many to remain and work in the villages. A vigorous effort in HIV prevention is needed with wide-ranging measures to improve the living standards of people in the rural areas. If people find decent jobs in their villages without having to leave their families and communities, it will undoubtedly help to reduce infection rates. There have been moves towards this goal in recent times by the Government of Ghana, exemplified by the setting up of such rural enterprises as the Ayensu Starch Factory under the President of Ghana's Special Initiative Programme. However, it is the view of many that all too often such rural development policies and programmes are unattractive, with hasty stop-gap measures designed only to score political points. It is the opinion of many that the unattractive conditions at the starch factory make the youth there leave for the cities 'for better opportunities for money'. Establishing well-planned, attractive programmes in the rural areas will surely encourage the youth to stay in their villages. In addition, there are many NGOs in Ghana who give support to women's groups. Similar efforts could be channelled to lineage groups to establish farms and other small-

scale agro-based businesses in their villages. When people have the means to earn money in their home villages it will undoubtedly discourage them from migrating to the urban areas and engaging in risky activities for survival. At the same time, people will not put all their hopes on kin members who migrate.

There is a general breakdown of traditional structures in Akan society, which may be dangerous in regards to vulnerability to HIV, as Anarfi (1993) points out too. Certain cultural values that used to restrict people's (sexual) behaviour have been abandoned, have lost or are losing their effectiveness. As I have suggested elsewhere (Crentsil 2007), the family/lineage needs to reform itself as a socializing institution and a vigilante for the moral uprightness of its members. Interpersonal dialogues need to move from individual targets to members of households as part of the campaign to prevent HIV infections.

#### NOTES

<sup>1</sup> A shorter version of this article was presented as a paper, The hidden burden: kinship, migration, and HIV/AIDS among the Akan of Ghana, at the Multidisciplinary Symposium on Global Health Research, Tampere, Finland in September 2006. The research received funding from the Academy of Finland, Kone Foundation and a travel grant from the Nordic Africa Institute in Uppsala, Sweden.

<sup>2</sup> Rural-urban migration is more common in Ghana, although there are other forms of internal migration—rural-rural, urban-rural, and urban-urban. This article concentrates on rural-urban migration.

<sup>3</sup> Ghana is ranked as a poor country with more than a third of its population living below the poverty line. The 2005 Human Report of the United Nations Development Programme (UNDP) rates Ghana 138th in human poverty among a group of sub-Saharan Africa's poor and in an overall 175 countries in the world (UNDP 2005).

<sup>4</sup> In 2003, the conservative estimate for the highest yield from a one-acre farm in the Kwawu area during the crop season (March to September) was 400,000 cedis (about 46.50 US dollars in 2003).

<sup>5</sup> Such petty traders, including market women, butchers and lorry operators, have become a social group lumped together as belonging to Ghana's informal sector (Nugent 1995). The informal sector, a concept adopted by the International Labour Organisation (ILO) in 1972 in a study of the Kenyan urban economy, is used to describe the urban economic system. It refers to economic activities outside of the regulated private or government establishments.

<sup>6</sup> See <<http://www.unfpa.org/hiv/women/report/chapter4.html>>

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ACRONYMS

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AIDS	Acquired Immune Deficiency Syndrome
FAO	Food and Agriculture Organization
HIV	Human Immuno-deficiency Virus
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNIFEM	United Nations Development Fund for Women
WHO	World Health Organisation

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