Building HIV/AIDS Competence in Ghana- Traditional Leadership and Shared Legitimacy:
A Grassroots Community Intervention Best Practices Model- With Some Preliminary Comparisons to South Africa and Botswana

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<u>Introduction</u>

The Joint Programme on HIV/AIDS of the United Nations (UNAIDS) and the World Health Organization (WHO) reported in December 2003 that there are approximately 40 million people in the world currently living with HIV/AIDS. Of this figure, approximately 95% live in developing countries with 70% living in sub-Saharan Africa. HIV/AIDS has potentially devastating implications for developing countries and economies. All productive resources, human and capital, must therefore be mobilized in the fight against HIV/AIDS. Communities in developing countries that are profoundly affected by HIV/AIDS, such as Ghana, are increasingly exploring local and grassroots initiatives that address many of their educational, support, and resource needs. AIDS competence involves the notion that communities can become empowered to create and implement successful AIDS prevention and support programming and initiatives. Further, AIDS competence arises from the actions that communities take to mitigate or alleviate risks to that community. As the case of Ghana will show, traditional leaders can play effective roles developing local AIDS competence through their involvement in mobilizing and delivering HIV/AIDS educational, support and resource initiatives.

The main argument of this paper is that because African chiefs (i.e. traditional leaders) have their own special historical and cultural sources of legitimacy or credibility, traditional leaders can play important roles in the development and implementation of HIV/AIDS policies and programs. Traditional leaders are part of the indigenous political and social structures that predate colonialism and the contemporary post-colonial state. In many African countries, governance is shared asymmetrically between the post-colonial state and traditional leaders because of the divided nature of legitimacy and sovereignty. Using the involvement of traditional leaders in Ghana in HIV/AIDS programs, the involvement of traditional leaders in the

implementation of existing governmental and other-run development and HIV/AIDS programs could increase program success rates because traditional leaders could add their legitimacy or credibility in convincing their subjects of the usefulness of these programs. If traditional leaders are to play a more prominent role in the implementation of HIV/AIDS and development programs in Africa, first we need to confirm and analyze the actual participation of traditional leaders in HIV/AIDS programs. This paper thus examines the participation and inclusion of traditional leaders in HIV/AIDS programming and policy apparatus in Ghana examined, and provides some preliminary comparisons with Botswana and South Africa. These three countries are analyzed in this paper because they were selected as the three country studies for the International Development Research Centre of Canada-funded research project, "Traditional leadership in Local Governance and Social Policy in West and Southern Africa" that is being carried out by the Traditional Authority Applied Research Network (TAARN). This paper utilizes the conceptual framework developed in the book, <u>Grassroots Governance? Chiefs in Africa and the Afro-Caribbean</u> (see attached information) and demonstrates how traditional leaders in Ghana have contributed to the development of AIDS competence in local communities, and thus serves as a grassroots community intervention best practices model.

<u>Section I: The Global Scope and Nature of HIV/AIDS: Ghana, Botswana and South Africa</u>

In the 2003 update on the global HIV/AIDS situation released in December 2003, the United Nations Joint Programme on HIV/AIDS (UNAIDS) and the World Health Organization reported that there are 40 million people in the world living with HIV/AIDS (See Figure 1.0 based on UNAIDS, 2003,3). The report notes that despite active and increasing HIV/AIDS prevention efforts in multiple sectors, there have been increases in HIV prevalence and incidence rates in many countries. There have also been continued increases in the number of people living

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with HIV/AIDS and AIDS deaths, most notably in sub-Saharan Africa, especially in Southern

Africa (UNAIDS, 2003: 2). Other regions that are witnessing increases in HIV/AIDS prevalence

rates include Asia, Eastern Europe and Central Asia (UNAIDS, 2003: 2). Growing epidemics are

being reported in China, Indonesia, Papua New Guinea, Vietnam, several Central Asian

republics, the Baltic states and North Africa. (UNAIDS, 2003, 5). In terms of prevalence rates,

sub-Saharan Africa has the highest prevalence of HIV/AIDS at 7.5-8.5% (See Figure 2.0),

followed by the Caribbean at 1.9-3.1%. In terms of absolute numbers, sub-Saharan Africa has the

greatest number of people (adults and children) living with HIV/AIDS in the world (25-28.2

million), followed by the South and South-East Asian region that has approximately 4.6-8.2

million people currently living with HIV/AIDS. (UNAIDS, 2003, 5). The 2003 report also shows

that the number of AIDS deaths has been growing, corresponding to increases in prevalence

years ago and poor access to life-prolonging antiretroviral medications (UNAIDS, 2003, 12).

Thus, the combination of high (and for some, rising) rates of AIDS mortality and continuing high

HIV incidence has resulted in stable rates of HIV prevalence (UNAIDS, 2003, 13).

Figure 1.0
Global Summary of the HIV/AIDS Epidemic (December 2003)

Number of people living with HIV/AIDS	Total 40 million (34-46 million) Adults 37 million (31-43 million) Children 2.5 million (2.1- 2.9 million) Under 15 years
People newly infected with HIV in 2003	Total 5 million (4.2-5.8 million) Adults 4.2 million (3.6-4.8 million) Children 700 000 (590 000-810 000) Under 15 years
AIDS Deaths in 2003	Total 3 million (2.5-3.5 million) Adults 2.5 million (2.1-2.9 million) Children 500 000 (420 000- 580 000) Under 15 years

Source: Joint United Nations Programme on HIV/AIDS & World Health Organization. 2003. AIDS Epidemic Update, December 2003. Geneva, Switzerland, p.3.

Figure 2.0
Regional HIV/AIDS Statistics and Features, End of 2003

Region	Adults and Children Living with HIV/AIDS	Adults and Children Newly Infected with HIV	Adult Prevalence (%) (Proportion of adults 15-49 living with HIV/AIDS in 2003)	Adult and Child Deaths due to AIDS
Sub-Saharan Africa	25-28.2 million	3.0-3.4 million	7.5-8.5%	2.2-2.4 million
North Africa and Middle-East	470 000 to 730 000	43 000- 67 000	0.2-0.4 %	35 000 –50 000
South and South-East Asia	4.6- 8.2 million	610 000 – 1.1 million	0.4 – 0.8 %	330 000- 590 000
East Asia & Pacific	700 000- 1.3 million	150 000 – 270 000	0.1- 0.1 %	32 000- 58 000
Latin America	1.3 – 1.9 million	120 000 – 180 000	0.5- 0.7 %	49 000 – 70 000
Caribbean	350 000- 590 000	45 000- 80 000	1.9 – 3.1 %	30 000- 50 000
Eastern Europe & Central Asia	1.2 – 1.8 million	180 000 – 280 000	0.5 – 0.9 %	23 000 – 37 000
Western Europe	520 000 – 680 000	30 000 – 40 000	0.3 – 0.3 %	2600- 3400
North America	790 000 – 1.2 million	36 000- 54 000	0.5 – 0.7 %	12 000 – 18 000
Australia & New Zealand	12 000 – 18 000	700 – 1000	0.1 – 0.1	< 100
TOTAL	40 million (34- 36 million)	5 million (4.2 – 5.8 million)	1.1% (0.9% - 1.3%)	3 million (2.5 – 3.5 million)

Source: Joint United Nations Programme on HIV/AIDS & World Health Organization. 2003. AIDS Epidemic Update, December 2003. Geneva, Switzerland, p.3.

HIV/AIDS: The Challenge for Sub-Saharan Africa

Across the African continent, HIV prevalence varies considerably. It ranges from less than 1% in Mauritania to nearly 40% in Botswana and Swaziland. As shown in Figure 2.0, in both absolute numbers and as a percentage of the total population (HIV prevalence), HIV/AIDS has massively and disproportionately afflicted sub-Saharan Africa. In 2003, an estimated 26.6 million people in sub-Saharan Africa were living with HIV/AIDS, including the 3.2 million who became infected during the previous year. AIDS was responsible for the deaths of approximately 2.3 million people in sub-Saharan Africa in 2003. (UNAIDS, 2003, 7). Furthermore, the number of people living with HIV/AIDS in sub-Saharan Africa has continued to rise, (UNAIDS, 2003, 12) which means that more people than ever are requiring care and support while living with HIV/AIDS.

Southern Africa

In sub-Saharan Africa, the Southern African region contains many of the highest levels of HIV prevalence. Botswana, Lesotho, Namibia, South Africa, Zimbabwe, Zambia and Swaziland have the highest rates of HIV prevalence in the world (World Health Organization, 2003). Antenatal clinic data is used to determine HIV prevalence (See Figure 3.0). According to this data, more than one in five pregnant women are HIV-infected in countries of Southern Africa, while elsewhere in sub-Saharan Africa median HIV prevalence in antenatal clinics exceeded 10% only in a few countries. (UNAIDS, 2003, 7, & refer to Figure 3.0 for adult antenatal prevalence rates in Africa). Because sexual activity tends to start earlier for African women, and because HIV is more easily transmitted from men to women than women to men, and because young women tend to have sex with older partners, African women are more likely- at least 1.2 times- to be infected with HIV than men. Among young people aged 15-24, this ratio is highest: women were found to be two-and-a-half times as likely to be HIV-infected as their male counterparts (UNAIDS, 2003, 7). There are urban-rural differences in HIV prevalence. Among pregnant women in rural areas in Southern Africa, HIV prevalence is significantly lower for urban women (UNAIDS, 2003, 8).

West Africa

West Africa has lower prevalence rates than other regions in Africa, with the exception of North Africa. However, prevalence rates are still higher in West Africa than for many other countries and regions around the world. Population-based and other surveys suggest that adult HIV prevalence levels remain relatively low in countries of the Sahel, around 2% in Mali, and 1% or lower in Gambia, Mauritania and Niger (UNAIDS, 2003, 11). At the end of 2001, the

highest prevalence rates in West Africa are in Cote D'Ivoire (around 10%). (UNAIDS, 2003, 12).

Figure 3.0
Adult HIV Prevalence (%) among women attending antenatal care clinics in Africa

Country	Year	All Locations	Capital City	Other Urban Locations	Rural Locations
Southern Africa					
Angola		2.4	3.2		
Botswana	2002	35.4	40.2	32.8	37
Lesotho	2000	20.9	42.2	22.5	19
Malawi	2001	16.9	28.5	18.6	11.3
Mozambique	2002	13.7	18		
Namibia	2002	22.5	26.7	25	22
South Africa	2002	26.5	31.6		
Swaziland	2002	38.6	41.2	40.6	35.9
Zambia	2002	20.4	26.9	27.7	9.9
Zimbabwe	2001	30.4	30.4	29.7	29.7
Eastern Africa					
Burundi	2001	5.6	16	8.7	1.6
Ethiopia	2001	11.2	16.2	12	1.7
Kenya	2002	6.5	14.2	14.3	6.3
Rwanda	2002				
United Republic of Tanzania	2002	8.1	11.5	9.8	4.2
Uganda	2001	5.6	10		
Central Afrca					
Cameroon	2000	10.3	10.3	5	11.1
Central African Republic	2002	14.8	15	12.8	16.5
Chad	2002	5.3	7.5	4.7	5.5
Congo	2002	4.3	3.6	5.2	
Democratic Republic of Congo	2002	3.6	2.9	3.7	
Gabon	2002		9		
Western Africa					
Algeria	2000	0.2			
Benin	2002	1.9	2.3	2.5	1.4
Burkina Faso	2002	4.6	4.7		

Cote D'Ivoire	2002	7.3	7.4	10.3	5.8
Gambia	2001	1.3			
Ghana	2002	3.4	4.1	3.4	3.2
Guinea	2001	2.8	1.9		2.8
Mali	2002	3.4	3.4	3.5	
Mauritania	2000	0.4	0.3		
Niger	2000	2.3	2	2.2	5.5
Nigeria	2001	5.1	2.6	4.5	5.3
Senegal	2002	1.1	1.1	1.2	
Togo	2000				2.2

SOURCE: World Health Organization Regional Office for Africa. 2003. HIV/AIDS Epidemiological Surveillance Update for the WHO African Region 2002 Country. Harare, Zimbabwe: World Health Organization. Chapter 3, p.10.

HIV/AIDS situations in Ghana, Botswana and South Africa

Ghana

In 2002 in Ghana, the adult (ages 15-49) HIV prevalence rate was 3.0%. Ghana has been demonstrating stable trends in its HIV prevalence rates. Median HIV prevalence rates among pregnant women have fluctuated between 2% and just over 3% since 1994 (and barely exceeding 4% in the capital, Accra, in 2002). (UNAIDS, 2003, 11). In Accra, HIV prevalence increased from 0.7% in 1992 to 3.1% in 2000, while in Kumasi, HIV prevalence has been fluctuating and was 3.8% in 2000. In Tamale, HIV has slowly risen from 1.0% in 1994 to 1.3% in 2000. Outside of the major urban areas, HIV prevalence increased, from 1% in 1991 to 3% in 1998. In 2000, prevalence in 18 sites ranged from 1% to 7.8%. Both HIV-1 and HIV-2 exist in Ghana with HIV-1 being the predominant type. The rates of HIV prevalence are considerably higher among selected population groups, such as sex workers, long-haul transportation drivers, mining and migrant workers. For sex workers in Accra and Tema, HIV prevalence by 1997/8, had reached 74.2% among 'seater' sex workers and 27.2% among the 'roamer' sex workers.[1] In 1999, sex workers in Kumasi had an HIV infection rate of 82%. (UNAIDS/WHO, 2002, 2). The major mode of transmission of HIV/AIDS is heterosexual intercourse. In terms of reported AIDS cases by 2002, 61.4% were female and 38.4% were male. West Africa, including Ghana, has not

escaped the impact of the HIV/AIDS pandemic, and is in fact an area where opportunities for intervention for prevention of new infections, may be successful in stemming the tide of the HIV epidemic. The active and growing presence of traditional leaders in social marketing campaigns against HIV/AIDS in Ghana, which had a prevalence rate of 3% in 2002 suggests that the effectiveness of traditional authority in HIV/AIDS strategies deserves further investigation.

Botswana

In 2002, the adult (15-49) prevalence rate in Botswana was 38.8%, the highest prevalence rate of HIV in the world (UNAIDS/WHO, 2002A, 2). Major urban areas in Botswana include Gaborone, Francistown and Selebi-Phikwe. In Gaborone, HIV prevalence increased from 14.9% in 1992 to 39.1% in 2001 while in Francistown the increase was from 23.7% in 1992 to 44.9% in 2001. In Selebi-Phikwe, HIV prevalence doubled from 27% in 1994 to 55.6% in 2001. Sites outside the major urban areas are also experiencing increasing HIV infection trends. In 2001, median HIV prevalence in areas outside the major urban areas was 38.6% with rates ranging from 26.4% to 50.9%.

The involvement of traditional authorities in HIV/AIDS campaigns in Botswana appears to be more limited than in Ghana. However, political commitment, leadership and response policies and programming are strong and growing. Public-private partnerships have been established and prevention and treatment efforts are well-mobilized and funded. Response policies and programming are coordinated and supported by international and non-governmental funding and delivery agencies. The urgency of the crisis in Botswana demands a full-scale and sustained response through a coordinated and multi-sectoral response. Section three examines the Government's National policy framework. While traditional authorities appear to play a more

minor role in policy and program design and implementation, the national policy framework recognizes them as stakeholders in the Botswana HIV/AIDS policy process.

South Africa

Based on the country's latest antenatal clinic-based surveillance, it was estimated that 5.3 million South Africans were living with HIV at the end of 2002. (UNAIDS, 2003, 9). Surveillance data reveal that the average rate of HIV prevalence in pregnant women attending antenatal clinics has remained at roughly the same high levels since 1998, ranging between 22% and 23% in 1998-99 and then higher at 25% from 2000-2002 (UNAIDS, 2003, 8). The Gauteng province has the highest numbers of people living with of HIV/AIDS, with a rate exceeding 30%.[2] In five of the country's nine provinces at least 25% of pregnant women are now HIV positive. (UNAIDS, 2003, 8). HIV prevalence is highest for Kwa-Zulu Natal province at 37%. HIV infections rates are increasing in KwaZulu-Natal, Mpumulaga and Gauteng provinces. In other provinces, HIV prevalence rates seem to be stabilizing at rates ranging from 11.2% to 27.9. Clearly, South Africa is experiencing a severe epidemic, and in many parts of South Africa, the epidemic does not appear to be showing signs of receding.

Upon an examination of the inclusion of traditional leaders in national HIV/AIDS policy and programming strategies, there appears to have been little inclusion of traditional leaders in national policy and programme design and implementation. However, there have been recent changes and initiatives, most notably in the provinces and in non-governmental organizations (NGOs), For example, the traditional leaders project of the Nelson Mandela Foundation[3] aims to include and educate traditional leaders in the implementation of HIV/AIDS education, prevention and anti-stigmatization activities. Further, traditional leaders' task forces in Kwa-Zulu Natal are being developed, with the objective of educating traditional leaders on HIV/AIDS

prevention, treatment and support. These task forces have been established and coordinated by the provincial government and traditional leaders. Information and training workshops have already been conducted across the province. These initiatives are in their early stages, but suggest that traditional leaders in South Africa are increasingly being regarded as integral to the fight against HIV/AIDS.

Figure 4.0
Economic, Social, and Health Indicators from Ghana, Botswana and South Africa

Indicator	Ghana	Botswana	South Africa
Total Population 2002	20,741,000	1,770,000	44,759,000
Population aged 15-49 (in 2002)	10,117,000	900,000	24,146,000
% of urban population	38	Data not available	50
Average Annual Growth Rate of Urban Population (1995-2000)	4.0	3.0	1.9
% Gov't Budget Spent on Health Care (1998)	9.0	5.5	11.6%
Per Capita Expenditure on Health (1998)	$19	$127	$230
Adult Literacy Rate (1997)	68	75	84
Male Literacy Rate (1997)	78	72	85
Female Literacy Rate (1997)	58	77	84
Life Expectancy at Birth (1995-2000)	56	44	57
Infant Mortality Rate (per 1000 live births) 1995-2000	69	74	58
HIV/AIDS			
Estimated Number of Adults and Children living with HIV/AIDS at the end of 2001	360,000	330,000	5,000,000
Estimated Number of Adults (Women and men aged 15-49) living with HIV/AIDS at the end of 2001	330,000	300,000	4,700,000
Estimated Number of Children (0-15) living with HIV/AIDS at the end of 2001	30,000	28,000	250,000
Adult Rate (Women and men aged 15-49 living with HIV/AIDS at the end of 2001)	3.0%	38.8%	20.1%
Estimated number of deaths to AIDS in 2001 (adults and children)	28,000	26,000	360,000
Estimated number of children who lost their mother or father or both parents to AIDS and who were alive and under age 15 at the end of 2001	200,000	69,000	660,000

Source: Joint United Nations Programme on HIV/AIDS & World Health Organization. 2002. Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections. 2002 Update. Geneva, Switzerland.

Impact of HIV/AIDS

The HIV/AIDS pandemic has multidimensional and far-reaching implications. The epidemic creates demographic, political, security, economic, social, and cultural implications. Demographically, HIV/AIDS is contributing to a reversal of age-specific mortality patterns, with increasing proportions of younger people dying. With increased adult mortality due to AIDS, societies have witnessed the creation of child-headed, elderly-headed, single parent, and over-extended families. Moreover, there have been increased instances of cluster foster care homes (housing 1 or more AIDS orphans), itinerant and homeless children and gang families in severely affected areas. The numbers of AIDS orphans in developing areas are growing. In addition to the concerns of how to care for and support these orphans is the question of how these children will affect social stability in the future.

The impact of HIV/AIDS on individuals and households will be felt earlier and will vary according to existing resources of capacities they are able to draw upon. Thus, individuals, especially those with full-blown AIDS will experience immediate impacts on their health status via their experience with increases in morbidity and illness. These immediate impacts on health may have adverse implications on their social and economic productivity and participation. Thus impacts on an individual will ultimately create impacts on their families, households and communities, as a previously productive individual becomes semi or non-productive and requires care and support from their household and community. Whiteside & Barnett (2002) demonstrate how impacts on the individual radiate outwards to the family, household, and community. When individuals affected with or by HIV/AIDS, change their social and economic patterns of consumption, production and participation, this creates effects for agriculture, business,

government, and civil society. Thus, aggregate individual impacts from HIV/AIDS bear profound, and often difficult to measure, impacts for multiple levels and sectors.

Further, because the HIV/AIDS pandemic disproportionately affects sub-Saharan Africa, it is largely developing countries that must contend with this devastating epidemic. Struggling to develop their countries, HIV/AIDS threatens to undermine, debilitate or destroy their efforts. Ultimately, HIV/AIDS is expected to intersect with and exacerbate existing social, political and economic issues and inequities. Because of the multi-dimensional impact and expression of disease, HIV/AIDS is expected to bear profound and complex implications for human health and well being that goes well beyond its immediate clinical impact.

The HIV/AIDS pandemic requires a strong and collective global response. Globally, political commitment has grown stronger, grass-roots mobilization is becoming more dynamic, funding is increasing, treatment programmes are being developed and initiated, and prevention efforts are increasing, however, the global response must be intensified in order to provide the necessary resources and commitment which are required to prevent new infections and to care for those currently living with HIV/AIDS. All productive resources, human and capital, must be mobilized in the fight against HIV/AIDS. As the case of Ghana shows, traditional leaders can play effective roles in this fight.

Section II: Traditional Authority and Divided Legitimacy in Pre-Colonial, Colonial and Post-Colonial States: Building on Grassroots Governance (Ray & Reddy (eds) 2003)

Traditional leaders are known in English as chiefs, traditional authorities, traditional rulers, monarchs, kings, nobles, aristocrats, and natural rulers in a variety of African and other countries. Traditional leadership is meant to include those political, socio-political and politico-religious structures that are rooted in the pre-colonial period rather than in the creations of the colonial and post-colonial states. By this key consideration, traditional leaders can include kings,

other aristocrats holding offices, heads of extended families, and office holders in decentralized polities, as long as their offices are rooted in pre-colonial states and other political entities. If the office is purely a creation of the colonial or post-colonial states but still involves indigenous peoples, then the office should be called "neo-traditional."

The division of the chronology of African political organization into three periods (pre-colonial, colonial, and post-colonial) is well accepted, but should not be seen as applicable only to Africa. As well, the special significance of this terminological genealogy needs to be noted briefly here. The trilogy of pre-colonial state, colonial state, and post-colonial state applies to any contemporary state in Africa, Asia, the Americas or elsewhere that was the product of the imposition of European imperialism and colonialism since the expansion of capitalism out of Europe from the 1400s onwards. However, one might characterize the pre-colonial states and other political entities as being rooted in political legitimacies that were particular to their special histories which existed before these pre-colonial states and other polities were *absorbed* one way or another by European empires. Such absorption involved the creation of colonial states by which the European ruled their newly subjugated and/or subordinated colonies into which the various pre-colonial states and polities were drawn. These pre-colonial states and other polities were then processed into various components of the colonial states. In many cases, the indigenous peoples had their political leadership turned into instruments of colonial rule for the benefit of the empires, but the empires were not strong enough to eliminate completely all elements or traces of this pre-colonial heritage: "kings" became "chiefs" in the lexicon of imperialism and colonialism. While the colonial state intended to indicate the subordinated status of the former pre-colonial leader by this linguistic trick, ironically the real pre-colonial terms of the "chiefs" survived in their own languages. Even more ironically for colonialism, often these

"chiefs" or "traditional leaders" became rallying points of resistance to colonialism and sources of cultural pride to those indigenous peoples who had been colonised. Where traditional leaders/chiefs thus survived into the periods of the colonial state and the post-colonial state, they often retained sources of political legitimacy rooted in the pre-colonial period, and which were unavailable to the colonial state because it had been forced on the indigenous people.

Political legitimacy deals with the reasons that people are expected to obey political authority, especially that of government. Baynes (1993) argues that political legitimacy is an important mechanism of the state to obtain the compliance of its citizens (or subjects) with the laws (or other wishes) of the state. Traditional authorities have specific and distinct claims to legitimacy that are recognized by their subjects. Traditional authorities can claim special legitimacy in the eyes of their people because these institutions are seen as embodying their people's history, culture, laws and values, religion, and even remnants of pre-colonial sovereignty.

The colonial states and the post-colonial states draw upon different roots of legitimacy and sovereignty than those of the pre-colonial states. Looked at in the brilliant light of democracy, the colonial state would have to admit that its claims to sovereignty were based in the main on violence, racism, and diplomatic trickery, and that its claims to legitimacy as to why the indigenous people should obey its dictates were usually based on (1) rights of the conqueror rather than the consent of the people, (2) assertions of culture or racial superiority of the colonizers over the indigenous people, and (3) the use of a constitutional and legal order based on or rooted in the imperial power. For these and other reasons, the colonial state was unable to take over the legitimacy base of the pre-colonial period: to do so would be to call into question its own legitimacy. The post-colonial state is in a more ambiguous position with regard to the

pre-colonial period and to traditional leaders than is the colonial state. Although the post-colonial state has often had its constitutional and legal legitimacy rooted in the colonial state, especially when there was a peaceful handover of power from the colonial state to the post-colonial state, the post-colonial state can claim its legitimacy from the additional roots of (1) the nationalist struggle for independence by the people, and (2) the expression of the democratic will of the people through elections and other political processes and, eventually, a legal-constitutional system that has been processed, re-validated and created by the institutions created by the post-colonial state which express the democratic will of the people. However, the legitimacy of traditional leadership/chieftaincy institutions remains, in nearly all cases beyond the grasp of the post-colonial state precisely because chieftaincy legitimacy is rooted in the pre-colonial period and there has been a fundamental rupture in the political fabric caused by the imposition of colonialism. Thus a people may choose to express themselves politically for many policy areas through the legislative, executive, and judicial institutions of the post-colonial state, but also decide that certain policy matters, e.g., custom, land, other local matters, are best expressed by their traditional leaders. Thus, because the people of a post-colonial state recognize that the roots of political legitimacy are divided between the post-colonial state and the traditional (i.e., pre-colonially rooted) leadership, these peoples may well decide that their democratic practice includes aspects of both the post-colonial state and traditional leadership. This then would lead to a situation in which the division of the different roots of legitimacy would create a shared legitimacy as the traditional authorities and the post-colonial state pool their legitimacy to promote more and better development, especially more effective responses to HIV/AIDS (See Figure 5.0). The book <u>Grassroots Governance</u>, in particular the chapters by Ray, Owusu-Sarpong, Thornton and Zips explores these and related concepts.[4]

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Traditional leaders have long been recognized by the colonial and post-colonial states as being important to the processes of rural local government in Ghana. In both the colonial and post-colonial states, traditional leaders have been incorporated directly into local government and local governance, albeit in various formats. The advent of the National and Regional Houses of Chiefs has institutionalized and entrenched important political functions for traditional leaders. The National House of Chiefs has fifty members comprised of five members from each of the 10 Regional Houses of Chiefs. There are ten regional houses of chiefs and one hundred and sixty (160) traditional councils (Ray 2003, 2003a). While they were initially perceived as 'auxiliaries' or 'subordinate allies' in colonial rule, traditional leaders are now occupying different roles in the Ghanaian contemporary post-colonial state. Christiane Owusu-Sarpong (2003) suggests that traditional leaders function as 'intermediaries' between ministries, Parliament and the people. Ray (2003a) suggests that traditional leaders may contribute to the 'legitimacy pool' of the contemporary post-colonial state. Hence, both Owusu-Sarpong (2003) and Ray (2003a) concur that not only do traditional leaders possess their own unique sources of political authority, but also that the exercise and cooperation of this authority in conjunction with the post-colonial state is necessary for the achievement of development goals. Owusu-Sarpong (2003) argues that not only may their legitimacy be 'added' to the post-colonial state's legitimacy resources, but that they may indeed serve as a necessary condition to certain governmental actions and activities. She argues that no decision taken at the level of central government, and directly concerning the people in matters such as communal health, education, use and distribution of land, gender issues, etc., can easily be implemented without the active involvement of the traditional authorities in the various regions.

Chiefs in Ghana are influential with their subjects in terms of their abilities to mobilize their people for development, in their articulation of their sense of public morality, and to influence and shape public opinion. Thus, traditional leaders in Ghana can potentially exert significant influence within their communities. Owusu-Sarpong (2003) argues that chiefs are active opinion leaders, and cites their presence in media sources and official and informal gatherings as evidence that their opinions and activities are considered important. Moreover, as active opinion leaders, traditional leaders have the potential to be an important source of public education on many social issues. Given their position within a community, traditional leaders can effectively transmit important social messages and values that contribute to development goals. For instance, if traditional leaders impart positive messages and strategies for HIV/AIDS, gender empowerment, environmental stewardship, and cultural and heritage preservation, this is likely to both persuade and mobilize people to alter their behaviours in ways that produce a more positive and supportive social and cultural environment.

Furthermore, empowering and encouraging female traditional authorities to act as moral and opinion leaders for important social issues helps women and girls in rural and urban communities to access and alter behaviours. In Ghana, queenmothers advise chiefs and serve as moral leaders of the community (Ray, 2003, 25). For instance, Nana Boatema-Afrakoma II, queenmother of Juansua, is the chief's major councilor and is very influential in the selection of new chief or in his impeachment. Her traditional responsibilities relate to the role of women in society and the moral education of the young girls in society. Accordingly, she has organized workshops for queenmothers on various issues affecting her people and believes they need to reflect on the conditions prevailing in their communities and find ways of introducing changes that will promote development (Owusu-Sarpong, 2003, 60). Thus, traditional authorities have the

potential to influence and create important social and behavioural changes that will promote development goals, including those of fighting HIV/AIDS, within their communities and Ghana.

Traditional leadership is a factor that has been significantly overlooked in the evaluations of government and governance in much of contemporary Sub-Saharan Africa and even in parts of the Afro-Caribbean (See Zips, 2003 and Pakosie, 1996). This oversight continues to result in lost opportunities, especially with regard to anti-HIV/AIDS strategies, in terms of both development and understanding. Accordingly, we need to consider what role traditional leaders might play in the struggle against HIV/AIDS. The fight against HIV/AIDS requires the mobilization of all available and credible resources and actors. Given their special legitimacy and credibility, traditional authorities may be able to play an important role by pooling their legitimacy or credibility with government and others to build AIDS competent communities by strengthening and facilitating social marketing campaigns, fostering positive and supportive environments for people living with HIV/AIDS and affected by HIV/AIDS, and mobilizing community resources and participation in the fight against HIV/AIDS.

Figure 5.0

The Collaboration of Differently Rooted Legitimacies Produces More Effective Responses to HIV/AIDS

MORE EFFECTIVE
RESPONSES TO
HIV/AIDS

BETTER
DEMOCRACY

BETTER
MANAGEMENT

A MORE INCLUSIVE
POLITICAL CULTURE

ROOTS OF LEGITIMACY

POST-COLONIAL STATE

CONSTITUTIONAL
LEGALISM

NATIONALIST
STRUGGLE

DEMOCRATIC
ELECTION

TRADITIONAL LEADERS

PRE-COLONIAL RELIGION

PRE-COLONIAL HISTORY AND
CULTURE

PRE-COLONIAL   POLITICAL
CULTURE

PRE-COLONIAL
CONSTITUTIONAL LEGALISM

Section III: National Policy Responses from Ghana, Botswana and South Africa

Several governments in Sub-Saharan Africa have responded at the national level with the design of national strategic frameworks that describe government's policy plans and objectives for HIV/AIDS prevention, treatment and support. The frameworks describe the government's objectives, usually over a four to six year period. They highlight policy and programmatic themes, objectives, target audiences and actors. They are typically designed by a group of stakeholders selected by the national government and often include participants from private, public and civil society sectors.

In response to the HIV/AIDS epidemic in their countries, the governments of Ghana, Botswana and South Africa each formulated national policy and strategic frameworks that outline their policy objectives and strategies in the fight against HIV/AIDS. These national strategic frameworks address the HIV/AIDS situation in their countries; identify priority action areas, target audiences, policy objectives, and governmental and non-governmental partners in the development and implementation of their national strategic framework. Figure 6.0 outlines key components of the national policy responses from the governments of Ghana, Botswana and South Africa.

Ghana

The Ghana HIV/AIDS Strategic Framework covers the period from 2001-2005. It will thus be re-visited in 2005. A multisectoral team including the National Population Council, National Development Planning Commission, Ministry of Health, the former Ministry of Employment and Social Welfare (now Ministry of Manpower Development and Employment), the private sector and NGOs with input from regional and district level officials developed the Ghana HIV/AIDS National Strategic Framework.

The preface of Ghana's strategic framework states that HIV/AIDS "requires a holistic multisectoral and multidisciplinary response to confront it and bring it under control" Consequently, the framework embodies these principles by identifying and employing multiple partners and sectors in the fight against HIV/AIDS in Ghana.

The framework identifies five priority action areas: 1) prevention of new transmission, 2) care and support for people living with HIV/AIDS, 3) creating an enabling environment, 4) decentralized implementation and institutional arrangements, and 5) research, monitoring and evaluation of existing trends and programs. The framework ultimately serves to address and outline the goals, guiding principles and strategies for the prevention of HIV transmission, the provision of care and support for people living with HIV/AIDS and people affected by HIV/AIDS, and the creation of a supportive and empowering legal and ethical environment.

Chapter one of the framework provides statistics on HIV/AIDS modes of transmission, prevalence rates and groups, population structure, etc. The framework describes that the distribution of HIV/AIDS in Ghana is higher in densely populated areas. Higher numbers of cases occur in the southern regions of the country particularly in densely populated regional capitals like Kumasi, Koforidua and Accra. Prevalence of HIV/AIDS is also very high in mining towns like Obuasi and Tarkwa as well as in border towns.

Political Organization in Ghana

Ghana is comprised of 10 regions and 110 districts with a decentralized system of administration. The national level is responsible for policy and strategy development. The regional level is the intermediate level responsible for translating national policy into regional strategies and coordinating district activities. All government policies are implemented at the district level. At the local level, the District Assemblies are the highest political and

administrative authority. The District Assemblies (DA) co-ordinate plans and activities of all decentralized ministries. They also facilitate grassroots participation and community involvement in socio-economic development programmes and activities. Traditional authorities can and do serve on district assembly councils.

Priority Action Areas of the Ghana HIV/AIDS National Strategic Framework

The first priority action area is the prevention of new transmissions. The strategic framework identifies objectives and strategies for preventing new transmissions as well as identifying target audiences as well as partners in the implementation of policy strategies and programs. The framework understands safer sex promotion to be key to preventing new HIV infections. Accordingly, the framework identifies social marketing strategies and preventative clinical interventions (through the improved use of blood transfusion screening, management of sexually transmitted infections and targeting of sex workers) as key strategies to reducing the rate of new infections and slowing the spread of HIV infection. Specifically, the framework identifies three major strategies in the prevention of HIV transmission:

1. Providing effective and culturally appropriate information and communication strategies
2. Promoting condom use and accessibility and affordability
3. Intensifying poverty reduction programmes

In regards to the first strategy, the framework suggests that the mass media and Faith-Based Organisations (FBOs) have a role to play in educating and motivating target groups to adopt healthier behaviours. It suggests that these mediums would help to sensitize various target groups to the risk factors of early sexual activity, infidelity and unprotected sex. Further, it acknowledges the need to improve access to information, education and communication in rural areas and suggests the use of appropriate media such as mobile cinema vans, drama etc. to carry rural specific educational material in the various languages. The third strategy of intensifying

poverty reduction programmes recognizes the need to empower women and young people economically and suggests that key sectors and partners (non-governmental and governmental) implement or strengthen functional literacy programmes for women and other vulnerable groups; link safer sex promotion programmes targeted at specific groups, to poverty reduction programmes, and promote access to non-formal education for women. It calls for the creation and development of advocacy activities that encourage sustainable girl-child education programmes.

Ghana's HIV/AIDS Strategic Framework recognizes traditional authorities as a key sector for programme targeting and implementation. Traditional authorities are thus expected to receive and transmit policy strategies within their communities. The strategic framework regards the participation of traditional authorities as integral to the implementation and realization of their policy strategies and objectives.

Most importantly, the framework recognizes that these key strategies will require the involvement and participation of selected groups and organization. The framework identifies key sectors, settings and population groups (providers/patients/audience) in the implementation or targeting of these three key prevention strategies. Traditional authorities are identified as a key sector in both the targeting and implementation of policy strategies. Thus, traditional authorities are recognized as requiring education on prevention strategies and behaviours and seen as potential facilitators and implementers of policy strategies as they relate to the prevention of HIV transmission.

The second priority action area of the framework is the provision of care and support for people living with HIV/AIDS and people affected by HIV/AIDS. The framework discusses two

major strategies to intensify and implement strategies for providing care and support to these individuals and groups.

1. Providing and strengthening institutional care people living with HIV/AIDS

2. Providing and strengthening home care support for people living with HIV/AIDS

Accordingly, the framework discusses the need to mobilize funds for institutional and home care support, HIV/AIDS orphans, build the capacity of community networks such as church-based organizations, faith-based organizations and community volunteers in caring and support people living with HIV or AIDS (PLWHA) and people affected by HIV/AIDS. The framework considers traditional authorities and the Chieftaincy Secretariat (Houses of Chiefs) as a key sector in the implementation of its policy strategies and objectives.

The fourth priority action area calls for the creation of a supportive, legal, ethical policy environment for HIV/AIDS programmes. The framework identifies three major strategies for this policy objective:

1. Improving the knowledge of the general public on HIV/AIDS and the rights of PLWHA.
2. Promoting non-discriminatory policies and practices at workplaces, service delivery points, in communities and in families.
3. Programmes for sex workers

The framework indicates that Ghana needs to develop a rights-based approach to HIV/AIDS, and thus needs to formulate a legally binding foundation for dealing with procedural, institutional and other accountability mechanisms related to HIV/AIDS in society. Again, the Chieftaincy Secretariat, (Houses of Chiefs) is identified as a key sector.

Chapter six highlights the coordination and implementation approaches for the Strategic Framework. The approaches acknowledge not only the importance of articulating viable implementation arrangements, but also the need to mainstream HIV/AIDS into sectors and programmes. Furthermore, private-sector organizations, NGOs, community-based organizations

(CBOs), traditional authorities, religious institutions, professional bodies and associations, youth groups etc. will develop and implement respective programmes in accordance with priorities and intervention strategies outlined in the framework. At the district level, committees on AIDS have been established to co-ordinate, monitor and supervise all HIV/AIDS activities. The District Chief Executive chairs the committees. The composition of the District HIV/AIDS Committee includes all NGOs, religious bodies, traditional authorities, youth and women's associations, private sector institutions, people living with HIV/AIDS and other individuals who are competent in developmental issues.

At the national level, Ghana's National Strategic Framework recognizes traditional authorities as a key sector in both programme targeting and implementation. At the district level, traditional authorities are involved in and represented on HIV/AIDS committees. At the local level, traditional leaders are involved in joint and multi-sectoral social marketing campaigns against HIV/AIDS. Their involvement includes acting as directors, spokespersons, intermediaries and advisers for HIV awareness and education campaigns and providing supports for people living with HIV/AIDS and persons affected by HIV/AIDS. Section IV of this paper describes in greater detail instances and cases of traditional leaders' involvement in HIV/AIDS prevention and impact mitigation activities.

Botswana

According to UNAIDS, Botswana was faced at the end of 2001 with having the highest rate of adult HIV prevalence in the world at 38.8% (See Figure 4.0). In the face of a potentially devastating epidemic, the Government of Botswana, in partnership with non-governmental and private-sector organizations and groups has cultivated massive and dynamic responses to the problems of HIV/AIDS in their country. Botswana is among the first African countries to move

into second generation planning under the UNAIDS strategic planning process for HIV/AIDS. The country has a well-established programme providing free anti-retroviral therapy to pregnant women in an attempt to prevent transmission of HIV from mother to child, as well as a pilot programme offering free anti-retroviral therapy to about 7,000 patients.

The National Strategic Framework, covering the period 2003-2009, identifies five priority action areas. The first priority action area relates to the prevention of HIV infection. The second concerns the provision of care and support to people living with and/or affected by HIV/AIDS. The third priority action area is the management of the national response. Botswana's intensive epidemic will require continual monitoring, evaluation and updating in order to effectively respond to new and developing issues. The fourth priority action area concerns impact mitigation, specifically psychosocial and economic impact mitigation. The fifth priority action area deals with strengthening the legal and ethical environment in Botswana. This area concerns the rights and treatment (medical and social) of those living with HIV/AIDS. The strategic framework is largely a creation by the Ministry of State (Office of the President), although the National AIDS Coordinating Agency facilitated the process of developing the national strategic framework.

The National Strategic Framework formally integrates traditional authorities within its description of policy strategies and objectives in the area of HIV prevention. It states that traditional leaders will be educated on HIV prevention. Further, it provides for the design and airtime for appropriate HIV/AIDS education programmes targeting politicians, youth, commercial sex workers, traditional leaders and drug users. It also alludes on several occasions to the involvement and importance of traditional authorities in HIV/AIDS education, prevention

and impact mitigation activities. Furthermore, the Chairperson of the National House of Chiefs is an active member of the National AIDS Council. The framework states that at the local level, kgotla meetings addressed by chiefs and headmen are often used as forums for advocacy and education of HIV/AIDS issues. Thus, it appears that some traditional authorities in Botswana are beginning to convey educational and advocacy messages to their communities. These activities are endorsed in the National Strategic Framework. It recognizes that,

> "Community mobilization can be most effectively undertaken and facilitated through a partnership of internal and external agents. Internal agents can be opinion leaders, traditional authorities, church members, etc., from within the community that can rally the community."

The final mention of traditional leaders in Botswana's strategic framework is to establish strategic partnerships with key stakeholders including traditional leaders (Dikgosi), politicians, NGO's, CBOs, FBOs, parastatals and the private sectors. Although it does not go into detail on how they intend to activate these partnerships, the framework recognizes the importance of these partnerships in the implementation and realization of their policy strategies and objectives.

South Africa

South Africa has been the hardest hit of the any country in the world in terms of absolute numbers of persons living with HIV/AIDS. At the end of 2001, the adult (15-49) HIV prevalence rate was 20.1%. There is an estimated 5 million people (adults and children) currently living with HIV/AIDS in South Africa (see Figure 4.0). South Africa's National Strategic Framework identifies four priority action areas. Prevention is the first priority action area, and the strategic framework calls for the promotion of safe and healthy sexual behaviour, addressing issues relating to blood transfusion and HIV, the provision of appropriate post-exposure services, improving access to voluntary HIV Testing and Counselling, reducing mother-to-child transmissions and improving the management and control of STDs. The second priority action

area is treatment and support. Thus, the goals of the strategic plan are to provide treatment, care and support services in health facilities and communities, and to develop and expand the provision of care to children and orphans. The third priority action area is research, monitoring and evaluation. The goals of the framework in this area are to ensure AIDS vaccine development, investigate treatment and care options, and to conduct policy research and regular surveillance. The fourth priority action area is human and legal rights. This refers to the creation of supportive and caring social environments and the development of an appropriate legal and policy environment.

The strategic plan identifies traditional leaders as one of several sectors in the targeting and implementation of its objectives. The plan only specifically identifies traditional leaders' involvement in the area of HIV prevention, but does not explain in what capacity traditional leaders will be involved. However, evidence from provinces and non-governmental organizations in South Africa demonstrates that traditional leaders are increasingly involved in HIV/AIDS prevention and support activities. This is mostly taking place under the auspices of the provincial governments and through partnerships with non-governmental organizations (i.e. Nelson Mandela Foundation). The Nelson Mandela Foundation has developed the "Traditional Leaders Project" with a view to mobilizing the support of traditional leaders on HIV/AIDS. Mr. Mandela met with over 950 traditional leaders in South Africa and called upon them to disseminate important messages about sexual behaviour and HIV transmission. On December 1, 2002, several traditional leaders from across South Africa signed the 'leadership charter'. The charter commits the leader to fight stigma and discrimination of affected people within their communities. Mandela noted that traditional leaders must "stand by and support each other and

to ensure that we are united in fighting this disease." ("Traditional Leaders sign Charter on HIV/AIDS", [on-line], Dec 1, 02).

Traditional leaders are also being trained and are setting up task forces for HIV/AIDS prevention and education programming. Traditional leaders' HIV/AIDS forums have been formed at national, provincial and local levels in order to create partnerships between traditional leaders, government and people involved in AIDS awareness campaigns in rural areas. Queens from the Eastern Cape province in South Africa have also been taking courses in HIV/AIDS issues. ("Traditional leaders are helping in campaign against HIV/AIDS", Aug 27, 2003). These forums and workshops equip traditional leaders with knowledge and information that can be then communicated to their communities. Thus, while the National Strategic Plan does not explicitly or formally lay out the activities and involvement of traditional leaders in HIV/AIDS, evidence exists to suggest that traditional leaders in South Africa are participating in HIV/AIDS programming at provincial and local levels.

Section IV: Social Marketing, Traditional Authorities and HIV/AIDS Prevention and Support Programming

Philip Kotler and Gerald Zaltman define social marketing as the "design, implementation and control of programs calculated to influence the acceptability of social ideas" (Kotler & Zaltman, 1971, p.5). Social marketing applies commercial marketing principles to social problems and objectives. Social marketing has its roots in religion, politics, and education, and its intellectual roots are found in the disciplines of psychology, sociology, political science, communication theory and anthropology. Fundamentally, social marketing is about capturing audience attention through planned and creative communication strategies. Social marketing is distinguished from commercial marketing by its emphasis on non-tangible products, such as ideas and practices. Its purpose is to positively influence the voluntary behaviour of a target audience and therefore,

improve their personal welfare and that of the society. Governments and multilateral organizations are increasingly employing social marketing strategies as an effective means of addressing serious health issues in developing countries. Successful social marketing programmes improve the health of people by promoting healthy behaviour, ensuring the availability of health products and services, and motivating and educating people to use them ("Social Marketing",http: //www.gsmf.com.gh/strategy/social.htm)

In sub-Saharan Africa in 2001, twenty-four countries had HIV prevalence rates over 5% (Kumaranayake & Watts, 2001, 541). Many countries in Africa are demonstrating increasing rates of HIV prevalence. With no cure or vaccine in sight (in the foreseeable future), HIV prevention efforts must be a top priority. In order to educate Africans on HIV/AIDS, creative and effective social marketing strategies and campaigns are imperative if we hope to slow the spread of HIV/AIDS, reduce the rate of new infections and provide caring and supportive environments for those currently living with HIV/AIDS.

Social Marketing and AIDS Competence

AIDS competence has been defined as:

"the ability of people to maintain and improve the quality of their lives by facing up to HIV and AIDS. They determine and manage their own responses to the HIV/AIDS epidemic in their own community by assessing accurately the factors that make them vulnerable to, or put them at risk of infection with, HIV. They act so as to reduce their vulnerability and those risks, and they mobilize adequate holistic care and support when infected with, or affected by HIV/AIDS"
(Lamboray & Skevington, 2001, 514).

AIDS competence means that communities become empowered to create and implement successful AIDS prevention and support programming and initiatives. AIDS competence arises from the actions that communities take to mitigate or alleviate risks to that community (Lamboray & Skevington, 2001, 514). AIDS competence involves grassroots movements and

campaigns whose objective is behavioural change in regards to both sexual behaviour (HIV prevention) and social behaviours (de-stigmatization) (Lamboray & Skevington, 2001, 516-518).

When traditional authorities are mobilized and integrated into the fight against HIV/AIDS, they can become powerful agents in the development of AIDS competent communities. They can act as influential intermediaries for HIV/AIDS social marketing campaigns led by individuals or groups within the community, or can serve as campaign leaders and spokespersons. Traditional leaders may also help to build AIDS competence by identifying potentially harmful social and customary practices that constitute a hindrance to anti-HIV/AIDS efforts. Traditional leaders can also help to mobilize community resources and participation for the care and support of people living with or affected by HIV/AIDS. Given their position within their communities, traditional authorities have the potential to be powerful and persuasive agents for social and behavioural change.

<u>Social Marketing and Traditional Authorities</u>

In Ghana, traditional leaders have actively engaged in the fight against HIV/AIDS in several capacities. Given their legitimacy and credibility amongst their subjects, they are well positioned to play effective roles in HIV prevention and support within their communities. President John Kufuor suggested that traditional leaders could serve as "instruments of socio-political cohesion to facilitate national development" ("Chiefs must be instruments of social-political cohesion,"http://www.mclglobal.com/History/Jan2003/07a2003/07a3n._html). Traditional leaders in Ghana have demonstrated their commitment to fulfilling this role and extending this to HIV prevention and support through their participation in various activities and campaigns. They are increasingly serving as collaborative and informed partners in the fight against HIV/AIDS. They are functioning as advisers, intermediaries, and educators in HIV/AIDS education, prevention

and support programming in their communities and traditional areas. They can also play important roles in fighting stigmatization against people living with HIV/AIDS by fostering the develop ment of supportive and informed communities. The Omanhene of the Manso-Nkwanta traditional area in the Amansi West district said that stigmatization is one of the most problematic aspects in the fight against HIV/AIDS and has consistently appealed to his people to create a climate of acceptance and support for those living with HIV/AIDS ("Omanhene donates computer for HIV/AIDS data processing, [on-line], June 8, 2003)/ Traditional leaders can also play a role by identifying social or cultural practices that may contribute to the spread of HIV/AIDS (ie tattooing, puberty rites, love covenants). Susan Osam, a Reproductive Rights/Health expert of the United Nations System Gender Programme has called on Chiefs and Queenmothers to reflect on social and cultural practices that may be problematic in the fight against HIV/AIDS in their communities (Chiefs/Queenmothers attend AIDS Workshop, [on-line], September 17, 2003). Traditional leaders can play an important role by reviewing social and cultural practices in their communities with a view to identifying practices that may be harmful or potentially expose people to HIV infection, and subsequently identify safer solutions or alternatives.

Traditional leaders have an important role to play in HIV/AIDS education and prevention in their communities. Many traditional leaders have either developed HIV/AIDS awareness and prevention programmes or act as spokespersons, advisers or intermediaries for prevention programmes. For example, the Paramount Chief of the New Juaben Traditional Area, Daasebre Dr. Oti Boateng donated a 7-million-cedi computer to the New Juaben Traditional Council in support of its anti-HIV/AIDS programme launched at Koforidua on June 6, 2003. The collaborative campaign, "Coalition of Life Preservers" involves 18 civil society organizations

including the New Juaben Traditional Council. The programme includes roundtable discussion attended by chiefs, queenmothers and headmasters of schools in the Ada and Akwadum circuits in the Koforidua municipality. ("Omanhene donates computer for HIV/AIDS data processing", Jun 8, 03). Osagyefo Agyemang Badu (Dormaahene) advised chiefs in his area to educate the youth on HIV/AIDS and cited HIV/AIDS as a major threat for future generations ("Dormaahene warns chieftaincy contractors", Nov. 3, 99). In the Tapa traditional area, traditional leaders have partnered with Freedom International, an NGO, in developing an HIV/AIDS education campaign ("NGO and chiefs launch HIV/AIDS education campaign", Sept.2, 03).

The Okyenhene, Osagyefuo Amotia Ofori Panin (King of Akyem Abuakwa in Ghana) has had an enormous impact on HIV prevention, education, de-stigmatization, research, and support in his traditional area. In May 2002, his Traditional Council launched an HIV/AIDS research centre. He has also participated in numerous public events for HIV/AIDS awareness, including leading a large number of members of keep-fit clubs from Accra, children and individuals from Okyenman in a 12 kilometer run to mark the second Okyenman HIV/AIDS day celebrations (2002). The year before at the first HIV/AIDS day celebrations, the Okyenhene was publicly tested for HIV (Interview, October 13, 2002). At this race, the Okyenhene urged people to discard the notion that the disease is caused by witchcraft. The Okyenhene has shown that in the fight against HIV/AIDS, superstitions and customary taboos must be examined for both their impact on stigmatization of persons living with HIV/AIDS, as well as for their potential to elevate risk of transmission of HIV. He publicly appealed citizens of Akyem Abuakwa to help eradicate poverty and ignorance in rural communities in the traditional area. He made the appeal when he briefed the Second Session of the Akyem Abuakwa Traditional Council on his tour of the 160 towns and villages in the traditional area ("Okyenhene Appeals to Successful Akyems,"

[on-line], May 30, 2001). The Okyenhene offers an excellent example of how traditional leaders can play effective and important roles in HIV/AIDS education, prevention, de-stigmatization and support within their communities.

Traditional leaders have also been encouraging schools, families and community groups to include HIV/AIDS education in their homes and curriculum. Nana Bi-Kusi Appiah II, Omanhene of the Manso-Nkwanta traditional area in the Amansi West district appealed to parents to invest in the education of their children, particularly the girls to prevent them from engaging in early sex. Nana Frempongmaa II, Dwantuahemaa of Dormaa Traditional area said traditional rulers in the country have a major role to play in the AIDS campaign. She articulated that she "strongly believe(s) that we must inculcate HIV/AIDS education into the school curriculum" ("Queenmother blames media," [on-line], March 4, 2002). Mobilizing the support and involvement of traditional leaders in HIV/AIDS education and prevention increases the effectiveness of such programming, and thus can mitigate the impact and progression of HIV/AIDS in their communities. Nana Frempongmaa II, Dwantuahemaa of Dormaa Traditional area noted that:

> "When a traditional ruler talks people listen. He gets the audience. His people are in love with him, so whenever he advises the children, they take it. It is not just about advising but about the ruler leading a life that makes his subjects know that he has the commitment at heart."
> ("Queenmother Blames Media", March 4, 02)

Traditional leaders have special sources of legitimacy and credibility within their communities and their subjects closely regard their actions and activities. Accordingly, their mobilization can enhance and complement the efforts of government and others, and ultimately build AIDS competent communities.

The history of the offices of the king, queenmothers and other chiefs amongst the Krobo people is rooted in the pre-colonial period. When Manya Krobo, which is to the east and north of Accra, came under the control of the British colonial state, the pre-colonial or traditional offices were subordinated to it and transformed and renamed in English as chieftaincy offices. The Konor had been considered by his pre-colonial state as being the king of Manya Krobo but was considered by the British colonial state to be a "paramount chief", ie a superior chief to whom other chiefs owed allegiance.[6]

After independence in 1957, the post-colonial state created the Regional Houses of Chiefs and in 1971 created a National House of Chiefs. While the title "paramount chief" continued to be recognized by the post-colonial state, the use of the English-language title, "King" and terms such as "His Majesty" have been noticeably used by the kings themselves who continue to use their indigenous, traditional titles as well. In the case of the present (1998-) Konor or King of Manya Krobo uses the title, His Majesty Nene Sakite II. The female traditional leaders went through a similar transition in states and the title used today, the term "queenmother" (also spelled queen-mother or queen mother) is used in the English language and in the Fourth Republic's constitution to mean a female chief (It should be noted that the term queenmother is not used for a woman who occupies a traditional office that is nearly always held by a man).

The Manya Krobo queenmothers created the Manya Krobo Queenmothers Association (MKQMA) in 1988. An association of queenmothers is a form of organization which combines individual traditional offices in a new manner even while it continues to recognize the traditional hierarchy in certain ways- e.g. the paramount queenmother is the President of the Manya Krobo

Queenmothers Association. Three hundred and seventy-one queenmothers of various ranks form the membership of the Manya Krobo Queenmothers Association. They are drawn from all six divisions of the Manya Krobo Traditional Area.[7]

The Manya Krobo paramount queenmother, Manye Mamle Okleyo, is the President of the Manya Krobo Queenmothers Association. The Programme Manager of the MKQMA is Manye Seyelor Natekie I, who is also the Deputy to the Paramount Queenmother.

The MKQMA was one of a number of district and regional associations of queenmothers that were established in the 1980s and 1990s to address the potential that women traditional leaders were believed to have for the promotion of development, especially for women and children in their communities. In the case of the Manya Krobo Queenmothers Association, the queenmothers noticed an increase in the number of orphans for whom the queenmothers were traditionally expected to arrange fostering. Furthermore, the queenmothers noticed that these orphans were far more difficult to place with what should have been their natural extended family which appeared to have somehow broken down. In the queenmothers' discussions with each other and other members of the Manya Krobo community, one of the district health officers noted that cases of young mothers dying from HIV/AIDS were beginning to be seen. The queenmothers, educators and health officials arrived at a joint analysis that suggested that HIV/AIDS was now significantly present in their community and that the orphans were the children of community members who had died from HIV/AIDS. The queenmothers, the health officers and others faced several questions of how to respond to the presence of HIV/AIDS in their community. What should be done? Who should do it? From where would the resources come? Since the primary method of transmission of HIV/AIDS in Ghana is heterosexual

transmission, how could this be discussed in public? Was this not a source of shame for the community? Should the community therefore just be silent over the issue?

As these discussions progressed, the queenmothers decided, with the medical advice of the government medical officers and Family Health International (of the U.S.), that their traditional responsibilities to the community would entitle them to play a leading role in their community's responses to the newly discovered presence of HIV/AIDS in their community. First, as queenmothers, they had their responsibilities to the Manya Krobo girls and young women in educating them for the Dipo ceremonies that marked their recognition as adult women of the community. The queenmothers decided to extend this education to include questions concerning how to prevent exposure to HIV or how to deal with it after infection. Second, since queenmothers had customarily played a role in fostering the community's orphans, it would be very natural for the queenmothers to organize community responses to the growing number of HIV/AIDS orphans. The queenmothers decided that they would organize their actions through the previously organized Manya Krobo Queenmothers Association. In short, the queenmothers, with the agreement and support of the Konor (king) of Manya Krobo, the government and NGO medical officials, and many in the community, decided to use their traditionally-rooted legitimacy to act for the health, protection and development of their grassroots community. The Manya Krobo Queenmothers Association strategy has been composed of five main tasks: social marketing/public education; income-generation for young women; support for people, directly or indirectly, living with HIV/AIDS; and mobilizing resources for the community to increase their AIDS-fighting capacity. Ultimately, the activities of the Manya Krobo Queenmothers Association have helped to build an AIDS competent community.

The Manya Krobo Queenmothers Association worked to build AIDS competence at the grassroots level in addition to the AIDS competence that already existed in local medical facilities such as the two local hospitals. The queenmothers themselves needed to be educated in HIV/AIDS, its transmission, existing strategies to prevent its spread to more people, and what strategies and resources are available to deal medically and socially with people who have contracted HIV/AIDS. They negotiated with local medical facilities, such as the hospital and medical officers of the Ministry of Health and other bodies such as the Ghana AIDS Commission as well as international NGOs present in Ghana, such as Family Health International (www.fhi.org). These bodies provided expertise and other resources that have allowed the queenmothers to be trained to have that technical competence that would allow them to conduct social marketing/public education campaigns in their sub-communities of Manya Krobo. These AIDS competence-building actions in the community resulted in increasing the number of people with knowledge of HIV/AIDS, as well as increasing the amount of knowledge that they had. In short, a corps of non-medical people in Manya Krobo who could act as trainers and actors in social marketing campaigns was created. The queenmothers' actions also brought in the additional competence and resources of such key bodies as Family Health International and the Ghana AIDS Commission.

As the queenmothers began to build AIDS competence within their community, they expanded the scope and nature of their public education activities into social marketing programmes against HIV/AIDS. Whereas at the start, a queenmother would have warned in general of the dangers of HIV/AIDS to a community gathering, as the social marketing programmes of the MKQMA developed, the queenmothers talked to their communities as part of coordinated programmes with specific social marketing messages to be conveyed. The MKQMA

focused their social marketing campaigns on female children and women, groups who had been identified as being at risk to HIV infection, these foci reflected the traditionally defined, endorsed and expected activities of queenmothers.[8]

One of the traditional ceremonies that Manya Krobo queenmothers supervise is Dipo. Dipo marks the transition from being a female child to being recognized as an adult woman. Before the ceremony begins, there is a period of education for each group of girls as to Krobo society's expectations of them as women. The MKQMA made or is trying to make several changes to the ceremony. First, the queenmothers have added in a new section on HIV/AIDS during the education sessions in order to alert the girls to new sexual issues that they will confront as women. Second, the queenmothers have adopted the slogan and practice of "one initiate, one razor blade." In the past, many girls might have their hair shaved by an initiator using the same razor blade. However, now in the age of HIV/AIDS, the sharing of a blade that could potentially transmit HIV is problematic to say the least. Third, the MKQMA have been attempting to raise the age at which girls become women so as to delay the onset of societal-sanctioned sexual activity through marriage.

Besides the Dipo ceremony, the queenmothers built upon their traditional functions of calling together a number of girls and young women to discuss societal morals, etc, by adding topics drawn from HIV/AIDS resources and presenting them to young girls, women and others in culturally appropriate terms. For example, the type of cloth that is worn by chiefs on official duty can send a message to their communities. The MKQMA members have adopted the wearing of a special blue batik cloth when they are on some official AIDS duties. As this is broadly known throughout their communities, the wearing of this cloth by the queenmother sends a clear social marketing message to those who see them and to the girls and young women

who take part in the educational discussions with the queenmothers. The MKQMA with Family Health International (and USAID funding) and the Ministry of Health developed a book-sized 10-12-page flip chart to be used by the queenmothers in their social marketing discussions with girls and young women. On one side, there is a colour photograph of a dramatized situation that could lead the depicted young women to be exposed to HIV by getting involved in sexual activity. On the other side of the laminated page, there are a series of questions in English and Krobo (to serve those wishing to speak one language or the other). The queenmother shows the picture to the young women and leads them through the questions so that the young women can perceive how certain unfamiliar situations can cause exposure to HIV. Another example is the docudrama video that the MKQMA developed with the support of Family Health International, USAID and the Ministry of Health. This video dramatizes how young women can become infected with HIV and the subsequent stigmatization that they may suffer. The video shows the MKQMA intervening successfully on behalf of the newly HIV+ young woman by utilizing several social marketing messages.

The MKQMA formed a "Smart Ladies Association" for young women in which they received education on HIV/AIDS as well as mentoring and training the queenmothers. The MKQMA members have also formed a choir so that they can use music to deliver HIV/AIDS social marketing messages. They have composed a number of HIV/AIDS songs in Krobo, one of which ends with the words (English translation) : "If you can't control yourself, at least use a condom." This reflects one of the main social marketing messages of the Ghana AIDS Commission of A,B,C- Abstain, B-Be Faithful, or C- use a condom.

Income generation was the third major task that the Manya Krobo Queenmothers Association faced in the implementation of their strategy to fight HIV/AIDS in their community.

The queenmothers needed to create employment for at least some of the young women who were at risk because of economic factors. Such young women also were part of the traditional mandate of the offices of the queenmothers. The Krobo area is known for its beautiful, multi-coloured beads. Traditional leaders wear these beads, often large in size, as part of their regalia. There is some cultural tourism in Ghana and in Krobo, relating to the selling of these beads. As part of the MKQMA's project, young women have been hired to string the beads into necklaces and bracelets. These are then sold through a variety of networks, mainly in Ghana, but reaching as far as Calgary, Alberta, Canada. Young women at the project also make batik cloth, which is sold as wraps, or it may be sewn into shirts, dresses, etc. This is the cloth that the queenmothers wear on their official anti-HIV/AIDS duties. The project also makes soap in order to generate income for the young women.

Providing support for the Manya Krobo people living with HIV/AIDS is the fourth major task of the MKQMA's strategy. For the adults living with HIV/AIDS, the main activity of the MKQMA has been carrying out the 2002 (and other) anti-stigmatization campaigns of the Ghana AIDS Commission. Perhaps, in part as a result of all the AIDS competence and social marketing work done by the MKQMA in their area, St. Martin's Hospital, which had conducted an initial pilot project with anti-retroviral drug therapies in their area, was one of only three hospitals in Ghana chosen to administer an expanded pilot project in the distribution of anti-retroviral drugs to 2000 people for two years starting in January, 2004. Providing support for the AIDS orphans is a major part of the MKQMA. There are some 586-660 male and female children of Manya Krobo women who have died of HIV/AIDS. The MKQMA attempts to provide food, clothing and other subsistence to the AIDS orphans. The Ghana AIDS Commission has been providing this for 120 orphans but the MKQMA are continually searching for new support, some of which

has come from as far away as Calgary, Canada. For example, presentations of Prof. D.I. Ray, based on his International Development Research Centre (IDRC) funded research to Calgary groups such as the Women's Network on HIV/AIDS and the University of Calgary student group, the Global AIDS Awareness Group (GAAG) led the groups to donate funds for the support and education of the AIDS orphans sponsored by the MKQMA. Funding is required in order to pay the extra fees for schooling for the AIDS orphans. For example, money is needed to provide for school supplies such as exercise books, the special costs of exams and lessons, etc. Such education costs range from CDN$ 5 to $20 per year

Mobilizing resources for the community in order to increase their AIDS-fighting capacity is the fifth major task of the MKQMA strategy. The queenmothers acted as resource mobilizers by organizing their HIV/AIDS programme in formats that were acceptable to those non-traditional authority organizers that could provide resources of funds and expertise. The queenmothers acted as mediators and facilitators between those needing the resources (the local community) and those with the resources (Ghana government, diplomats, NGOs and CBOs) outside the community such as Family Health International and USAID, and internationally-based groups such as the International Development Research Centre of Canada-funded research project[9], the Traditional Authority Applied Research Network (TAARN). TAARN's IDRC-funded research led to students at the University of Calgary's Global AIDS Awareness Group raising funds for the MKQMA AIDS Project. One student, Ms. Kim Schoon, traveled to Ghana, met with the MKQMA and was made an honorary queenmother. She has continued to raise funds for the MKQMA's projects since her return. International dignitaries such as Mrs. Theresa Kufuor, wife of Ghana's President, John Kufuor and also UNDP Goodwill Ambassador from Japan, Ms. Misako Konno, have been made honorary queenmothers.

Conclusion: Policy Implications

UNAIDS (UNAIDS, 2003, 3) estimates that there is a staggering 40 million people (adults and children) in the world currently living with HIV/AIDS. Approximately 95% of these live in developing countries, and sub-Saharan Africa alone accounts for 70% of all persons living with HIV/AIDS. Ghana, Botswana and South Africa have been gravely affected by HIV/AIDS. Botswana has the highest prevalence of HIV in the world, while South Africa contains the highest absolute numbers of persons living with HIV/AIDS. Ghana has approximately 360,000 people (adults and children) living with HIV/AIDS and there are signs that the epidemic may not yet be stabilizing (UNAIDS, 2002).

HIV/AIDS has far-reaching and extensive social, political, economic, cultural, and security implications. For developing countries, challenges and goals for development are massively compounded and frustrated by HIV/AIDS. Ghana, Botswana and South Africa's national policy responses articulate the necessity of formulating and mobilizing multi-sectoral participation in HIV/AIDS policies and programming in their countries. Ghana, Botswana and South Africa each recognize traditional leaders as a sector within their countries and have proposed (to varying degrees) means for the involvement of traditional leaders in the fight against HIV/AIDS.

Prevention and impact mitigation of HIV/AIDS in developing countries will require the complete mobilization of all productive resources, human and capital, in the fight against HIV/AIDS. As the case of Ghana shows, traditional leaders can play effective roles in this fight. Drawing upon the concepts of differently rooted legitimacies, shared legitimacy, social marketing and AIDS competence, and the examples of a number of traditional leaders in Ghana, especially cases of the Asantehene, Okyenhene and the Manya Krobo Queenmothers, it has been

argued that traditional leaders can and have served in various capacities in HIV prevention and impact mitigation. Acting as directors, intermediaries, advocates and advisers, traditional leaders have contributed to social marketing campaigns which ultimately contribute to the development of local AIDS competence. By lending their authority and credibility to HIV prevention, awareness and support, traditional leaders contribute to the creation of positive and informed communities. Traditional leaders who have local credibility are thus an example of a grassroots governance community intervention best-practices model. Thus, the pooling and collaboration of differently rooted legitimacies (traditional leaders and the post-colonial state) produces more effective responses to HIV/AIDS. Traditional leaders' involvement will therefore become part of what Prof. Sakyi Amoa, Director of the Ghana AIDS Commission, has advocated as the "social vaccine" (Ghana AIDS Treatment Plan begins in January, [on-line], November 30, 2003).

NOTES

[1] The difference between 'roamer' and 'seater' sex workers is discussed in the article "Redefining Prostitution as Sex Work on the International Agenda." Author: Jo Bindman. 1997. [on-line] available from http://www.walnet.org/csis/papers/redefining.html. The author describes 'seaters' as home-based sex workers, often widows or divorcees, although younger women are increasingly entering this sector. Seater sex workers tend to live in settlements, areas of the city that are traditionally associated with the sex industry. These women often sit in the front part of the house and invite clients. 'Roamer' sex workers are from a younger age group, and seek clients in bars, hotels or streets.

[2] Although the province of Kwa-Zulu Natal (KZN) has a higher prevalence rate than the Gauteng province, Gauteng's higher population results in higher absolute numbers of people living with HIV/AIDS in the Gauteng province.

[3] www.nelsonmandela.org

[4] Don Ray appreciates the discussions and debates with Werner Zips, Christiane and Albert Owusu-Sarpong, Robert Thornton, Tim Quinlan, Keshav Sharma, M. Molomo, Kwame Arhin, Jean-Michel Labatut and Sherri Brown, which have led to the enhancement of the "divided legitimacy" school to by also using the concepts of "shared legitimacy", and "pooled legitimacy". See also Ray (1996) and Ray (1997) for earlier discussions of divided legitimacy contributing to development. Ray (1997) can be accessed at the TAARN website (http://www.ucalgary.ca/UofC/faculties/SS/POLI/RUPP/taarn/taarn.htm)

[4] We had hoped to do a similar study of the Okyenhene and the Asantehene but were unable to do so because of time constraints. Nevertheless, we will do so for the revised draft.

[5] Interestingly, one of the meanings of "allegiance" in the Oxford Illustrated Dictionary is "Duty of subject to sovereign or government").

[6] The term "Traditional area" refers to a post-colonial state recognized in a geographically defined area and which is usually headed by a paramount chief (otherwise called a King) who is automatically the President of the Traditional

Acknowledgments

References Cited

"A Monarch of His Time." December 15, 2001. [on-line] available from:
www.ghanaweb.com/GhanaHomePage/features/artikel.php?ID=20266

"Asantehene to set up AIDS Research Centre." October 25, 1999. [on-line] available
from: www.ghanaweb.com/GhanaHomePage/NewsArchive/artikel.php?ID=8881

Baynes, Kenneth. 1993. Legitimacy. In *The Oxford Companion to Politics of the World.*
Joel Krieger et al., eds., 533-34. Oxford and New York: Oxford University Press.

"Break self-imposed silence on HIV/AIDS-Chief advises" Vol 11, no. 39. January 8,

2003. [on-line] available from:
www.ghanaweb.com/GhanaHomePage/NewsArchive/artikel.php?ID=31220

"Chiefs must be instruments of socio-political cohesion" January 6, 2003. [on-line]
available from:
www.ghanaweb.com/GhanaHomePage/NewsArchive/artikel.php?ID=31234

"Chiefs/Queenmothers attend AIDS Workshop" September 17, 2003. [on-line] available
from www.ghanaweb.com

"Dormaahene warns chieftaincy contractors." November 3, 1999. [on-line] available
from:
www.ghanaweb.com/GhanaHomePage/NewsArchive/artikel.php?ID=8938

"Ghana AIDS Treatment Plan begins in January." November 30, 2003. [on-line]
available from www.massiveeffort.org/showstory.asp?id=2101

Ghana Social Marketing Foundation. 2003. *Social Marketing* [on-line]. Accra, Ghana.
available from http://www.gsmf.com.gh/strategy/social.htm; accessed February 19,
2004.

Government of Ghana. 2001. Ghana HIV/AIDS Strategic Framework 2001-2005. Accra,
Ghana.

Government of South Africa, Ministry of Health. 2000. HIV/AIDS & STD: Strategic
Plan for South Africa 2000-2005. Johannesburg, South Africa.

Joint United Nations Programme on HIV/AIDS (UNAIDS) & World Health
Organization. 2003. AIDS Epidemic Update, December, 2003. Geneva, Switzerland:
Joint United Nations Programme on HIV/AIDS & World Health Organization.

Joint United Nations Programme on HIV/AIDS (UNAIDS) & World Health
Organization. 2002. Ghana: Epidemiological Fact Sheets on HIV/AIDS and Sexually
Transmitted Infections. 2002 Update. Geneva, Switzerland: Joint United Nations
Programme on HIV/AIDS & World Health Organization.

Joint United Nations Programme on HIV/AIDS & World Health Organization
(UNAIDS). 2002a. Botswana: Epidemiological Fact Sheets on HIV/AIDS and Sexually
Transmitted Infections: 2002 Update. Geneva, Switzerland: Joint United Nations
Programme on HIV/AIDS & World Health Organization.

Joint United Nations Programme on HIV/AIDS & World Health
Organization.(UNAIDS). 2002b. South Africa: Epidemiological Fact Sheets on
HIV/AIDS and Sexually Transmitted Infections: 2002 Update. Geneva, Switzerland:
Joint United Nations Programme on HIV/AIDS & World Health Organization.

Kotler, Philip, & Gerald Zaltman. 1971. "Social Marketing: An Approach to Social Change." <u>Journal of Marketing,</u> vol. 35., 3-12.

Kumaranayake, Lilani., & Charlotte Watts. 2001. "Resource Allocation and Priority Setting of AIDS Interventions: Addressing the Generalized Epidemic in sub-Saharan Africa." <u>Journal of International </u>Development, 13(4), 451-466.

Lamboray, Jean-Louis, & Suzanne M. Skevington. 2001. "Defining AIDS Competence: A Working Model for Practical Purposes." <u>Journal of International Development</u>, 13(4), 513-532.

"Mobilising the support of Traditional leaders on HIV/AIDS." Nelson Mandela Foundation. [on-line] available from www.nelsonmandela.org accessed 9/11/2003.

National AIDS Coordinating Agency. 2003. <u>National HIV/AIDS Strategic Framework 2003-2009.</u> Gaborone, Botswana.

"NGO and chiefs launch HIV/AIDS education campaign." September 2, 2003. [on-line] available from:
www.ghanaweb.com/GhanaHomePage/NewsArchive/artikel.php?ID=42215

"Okyenhene Appeals to Successful Akyems." May 30, 2001. [on-line] available from:
www.ghanaweb.com/GhanaHomePage/NewsArchive/artikel.php?ID=15633

"Okyenhene leads marathon race." December 1, 2002. [on-line] available from:
www.ghanaweb.com/GhanaHomePage/SportsArchive/artikel.php?ID=47593

"Omanhene donates computer for HIV/AIDS data processing." June 8, 2003. [on-line] available from:
www.ghanaweb.com/GhanaHomePage/NewsArchive/artikel.php?ID=37470

Owusu-Sarpong, Christiane. 2003. "Setting the Ghanaian Context of Rural Local Government: Traditional Authority Values" in D.I. Ray and P.S. Reddy (eds.) *Grass-Roots Governance? Chiefs in Africa and the Afro-Caribbean.* Calgary: University of Calgary Press, 2003, pp. 31-68.

Pakosie, André R.M. 1996. "Maroon Leadership and the Surinamese State (1760-1990). <u>Journal of Legal Pluralism,</u> No 37/38, pp 263-275.

"Queenmother blames media." March 4, 2002. [on-line] available from:
www.ghanaweb.com/GhanaHomePage/NewsArchive/artikel.php?ID=22169

Ray, Donald I., & P.S. Reddy (eds.) 2003. *Grassroots Governance? Chiefs in Africa and the Afro-Caribbean.* Calgary, AB: University of Calgary Press.

Ray, Donald I. 2003. "Rural Local Governance and Traditional Leadership in Africa and
the Afro-Caribbean: Policy and Research Implications from Africa to the Americas and
Australasia" in D.I. Ray and P.S. Reddy (eds.), *Grass-Roots Governance? Chiefs in
Africa and the Afro-Caribbean.* Calgary: University of Calgary Press, 2003, pp. 1-30.

Ray, Donald I. 2003a. "Ghana: Traditional Leadership and Rural Local Governance" in
D.I. Ray and P.S. Reddy (eds.) *Grass-Roots Governance? Chiefs in Africa and the Afro-
Caribbean..* Calgary: University of Calgary Press, 2003, pp. 83-122.

Ray, Donald I. 1997. Symposium on Traditional Leadership and Local Government,
Gaborone, Botswana, 23-26 September, 1997, London: Commonwealth Local
Government Forum, 1997, ii, 60 pp., Lead editor with K. Sharma and I.I. May-Parker.

Ray, Donald I. 1996. "The New Relevance of Traditional Authority", Journal of Legal
Pluralism, No. 37/38, (with E.A.B. van Rouveroy van Nieuwaal, eds.) 1996, xviii,
430 pp., illus.

"Traditional Council launches HIV/AIDS research centre." May 4, 2002. [on-line]
available from www.ghanaweb.com

"Traditional leaders are helping in the campaign against HIV/AIDS." August 27, 2003.
Business Day [on-line] available from
www.journ-aids.org/reports/27082003a.htm

"Traditional leaders sign charter on HIV/AIDS." December 1, 2002. Nelson Mandela
Foundation. [on-line] available from www.nelsonmandela.org accessed 9/11/2003

World Health Organization Regional Office for Africa. 2003. HIV/AIDS
Epidemiological Surveillance Update for the WHO African Region 2002
Country. Harare, Zimbabwe: World Health Organization.

Zips, Werner. 2003. "We Rule the Mountains and They Rule the Plains: The West
African Basis of Traditional Authority in Jamaica" in D.I. Ray and P.S. Reddy (eds.)
Grassroots Governance? Chiefs in Africa and the Afro-Caribbean.. Calgary: University
of Calgary Press, 2003, pp.227-248.