

**PERCEPTION OF FEMALE VULNERABILITY AND RISK  
FACTORS OF HIV/AIDS: (A CASE STUDY OF ADABRAKA)**

*BY*

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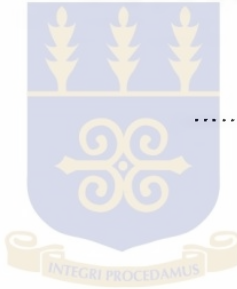
## DECLARATION

I declare that this dissertation is the result of my own research work carried out in the Institute of Adult Education, University of Ghana, under the supervision of Dr. P.K. Fordjor and Mr.S.K. Badu-Nyarko both lecturers of the Institute of Adult Education, University of Ghana.

All references cited in this work, have however been fully acknowledged.



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My sincerest thanks go to Mr. Randy Fairbanks for letting me have access to his computer for this manuscript to be typed. However, despite the advice given to me by my supervisors any errors in the work are my own making and I am therefore entirely responsible for them.

**Ransford Blankson**

Legon, September 2000

## **DEDICATION**

This research work is dedicated to all African women and children who have been infected by HIV/AIDS disease and to all those who are working hard for a cure to be found.

To the infected women and children I hope your wishes for a cure will be a reality.



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**LIST OF ABBREVIATIONS**

**AIDS - Acquired Immune Deficiency Syndrome**

**FGM - Female Genital Mutilation**

**GDHS - Ghana Demographic Health Survey**

**GPA - Global Programme Of AIDS**

**HIV - Human Immunodeficiency Virus**

**MOH - Ministry Of Health**

**NACP - National AIDS/STD Control Programme**

**STD - Sexually Transmitted Disease**

**STI - Sexually Transmitted Infection**

**TBA - Traditional Birth Attendants**

**UNAIDS- Joint United Nations Programme On HIV/AIDS**

**UNFPA - United Nations Fund For Population Activities**

**UNICEF - United Nations International Children's Fund**

**WHO - World Health Organisation**

**WAPCA - West Africa Project To Combat HIV/AIDS**

## **ABSTRACT**

This is a case study of Adabraka on the perception of female vulnerability and risk factors to HIV/AIDS. Adabraka was chosen because of its heavy night activity such as nightclubs and drinking spots, which have generated into high incidence of prostitution.

At the beginning of the HIV/AIDS epidemic men were most infected persons as the mode of transmissions was mostly by exchange of syringe and homosexual activity. As the disease began to spread heterosexual intercourse became the major mode of transmission, then did women become more vulnerable. AIDS in Africa is a death sentence. Antiretroviral drugs that have helped other parts of the world have been unaffordable in Africa.

The study sought to:

To find out whether whose knowledge base on HIV/AIDS is related to a type of formal education.

To find out their source of information on HIV/AIDS and who transmit it.

To examine their knowledge of contraceptive and its use which makes them vulnerable to HIV/AIDS

To examine how their knowledge base affects their practice in sexual relations.

To determine the factors necessary for educating women on HIV/AIDS which will include female vulnerability.

A sample size of 150, comprising 60 women and 30 men from the residents of Adabraka,

simple random sampling was used for this group. 20 prostitutes (10 roamers and 10 sitters) and HIV/AIDS seropositive patients who attend Adabraka polyclinic. For this group purposive sample was used. With the aid of statistical tables, the data were analysed in simple percentage.

In reviewing the various literatures, it came to light that there were various factors, which make women more prone to the HIV/AIDS virus. These were widowhood rites, divorce, female genital mutilation, mobility and migration and gender dynamics in socialisation.

The findings of the study indicated that the knowledge base on HIV/AIDS had no relation to the formal education of the respondents. Knowledge on the mode of transmission was high. Radio did play a very important role in the transmission of information on HIV/AIDS. Knowledge on contraceptive were very high however, its use especially condoms was determined by the availability and the negotiating skills of the women. Though women were aware of the risk factors that make them vulnerable to HIV/AIDS their responses show that they had little or no control on their sexual relations.

After the conclusion, various recommendations worth enhancing HIV/AIDS campaign were made.

## CHAPTER ONE

### Introduction

The Human Immunodeficiency Virus HIV/Acquired Immune Deficiency Syndrome (HIV/AIDS) was first reported in America in 1981 and as at November 1986, 34,448 cases of AIDS were reported in 77 countries, that is five years after the disease was first reported. By October 1991, ten years later, 418,404 cases were reported in 163 countries( World Health Organisation 1991). Earlier reports indicated that transmissions were mainly in homosexuals and intravenous drug users with a male preponderance (WHO ,1991) but recent reports particularly in developing countries show heterosexual intercourse as the major mode of transmission , making women more vulnerable.

Of the all continents in the world, the heaviest burden of the world's HIV/AIDS is on Africa. Africa contains 11 percent of the world's population and over 60 percent of the world's HIV infections. Most of these infections are found in Sub-Saharan and over 90 percent are attributable to heterosexual transmission ( Mann and Chin ,1988). In some major cities in Sub-Saharan Africa, AIDS is the leading cause of death among women twenty to forty years of age (Chin ,1990).

At present HIV-AIDS has made 12.1million children orphans in Sub -Saharan Africa, as opposed to 1.1 million in the rest of the world (West Africa Issue 4244, 2000). United Nations Programme on HIV/AIDS (UNAIDS) and United Nations International Cultural Education Fund (UNICEF) demographic and health survey estimate that 2.9 percent of girls and 1.2 percent of boys between the ages of 15 and 25 are infected with HIV-AIDS in Sub -Saharan Africa. HIV/AIDS is the fourth cause of death globally, but in Africa, it is the leading cause .The prevalence level of HIV/AIDS among countries in Africa is disproportionate. Countries in Southern and Eastern Africa like Botswana, Uganda and Zimbabwe have an epidemic that is infecting the majority of their citizens, while countries in North and West Africa have a varied proportion of HIV/AIDS infection, but a much lower prevalence rate. That is to say some countries in these regions have a high incidence of HIV/AIDS prevalence while others have a low HIV/AIDS prevalence. Yet even in the latter regions HIV/AIDS is fast growing into an epidemic.

A woman with HIV/AIDS is not only living under her own sentence of death but has to endure the damage to her child bearing and nurturing role. She has a 25 to 40 percent chance of passing on HIV to a child in the womb or at birth (UNICEF, 1990). UNICEF 1990 estimated roughly, that each woman dying of AIDS would leave behind an average of two children. Since she is the key provider of food, clothing and household utilities for all her children, a mother's

death has profound social and economic consequences for her orphans and for her husband if he survives.

The HIV/AIDS virus does not seem to spread at random. Women are increasingly bearing the brunt of the HIV/AIDS epidemic since they are more vulnerable to the disease due to certain factors like cultural practices, gender dynamics in socialisation and poverty. The epidemic is inextricably bound up with the social and cultural values and economic relations, which underlie the interaction between individuals within communities. This shapes their increased vulnerability to HIV infection. It is women's lack of power over their bodies and their sexual lives, supported and reinforced by their social and economic inequality, that make them such a vulnerable group in contracting, and living with HIV /AIDS.

Women therefore require special and urgent consideration in the response to the HIV/AIDS epidemic even though the virus can infect a person regardless of sex, race or social status.

The purpose of this research is to make both men and women aware of the factors that expose women to HIV/AIDS so as to enable individuals ,especially women, to protect themselves against these factors. It is also to alert governments and non-governmental organisations to take these factors into consideration when implementing projects and programmes in combating HIV/AIDS.

## **History Of HIV/AIDS**

The Human Immunodeficiency Virus (HIV) is the virus that causes Acquired Immune Deficiency Syndrome (AIDS). It acts by weakening the immune system making the body susceptible to and unable to recover from any disease. A person infected with HIV can for a long time show no sign of a symptom of the disease and this may vary from about 6-10 years depending on the health of the person. For children, however, the time from infection to developing AIDS is much shorter usually 5 years (Armstrong, 1991). However, the adult, before the symptoms develop can transmit the infection through sexual contact to other people. An infected woman can also transmit the disease to her infant during pregnancy or delivery or through breast-feeding. About 30-40 percent of infants born to infected mothers will themselves be infected. The other 60-70 percent will not become infected but are at risk of becoming orphans.

The origin of HIV/AIDS has not been ascertained. During the early stage of the disease the controversy was on the origin of the disease. Many writers gave conflicting and contrasting positions as to the origins of the disease. Many western experts were of the view that HIV/AIDS originated from Africa. (Miller, 1987) was one of such experts. Others attributed biological warfare, while others said it was intentionally produced to wipe out the black race. Others also said that it was transmitted from monkey to men. All these hypothetical speculations were not based on any conclusive evidence.

Currently the origin of the controversy is no more with Africa, as the reality of the day is that the disease is with Africa and it is spreading in epidemic proportions. With no sign of a cure in the foreseeable future the emphasis has now shifted on how to control the deadly disease. It has been proven extensively beyond all reasonable doubts that heterosexual mode of transmission is the most important method of spread, especially in developing countries. Scholars like (Konotey-Ahule ,1989) and( Anarfi ,1995) have extensively documented the heterosexual spread in their various works. Although heterosexuality accounts for a greater spread of the HIV/AIDS there are other modes of the spread of the disease.

### **Rationale Of The Study**

Globally, HIV/AIDS was the fourth cause of death. In 1998, 33.4million responded HIV positive globally and two-thirds of this number came from Africa (United Nations Fund For Population Activities ,1999) .In Africa HIV/AIDS is the leading cause of death and it is estimated that 95 percent of those infected live in developing countries and two -thirds in sub-Saharan Africa. In 29 African countries, the average life expectancy at birth is currently seven years less than it would have been in the absence of AIDS. However, the prevalence of HIV/AIDS in Africa is disproportionate. Southern and Eastern Africa are experiencing HIV/AIDS as an epidemic while in West Africa the situation is different with the exception of Cote d'Ivoire and Nigeria which are experiencing epidemic situations. Ghana is also showing a steady increase in the disease.

UNAIDS 1996 estimated that more than 10 million were infected with HIV. HIV/AIDS is closely related to a population's pattern of sexual behaviour. Among the adult population HIV/AIDS is distributed disproportionately among the sexes. The World Health Organisation ( WHO ,1999) has estimated that more than half of newly infected persons are women. Again, HIV/AIDS is also growing among the youth. WHO ,1999) has estimated that globally 11 new infections occur in a minute and over half of these are young, between the ages of 15-21 and in particular most of them are females.

Statistically in Africa and elsewhere it has been shown that many married women have been infected by their husbands (UNAIDS 1997). Simply being married is a major risk factor for women who have little control over abstinence or condom use at home or their husbands' sexual activity outside. Women with a sexually transmitted disease (STD) are likely to be infected by HIV. Studies have proved that STD facilitates the spread of the disease.

While the level of HIV infection and AIDS among women demonstrate clearly the magnitude of the problem, an understanding of HIV infection in women requires more than just an appreciation of statistics. Social and cultural determinants of HIV infection in women are very different from those of men because they relate to the role of women within relationships, families and communities, which in turn, determines the nature and patterns of sexual activity

and other factors that place women at risk of HIV infection .An understanding of the epidemic must therefore include not only how women have been affected but also why they have been affected. AIDS prevention campaigns often fail women by assuming that they are at low risk or by urging prevention methods that women have little or no power to apply, such as condom use, abstinence and mutual fidelity. The implication of HIV/AIDS shows that women are therefore an “endangered species” like the youth, who form an essential component of the human resource of every nation. The great strides achieved in the increase in life expectancy through good medical care will be eroded and the great role played by women in the economic, social and educational world would be lost.

The spread of HIV/AIDS is again a problem, because although scientists have known the virus for about two decades, no cure has yet been found. Therefore, prevention is the best known method of curbing this disease. A successful prevention strategy depends on an in-depth knowledge of the factors that cause particular groups to be at risk.

### **Statement Of The Problem**

Ghana's rate of infection of HIV/AIDS is about 4% and according to World Health Organization (WHO, 1994) report any country, which has an infection rate of 5% or more, will experience an HIV/AIDS epidemic. Ghana can therefore be said to be on the threshold of experiencing an epidemic if concrete

measures are not put in place to check the rapid rate of infection. The increase in infection of HIV may be due to the fact that people do not perceive themselves as being at risk. The 1998 Ghana Demographic Health Survey (G.D.H.S.) quoted that about 97% of the adult population had some knowledge on HIV/AIDS. In Ghana, AIDS was first recorded in March 1986 and by the end of the year, 42 new cases had been reported. The number of AIDS cases had increased to 7,752 by December 1999 according to the (National AIDS/STD Control Programme and Ministry of Health NACP/MOH).

In Ghana out of the total reported cases of 7,752, women comprise 4,616 with 3,136 being men. Among males, those aged between 30 and 34 years have the highest frequency of 692 and among the females, those aged between 25 and 29 years had the highest frequency of 1013. Since the gestation period may span even a decade it means that the age of infection is far lower than the frequency of infections for males (30-34 years) and females (25-29 years). These statistics show that females are more vulnerable to HIV/AIDS.

It is evident that many more cases of AIDS were being reported over the years but it was difficult to estimate how authentic AIDS reporting in the country was. It is a known fact that qualified health workers do not observe more HIV/AIDS cases as most of the cases are not brought to their health centers and so go unrecognised. Since no known cure or treatment is yet known abstinence and the use of condoms by sexually active people are the major means of preventing

## HIV/AIDS.

Vulnerability to infection and the ability to protect oneself are believed to be influenced by gender dynamics in socialisation: pressure to reproduce, polygamy, occupation, poverty, migration, mobility and abortion. There is therefore the need to investigate these factors to find out which are more prevalent than the others are and make recommendations to curb these risk factors. Investigating into the factors that make people vulnerable especially women should therefore curb the spread of HIV/AIDS.

### **Aims And Objectives**

- 1) To find out whether their knowledge base on HIV/AIDS is related to the type of formal education.
- 2) To find out their source of information on HIV/AIDS and who transmits it.
- 3) To examine their knowledge of contraceptive and its use.
- 4) To examine whether women are aware of the risk factors, which make them vulnerable to HIV/AIDS.
- 5) To examine how their knowledge base affect their practice in sexual relations.
- 6) To determine the factors necessary for educating women on HIV/AIDS which will include female vulnerability.

### **Significance Of The Study**

With the rapid increase in HIV/AIDS in Africa, if nothing concrete is done to reverse this trend, the most important resource that Africa needs for development (human resource) will be lost, at the macro level, it will be greatly felt in the public and private sectors. Overhead cost will increase as a result of rising medical expenditure, absenteeism from work and training of replacement. This will cause labour shortage as a result of HIV/AIDS mortality and mobility will have a great impact on the agriculture sector that is losing its main power requirements to the urban cities in search for work that are non-existent.

The socio-economic impact of HIV/AIDS on the household economy and the family value system is very enormous as it can either lead to the break down or the disintegration of the nuclear family, dependent on whether one or both parents have died. Household economy becomes impoverished thereby leading to the reduction in the number of meals, limiting diet to one or two staple foods. In the extreme case, children are orphaned when both parents die. Orphaned children may run away from home to escape the stigma and poverty, ending up as street children.

HIV/AIDS can also break the traditional norms and customs of the society, in other countries where the epidemic is hardest hit these traditional norms and customs are eroded. The result is that the social fabric of the extended family is

showing signs of erosion and the close bonds that hold family members together are disappearing. There is therefore the need to check this epidemic. The showing and spreading of HIV/AIDS will require improvements in comprehensive reproductive health care as well as better public education about the risks and consequences of HIV/AIDS infection.

### **Women's Vulnerability To HIV/AIDS**

All over the world women continue to make strides towards equality with men. Wherever they are educated, able to generate income, and enjoy equal protection under the law, they are in a position to have some control over their economic and personal life. But for millions of women these goals are still remote. These are the women who are the most vulnerable to infection with HIV. A vulnerable woman is one who is lacking in the power of control over her risk of HIV/AIDS infection. It has become clear that vulnerability to infection and the ability to protect oneself are profoundly influenced by biological, social, cultural, economic and political factors. AIDS is essentially a sexually transmitted disease (STD), which like some other such diseases can also be spread through blood and blood products and from an infected woman to her unborn or new born child.

World wide, the HIV risk for women is rising. In the developed countries, at the beginning of the HIV/AIDS epidemic, some few decades ago, men were the most infected persons as the mode of transmission was mostly by exchange of

syringe and homosexual activity. As the disease began to spread, heterosexual intercourse became the major mode of transmission. Then did women become more vulnerable. In Africa south of the Sahara there are already six women with HIV for every ten men. In countries where youngsters (15-24 years) account for 60% of all new infections, young women outnumber their male peers by a ratio of 2:1. Currently close to half of adults world wide, who become infected daily are women.

Research shows that the risk of becoming infected with HIV during unprotected vaginal intercourse is as much as 2-4 times higher for women than men. Women are also more vulnerable to other sexually transmitted diseases. This is because, as compared to men, women have a bigger surface area of mucosa exposed during intercourse to their partner's sexual secretions. And semen infected with HIV typically contains a higher concentration of virus than a woman's sexual secretions. This makes male to female transmission more efficient than female to male. Younger women are at even greater biological risk. Their physiologically immature cervix and scant vaginal secretions put up less of a barrier to HIV. There is evidence that women again become more vulnerable after the menopause. Tearing and bleeding during intercourse whether from 'rough sex', rape or genital mutilation (female circumcision) multiplies the risk of HIV infection. This form of sex often tears the delicate tissues and affords easy entry to the virus (UNAIDS 1997). Everyday women are battered, raped, sexually harassed and psychologically tortured. Sexually abused women

sometimes contract STD's or become infected with HIV.

In many societies in Africa girls are brought up with little understanding of their reproductive system or the transmission of STD and prevention. Even when this is taught in school girls are usually taken out of school earlier than boys often to assume domestic responsibilities. There is evidence that most elderly men are going out with even younger girls with the hope of avoiding infection but as they are older they might have had multiple partners therefore infect the younger girls. In many communities, school and homes are wary of providing sex education or issues to sexuality due to social and cultural concerns about 'protection' for young women from sexual experience. As a result, young women and men lack adequate information and skills to protect themselves if they become sexually active.

As a result of unequal access to schooling, training, and employment, women find themselves in the low paying clerical and service jobs. This situation is even worsening by fewer workplaces and fewer promotions (*vis-a-vis* men). Women are therefore confined in the informal sector. In the informal sector women also face discrimination as they lack access to technical assistance, training and credit facilities. For example, in the agricultural sector, policies have traditionally provided funds and technical training to men involved in cash crop farming and not to women, who have been more likely to be engaged in subsistence farming.

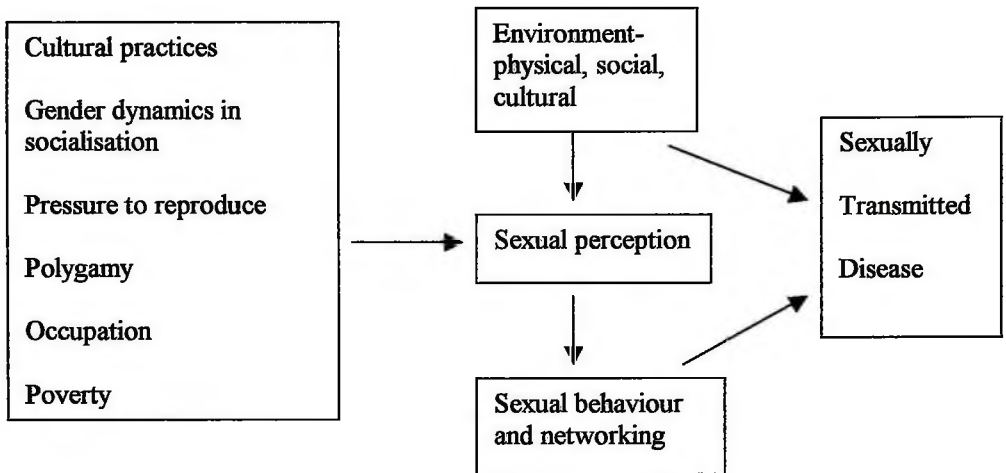
In some cultures women are more likely not to talk about sex with men or to negotiate safer sex practices. This can lead to one being stigmatised as being a spoilt woman. Despite this, many HIV/AIDS prevention and family planning programmes have expected women to assume responsibility for the prevention of both pregnancy and sexually transmitted disease (STD's) including HIV infection in a context in which they have limited control over when, and how they engage in sexual activity. Since the route of transmission to women is mainly through heterosexual intercourse in most developing countries the result is a growing HIV/AIDS burden on women. In many countries throughout the world, pregnant women attending antenatal clinics are showing a high prevalence of infection. Studies of women attending antenatal clinics find that many are in monogamous marriages and have been infected by their husbands. As infections in women rise, so do infections in the infants born to them. Overall about one- third of babies born to HIV infected mothers become infected themselves.

A great dilemma is that condoms are incompatible with pregnancy. Couples wanting children need to know their HIV status and if both are uninfected, agree to remain faithful or refrain from unsafe extramarital sex. Obstacles to the above safe way of preventing HIV are unwillingness to discuss these issues openly and a lack of voluntary HIV testing and counselling services.

Women who head households are more likely to be financially poor than those

households, which have residential working males. Women's economic dependence on male partners in order to avoid poverty for themselves and their children makes it difficult for women to negotiate safer sex practices to protect themselves from infections.

### Conceptual Framework



At present no single theory can satisfactorily explain, predict, and control the wide variety of behaviour that are linked to health the status. HIV/AIDS prevention will do well to apply more than one theoretical perspective to any given problem, since especially in this sensitive and complex area problems are likely to be multifaceted and influenced by many forces.

Efforts to find a solution to the HIV/AIDS prevention have been directed to certain class of people regarded as high risk behaviour groups and thereby

concentrating attention on them-homosexuals and intravenous drug users in the industrialised countries and female prostitutes in developing countries . In the process certain groups have become marginalized and hence cut off from mainstream HIV/AIDS prevention campaigns. As such the potential harm of HIV/AIDS to women seemed vague and was virtually neglected. The result was that by 1986, HIV/AIDS was the leading cause of death among women between 24-and 34 years.

Some recent researchers have however called for redirection of attention from the behaviour of individuals and groups towards institutions and environments within which they operate, thereby allowing the conditions within which the behaviour occurs to be studied. Writing on HIV/AIDS in Uganda, Barnett and Blaikie (1989) emphasised that focusing on individual behaviour alone can provide a clear target for a scapegoat since it identifies those who are vulnerable to infection and who, therefore are “dangerous” to the rest of society. They observe that because of civil disruption, war, smuggling, and unequal access to economic resources the question has become less one of certain sexual behaviour being risky, but all sexual behaviour being risky because the environment is one of high risk.

It is being conceptualised here that the community and all the actors within it could be an arena from where the HIV/AIDS virus could be transmitted into the general population. The study would therefore focus on the physical, social, cultural and economic environment within which the target population operates.

It is hoped that this approach would bring out the environmentally determined behavioural patterns that implicates women's vulnerability to HIV/AIDS.

### **Health Belief Model (H. B.M.)**

The Health Belief Model (H.B.M.) is a psychological model that attempts to explain and predict health behaviours by focusing on the attitudes and beliefs of individuals. The H.B.M. was developed in the 1950's as part of an effort by social psychologist in the United States public health service to explain the lack of public participation in health screening and prevention programmes (a free and conveniently located tuberculosis screening project).

The Health Belief Model (H.B. F.) key variables are as follows (Becker 1974).

- a) Perceived susceptibility or vulnerability to a health threat.
- b) Perceived severity of the consequences of a disease or health threat
- c) Perceived effectiveness of protective actions.
- d) Perceived cost of or barriers to protective actions.
- e) Cues to action, such as physician advice on symptoms
- f) Demographic, structural and social/psychological factors that "enable" behaviour.

These variables are hypothesized to have a multiplicative relationship to each other. For example, the likelihood of condom use as a means of preventing HIV infection will be greater when people perceive themselves as

susceptible to HIV, perceive the consequences of infection as very severe, perceive protective action as very effective, see few cost or barriers to self protection (such as embarrassment over condom purchases) have a cue to action (for example, a reminder of protective behaviours when dating) and are enabled to protect themselves (for example, have opportunity to get condoms ).

However H.B.M. has several weaknesses. Firstly people often fail to behave in line with their beliefs, even if there is a cue to action and the behaviour is enabled by outside forces. Secondly only health and motives are considered in this model. However, other beliefs and issues are important to the person who is engaging in high-risk behaviour. For example prostitutes make their living through sex with multiple partners, many of whom are anonymous. In spite of a desire to avoid becoming infected with HIV, they may not be vigilant about safer sex practices when using alcohol and drugs ( Mondanaro 1987 ).

The H.B.M. offers few explicit suggestions for intervention except to provide information to people .A final problem is that beliefs may or may not precede behaviour. It can sometimes be demonstrated that behaviour precedes beliefs ( Leventhal et al 1980).

### **Operational Definitions**

**Roamers:** These are women who roam from place to place in search of clients. They normally operate in hotels, nightclubs, and open spaces. They are often not full time prostitutes.

**Sitters:** These are traditionally referred to as ‘Tuutuu’. These women operate from their homes, sitting in front of their doors to receive clients. These women are much older than the roamers

**Seropositive HIV Patients:** These are patients who have been tested by a recognised hospital and declared to be HIV positive.

## **CHAPTER TWO**

### **LITERATURE REVIEW**

There has been a serious distortion of the understanding of the way the HIV/AIDS epidemic has affected women because of the singling out of sex workers by epidemiologist researchers and national HIV/AIDS programmes as a target or high-risk group. The targeting of sex workers encourages blame, stigma and discrimination not only against them but also against all women. The majority of women are not sex workers, they are wives, mothers, aunts, sisters, grandmothers and daughters. As mothers, women deal with the implications of HIV infection for unborn children. As mothers, women, aunts, sisters, grandmothers and daughters, women will have to take care for the children orphaned by the epidemic. As women bear the burden of caring for sick and dying partners, children, relatives and neighbours. This makes women disproportionately affected by the epidemic.

#### **Widowhood**

Despite the diverse culture groups and wide variation in culture across sub-Saharan Africa, the customs relating to widowhood are largely similar in the region and are unfortunately oppressive to widows. As custom demands in several African societies widows are supposed to remarry within the husband's

extended family. This is common among the Fulani of Mali. In some societies widows that resist remarriage with in-laws are thrown out of their husband's home and forced to leave their children behind as in Burkina Faso Women's Union (1990). Furthermore, widows in several African societies are often considered evil and responsible for their husband's death ( Women's Union 1990 ). As a result, many widows are forced to migrate to towns to find alternate means of livelihood, as they can no longer fit into the village. Ntozi (1970) in his article "Widowhood, remarriage and migration during the HIV/AIDS epidemic in Uganda" has stated that most widows migrate and remarry and most of them have lost their spouses because of AIDS or related causes. There is also the probability that the AIDS widows and widowers are HIV-infected. Many of these may not have known they are HIV- infected. It is therefore dangerous for widowers to migrate to strange places where their past is unknown and remarry.

### **Divorce**

Most available studies show that transmission of HIV is mainly the result of multiple sexual relationships WHO (1990). Multiple sex partnerships has a significant role to play in the evolution of the HIV epidemic and it occurs in several forms: a person may have several sexual partners concurrently or one after the other through divorce, separation, widowhood or inheritance. Wakanaabi and Sekimpi (1997) in their article have outlined that divorce or separated persons are more likely to be infected with HIV than those in marital unions.

### **Female Genital Mutilation**

In many African societies traditional forms of surgery mainly for social purposes are common which are undertaken in an unhygienic conditions and therefore constitutes possible route for the transmission of HIV. According to Ahmed (1988) about 90 percent of women aged between 45 and 49 years and 86 percent are reported as circumcised. Traditional birth attendants (T.B.A.'s) who usually perform such circumcisions tend to be old women (long -practiced in the art). It is clear that female circumcision is potentially a major route for HIV. Further, Ahmed (1988) has stated that skin piercing is another practice affecting especially female health. Ear piercing and tattooing can lead to the transfer of blood, which can therefore be a source of HIV transmission.

Today, the number of girls and women who have been subjected to female genital mutilation is estimated at more than 130 million individuals world wide, and a further two million are at risk of this practice World Development Report (1983). Female genital mutilation, a form of violence against the girl child that affects her life as an adult woman, is a traditional cultural practice. In those societies where it is practiced, it is believed that female genital mutilation surgery is necessary to ensure the self-respect of the girl and her family and increases her marriage opportunities. Female genital mutilation constitutes all procedures that involve partial or total injury of the female genital organs whether for cultural or any other non-therapeutic reasons.

## **Mobility And Migration**

HIV-AIDS was considered as a foreign disease in Ghana and was associated with people who have resided or made extended visits outside the country usually in search of jobs. This situation has now changed. In sub Sahara Africa, people who work along the road, especially along the major highways, transmit HIV/AIDS. Ogunjrmilua, 1982 has identified long distance truck drivers and women who sell goods along the road as playing a role in the spread of the infection. In the past, unmarried young women usually assisted their mothers in trading, but women are now selling on their own in the lorry parks or at the bus and truck stops along the road. Higher levels of infection with HIV have been found among these men and women than among other persons living and working in the same district. Though the danger of the disease transmission by those who work along the roads was not a prominent feature when HIV/AIDS was first identified. This is dangerous in an era of AIDS because of multiple relationships combined with the drivers outgoing and carefree attitude towards life.

Ogunjemilua 1982 make long distance driver promiscuous. Firstly, the drivers are relatively well off. Secondly the truck driving attracts adventurous men who are more likely than others to take risks. Although women do not often migrate it has a very telling effect in them the way of infecting them with the HIV/AIDS by the migrating men. This can be the cause of a high incidence of HIV/AIDS in

southern Africa as goods are transported by road.

Migrant labourers are a high-risk group both at their place of work and origin. At the place of work the migrant worker lives as single men and often have sexual relations with local women, mostly in pubs, canteens. At home, the earnings from migration play an important role in sexual and marital relations. Young men migrate to earn money and accumulate domestic goods for use in their families. Returning migrants engage in conspicuous spending and since their incomes are greatly higher than those of the average peasants at home, they become a major attraction to the rural women. It has been observed by Kishindo (1993) and Chiwa (1992) that the money and the domestic goods the migrants bring home make them “a big attraction to women in the village” As a result, migrants maintain multiple sexual partners and this makes migrants particularly susceptible to other STD's.

A recent study in HIV/AIDS and migration in Uganda showed a strong correlation between, HIV/AIDS infection and migration status Nunn et al (1995). The lowest rate of HIV was found in those people whose place of residence was more permanent. People who had moved within the last 5 years, for example, were three times more likely to be infected with HIV than those who had been living for the same period of time at the same place.

Itinerant trading is a major economic activity for women who constitute an

important chain in the distribution of foods in West Africa. With the outbreak of HIV/AIDS these women, some of who move far away from home for days or weeks are vulnerable to HIV/AIDS through their activities. The itinerant women traders appear highly vulnerable women and as highly mobile people. Their vulnerability is caused by extremely difficult conditions in which the women work, and are exploited for the sexual gratification of men with whom they come into contact. Nabila 1994 in his article "Migration of Frafra in Northern Ghana: a case study of cyclical labour migration in West Africa has stated some of the difficulties these itinerant traders face. Accommodation is one of the problems since these traders do not have sufficient money for hotels and sleeping in trucks outside in the open is hazardous. There is the danger of being assaulted or losing one's working capital through attacks by criminals.

Also, inadequacy of financial resources has repercussions on the supply of the item of trade. The nature of itinerant trade requires a sustainable source of supply of whatever item an individual trades in. Moreover, considering the distance covered by most of the traders and the cost involved, the quantity of items bought at a time must be substantial to render the exercise profitable. These two considerations added to the already disadvantaged condition of the itinerant women traders, compound their vulnerability and make them fall victims to the schemes of some unscrupulous men.

### **Gender Dynamics In Socialisation**

Gender roles differ substantially, women are taught to be submissive and obsequious while men are to be forthright and assertive. These attributes of male and females in African societies are taken into a sexual relationship where men take all the decisions in a sexual relationship. However, a study in Kenya which explored sexual decision-making and negotiation between partners in stable, long-term relationships Balmer et al (1974) came out with the findings that though men took the initiative in sexual activities, male participants admitted that women often did make the final decision regarding timing of intercourse. Also initiation and rejection strategies used by both partners were indirectly and rarely brought out of open communication.

### **Polygamy**

Many societies in Africa expect a man to have multiple sexual partners before marriage. Traditionally having many wives and fathering many children was a sign of success and virility Orubuloye et al (1994). Not all courtship leads to marriage and lover relationships can be enjoyed for their own sake. This practice, which is wide spread in most African societies, is a sure way of spreading the HIV/AIDS. This is because polygamous unions may lead to the formation of a wide network of infection because of extra marital relationships between males and females involved in such union .It has also been suggested that the instability of the marriage institutions facilitates the epidemic in Haiti and in parts of Africa Bazell (1988). Also, early in the epidemic, Berkeley et al

(1989) identified polygamous marriage, practiced by about a third of respondents as one of three risk factors prevalent among Uganda's Muslim minority Kagimu et al (1995).

### **Occupation**

Epidemiological studies confirmed an association between occupational exposure and infection with some disease. For instance, there have been reported associations between the time of exposure and the presence of hepatitis B viral markers Garcia et al (1994). Health Care Workers play a key role in the prevention and management of disease. Their perception, attitudes and practices have implications for the management of the disease in both health centres and communities. Health workers in sub-Sahara Africa have been reported to perceive themselves as being at high risk as compared to health workers in China who perceive others apart from themselves. These differences in perception are partly due to differences in reported cases of HIV/AIDS in these parts of the world. Whereas Africa has high rate of HIV/AIDS patients China has a low rate of HIV/AIDS patients. In a study in Mexico, of 12,151 adults HIV/AIDS cases reported by 1993, 2.9 percent (335) were health workers and two cases were directly linked to occupational transmission while in 45 cases (13.4 percent) no risk factors were identified. In Ghana, the reported case of Dr. Mary-Ann Okine is a reminder of the risk faced by some of our medical personnel. Although the above research did not come out with the number of women of health workers who were affected, since women are likely to be

affected more than men in the health sector. Women's role also as care givers in their homes also puts them at a greater risk of contracting the disease than men.

### **The Socio -Economic Impact Of HIV/AIDS**

With the rapid increase in HIV/AIDS in Africa, if nothing concrete is done to reverse this trend, the most important resource that Africa needs for development will be lost (human resource) .For example, Botswana that has the world's highest HIV/AIDS prevalence rate, one out of every four adults is infected. Life expectancy has fallen from 61 years in the late 1980's to 47 UNFPA (1990) .It is further estimated that Botswana's population by 2025 may be 23 percent smaller than it would have been in the absence of AIDS .In Zimbabwe, the second hardest hit country in the world, one in five adults is infected. Estimated life expectancy at birth is 44 years and will fall to 41 in 2020-2025.

The economic repercussion of the HIV epidemic at the macro level will be greatly felt in the public and private sectors. Overhead cost will increase as a result of rising medical expenditure, absenteeism from work and training of replacement. This will cause labour shortage as a result of HIV-AIDS mortality and morbidity will have a great impact on the agricultural sector, which is losing its main power requirements to the urban cities in search of work, which are non-existent.

Many countries in the South Eastern part of Africa are experiencing eradication of progress as a result of child mortality and increasing life expectancy. In addition HIV/AIDS is also affecting demographic change by reducing the fertility of women who are infected and influencing age at marriage, sexual behaviour and contraceptive use UNFPA (1999).

The socio - economic impact of HIV-AIDS in the household economy and the family value system is enormous as it can either lead to the break down or the disintegration of the nuclear family, depending on whether one or both parents have died. Household economy becomes impoverished there by leading to the reduction in the number of meals, and limiting diet to one or two staple food. Also, lack of resources to purchase essential medicine and treatment will result in the deterioration of the health status of the nuclear family or the extended family. Education of children has to be discontinued because of lack of resources or children's help is needed to take care of sick parents. Children also find it difficult to go to school as they are stigmatised by their peers at school. In the extreme case children are orphaned when both parents die. Orphaned children may run away from home to escape the stigma and poverty and ending up as street children. Orphans sometimes are taken out of school under the pressure of AIDS stigma, which often hamper the ability of young widows to earn a living Topoezis and Himrich (1995).

HIV/AIDS can also break the traditional norms and customs of the society. In other countries where the epidemic is hardest hit, these traditional norms and customs are eroded. The result is that the social fabric of the extended family is showing signs of erosion and the close bonds that hold family members together are disappearing.

There is therefore the need to check this epidemic. The slowing and stopping the spreading of AIDS will require improvements in comprehensive reproductive health care as well as better public education about the risks and consequences of HIV infection.

## **CHAPTER THREE**

### **RESEARCH METHODOLOGY**

#### **Why Adabraka Was Chosen**

Adabraka was chosen as the study area for this research. Administratively, Adabraka is centrally located within the Osu Klottey Sub-Metropolitan District Council. This sub-metropolitan area is made up of the following residential areas: Tudu, Osu, Adabraka, Asylumdown, and Ridge.

Adabraka has a total area of 6.33 Kilometre Square and a total population of 47,531 (1997 zone counting). The population of Adabraka accounts for 25.8 % of the population of the Osu Klottey Sub-Metropolitan area, which is one of the Sub-District Councils making up the Accra District. In terms of population density, Adabraka is one of the most densely populated suburbs within the sub-metropolitan area with a population density of about 7509 people per square kilometre.

It is worth stating that in recent times Adabraka has gradually been transformed into one of the busiest business districts within the Accra Metropolis, attracting all manner of people ranging from public workers, self-employed businessmen, and other petty traders.

The residents of Adabraka are a mixture of low and middle class socio-economic classes. Accessibility to the city of Accra has resulted in the establishment of restaurants, hotels and nightclubs that are concentrated some few metres away from the Kwame Nkrumah Circle. These have resulted in the high incidence of prostitution and the peddling of drugs. Prostitution in Adabraka can be divided into two types, the brothel prostitution and the night prostitution. Night prostitutions are centred on nightclubs and drinking spots. The brothel prostitution can be found around the river Odaw popularly known as Sahara. Most of these prostitutes are mature women and some well advanced in age. Night prostitution can be divided into two classes: high class and low class. The “high-class” prostitutes normally hang around the nightclubs and hotels while the low class usually stand along the street sides and around drinking spots in the area. Presently, because of the brutal killing of women in the city of Accra, there is regular police patrol, which has resulted in the spread of prostitution to the other parts of Adabraka.

Some residents of Adabraka use their houses and abandoned structures as sites for prostitution activities for a fee. These activities have brought about the presence of hard drug peddlers some of whom are residents of Adabraka. Some of these drug peddlers act as “frontliners” by insuring protection of the prostitutes for a fee. Some prostitutes also bring their boyfriends to guide and protect them from “junkies” and criminals who often rob them of their money

and jewelry. Very often some prostitutes and some “frontliners” connive to rob other unsuspecting victims of their money and valuables. This act is mainly the attribute of the low class prostitutes. Although these prostitutes are mostly not from Adabraka, the influence of their activity on the community of Adabraka is very great in terms of promiscuity and the use and sale of drugs.

### **Adabraka Polyclinic (The West African Project To Combat AIDS)**

The West Africa project to combat AIDS and STD is a Canadian International Development Agency (CIDA) funded project, which is being implemented by the Centre De Cooperation Internationale en Sante et Development (CCISD, a Canadian NGO), the Centre de Recherche Clinique Centre Hospitalier Universitaire de Sherbrooke (CRC-CHUS, a Canadian University hospital) and other partners. It has been in operation since 1995 in seven West African countries including Ghana. These other countries are Senegal, Mali, Burkina Faso, Ivory Coast, Benin and Guinea. Ghana is the only Anglophone country.

The goal of the unit is to ensure an effective and sustainable control of HIV and Sexually Transmitted Infection (STI), by strengthening primary and community health networks giving priority to high-risk groups and aiming at self-financing. To ensure the sustainability of the program, the project activities are integrated within the existing government health institutions, which are being manned by the government health professionals who were retrained to be able to work with vulnerable women.

Peer educators are also recruited and trained to educate people on sexual health at identifiable places and some time to bring them to the centre for sexual examination and treatment.

### **Gaining Respondent's Consent**

**Roamers:** The workers of STD unit of Adabraka Polyclinic, who have been in constant contact with the roamers, made gaining access to respondents easier. The only barrier was communications since most of them either had no education at all or were primary school drop-outs. Consequently, they found some of the issues difficult to comprehend. Language was also a problem, since some of the respondents were from the north and had not fully grasped the local dialects of Ga and Twi.

**Sitters:** These groups of prostitutes were much older than the roamers. One or two did not accept to be interviewed but on the whole they were cooperative.

**HIV Seropositive patients:** The HIV patients were cooperative and in some cases over willing to talk and sometimes delved into their private matters.

## **Problems Associated With The Interview Of Men And Women Of Adabraka**

On the whole the response was encouraging but some few people were skeptical about the issue of HIV and did not want to talk about it especially the women. Some also demanded that they should be given money for the interview.

## **Problem Associated With The Interview Of Prostitutes And HIV Seropositive Patients At Adabraka Polyclinic.**

Since the prostitutes and the HIV seropositive patients had no particular day of going to the clinic I had to visit the clinic as early as 8:00 a.m. and leave at 5:00 p.m. sometimes getting one respondent to interview was difficult.

## **Study Type**

This study was quantitative research which was aimed at the knowledge base of HIV/AIDS, source of information on HIV/AIDS and who transmits it, to examine knowledge of contraceptive and its use, to examine how knowledge base affects practice in sexual relations and the vulnerability risk factors of HIV/AIDS with reference to women.

## **Study Population**

For the survey, the study population comprised all men and women between the ages of 15-49 years resident in Adabraka, extending from the Kwame Nkrumah Circle along the Odaw River to Farisco, and then northward to the Psychiatric Hospital and Adabraka Polyclinic. The in-depth interview comprised all

prostitutes (roamers and sitters), HIV/AIDS, sero-positive patients who attend Adabraka polyclinic for counselling and the staff of the counselling unit of Adabraka polyclinic.

### **Sample Size**

The sample size for the survey was 150 respondents- 60 women and 30 men. For the prostitutes (roamers and sitters) and HIV/AIDS seropositives patients the sample size was 10 respondents each.

### **Sampling Methodology**

For the survey Adabraka was divided into polling stations (wards) using the electoral commission demarcation, a simple random sampling was used to select 5 wards. Out of these wards, the quota sampling was used where in each ward 20 women and 10 men were selected. For the selection of respondents from the wards, the various houses in these wards were numbered and this was not difficult because of the good layout of Adabraka. The houses in the various wards were numbered and the houses were randomly selected using the table of random numbers to select each house. Respondents were therefore selected from the chosen houses until the selected numbers of respondents in the various wards were achieved.

For the prostitutes and HIV/AIDS seropositive patients, purposive and opportunistic sampling was used for the case study because of the sensitivity of the topic

### **Data Collection Method**

Both primary and secondary sources were employed in the collection of data. The secondary source included articles from journals, newspapers, research findings and various documents on HIV/AIDS. The primary source of data was based on questionnaire and in-depth interviews.

### **Data Analysis**

Data collected from the survey was analysed quantitatively. Tables were applied in analysing the issues raised while the qualitative analyses were used to support some of the findings from the quantitative data. The study also gave some recommendations as to how best the problems raised could be solved.

### **Ethical Consideration**

The topic chosen (Female vulnerability and the risk factors to HIV/ AIDS) is a very sensitive topic, which culturally is not openly discussed. Because of this, questionnaire was used in the collection of data. The words were carefully chosen so that they are not offensive to the respondents. No focus group discussion was carried, as it tended to make people to shy away because of the sensitive nature of the topic.

Respondents were allowed to opt out if they do not want to participate in the research. Verbal consent was also sought from the respondents. Confidentiality and anonymity were be assured by not asking respondents to write down their names and nothing was used to identify them.

## CHAPTER FOUR

### Data Analysis And Findings

The selection for prostitutes (both sitters and roamers) was more purposive while simple random was used for both men and women of Adabraka.

#### Age Distribution Of Respondents

Since the upsurge of the HIV/AIDS epidemic, the youth have borne the brunt of the epidemic most. This has been a source of worry since the youth form the vibrant human resource of every economy. The age group 21-25 has the highest infection of the disease for females, 30-35 for males. This early infection of female may be due to the fact that the female develop physiologically faster than males and also start reproductive life earlier than males

**Table 4:1 Age Distribution Of Respondents**

Age	Prostitute	HIV Patient	Community (non Prostitute and HIV Patients)	Percentage
16-20	5	1	15	17.5
21-25	4	2	34	33.3
26-30	2	-	16	15
31-35	1	1	18	16.7
36-40	5	2	7	11.7
41-45	3	3		5
46-50	-	1	-	0.8
<b>Total</b>	<b>20</b>	<b>10</b>	<b>90</b>	<b>100%</b>

The mean age was calculated to be 28 years. In the above table, the prostitutes

aged 31 to 45 years were mostly sitters while those whose ages were between 16-30 years were mostly roamers. The table also depict that most of the HIV/AIDS seropositive patients are in their mid-life stage that is between 36 and 50 years.

### **Religious Denominations Of Respondents**

The proliferation of churches has been on the increase. One of the main tenets of Christianity is the abstinence from sex before marriage. Further more the Catholic church is against the use of condoms and other family planning methods even in marriage. It is therefore important to know the religious background of the respondents and whether they are abiding by the teaching and beliefs of their faith. However, it is not only Christianity that upholds the tenet that sex should be only for the married.

**Table 4:2 Religious Denominations of Respondents**

<b>Religion</b>	<b>Frequency</b>	<b>Percentage</b>
Catholic	10	8.3
Protestant	51	42.5
Spiritual/Pentecost	41	34.2
Traditional	1	0.8
Moslem	11	9.2
No religion	6	5.0
<b>Total</b>	<b>120</b>	<b>100</b>

Most of the respondents were Christians and regular church goers while others were mostly nominal church goers. The HIV/AIDS patients were also regular church goers as most of them were seeking miraculous healing from their

churches. Protestants form the highest frequency (42.5%) while traditional believers have the lowest (0.8%). Spiritual /Pentecost group formed the second highest with 34%. The catholic group had 8.3% respondents, Moslem religion had 9.2% and those with no religion had 5%.

### **Educational Statuses Of Respondents**

Access to formal educational is important in obtaining information about pertinent issues which promotes health and socio-economic development of the individual and the community. It is a known fact that women play second fiddle to men in terms of access to education which is mainly due to traditional and cultural practices in the African society.

**Table 4:3 Educational Status of Respondents**

<b>Educational Status</b>	<b>Frequency</b>	<b>Percentage</b>
No formal Education	7	5.8
Primary/J.S.S.	41	34.2
Secondary/S.S.S.	45	37.5
Tertiary	27	22.5
<b>Total</b>	<b>120</b>	<b>100</b>

Forty percent of the respondents had little or no formal education and this made it difficult to explain some of the questions. With regard to education, 5.8% had no formal education, 34.2% had Primary/J.S.S. education, while 22.5% had tertiary education (polytechnic, training college and university). This shows that 94.2% of the respondents had some sort of formal education.

### **First Sexual Experiences Of Respondents**

UNICEF 1998 has stated that the first sexual experience for female is between the ages of 12 to 15 years, while that of male is between 14-16 years. This may be so because females develop physiologically faster than males.

**Table 4:4 First Sexual Experience Of Respondents**

<b>Age</b>	<b>Frequency</b>	<b>Percentage</b>
6-10	9	7.5
11-15	16	13.3
16-20	70	58.3
21and above	25	20.9
<b>Total</b>	<b>120</b>	<b>100</b>

It is evident from table 4:4 that significant proportion of the respondents had their first acts of sexual intercourse between the ages 16-20. Most respondents therefore had their first sexual experience in their teens and also before marriage. There is also quite a significant number (13.3%), which had their first sexual experience at a much earlier age of 11-15years. However the mean age of the first sexual experience of the respondents is 17.6 years, which is very high in terms of what the literature says, that most youth have their first sexual experience between the ages of 12 to 15 years with girls having their first sexual experience much earlier than boys (UNICEF 1998).

### **First Age of Knowledge of Sex And Reproductive Issues**

Sexual issues are not openly discussed, most adolescents therefore obtain their

knowledge of sex from their friends. This is peculiar to African societies where sexual issues are not openly discussed more especially if one is a woman. Whenever a woman is heard openly discussing about sexual issues, she is branded to be 'bad' or 'spoilt' However, traditional customs like the 'dipo' performed for adolescent girls teach them about reproductive issues. The same cannot be said about the adolescent boys. Fathers have been known to shy away from educating their children on sexual issues. Family Planning activities have also been known to target women, ignoring the men.

While wide-scale public educational campaigns have increased general levels of AIDS risk and knowledge, this has not often been translated into behavioural change (Clemente and Peterson 1994).

**Table 4:5 First Age Of Knowledge Of Sex And Reproductive Issues**

<b>Age</b>	<b>Frequency</b>	<b>Percentage</b>
5-10 years	3	2.5
11-15 years	46	38.3
16-20 years	51	42.5
21 years and above	20	16.7
<b>Total</b>	<b>120</b>	<b>100</b>

Table 4:5 shows that the age 16-20 has the highest frequency of respondents of first knowledge of sex and reproductive issues (42.5%), which implies that most of the respondents had knowledge of reproductive issues in their late teens. The age group 5-10 had the least percentage 2.5%, the results exemplify that, and

peers might impart this, since sexual issues are not openly discussed in the society. Twenty respondents had knowledge of reproductive issues when they were 21 years and above. This can be attributed to the silence on reproductive issues by the society and more probably their upbringing.

### **Providers of Reproductive Knowledge**

In most African societies women have been known to be playing a laudable role in the dissemination of knowledge on reproductive issues, while the men normally shy away from this responsibility. This therefore leads the adolescent to obtain knowledge on reproductive issues from their peers.

**Table 4.6 Providers Of Reproductive Knowledge**

<b>Providers</b>	<b>Frequency</b>	<b>Percentage</b>
Father	9	7.5
Mother	48	40.0
Teachers	22	18.3
Peers	27	22.5
Aunts	2	1.7
Grandmothers	12	10.0
<b>Total</b>	<b>120</b>	<b>100</b>

Table 4:6 shows the relationship of the persons who gave knowledge of reproductive issues to the respondent. As can be seen from the table, mothers played a very significant role in educating the respondents on reproductive issues, forming about 40% of the total respondents. Twenty-seven respondents had their knowledge of sex and reproductive issues through peers, which can be dangerous, since they might not have been well equipped with the correct

played very significant role in educating the respondents on reproductive issues, forming about 40% of the total respondents. Twenty-seven respondents had their knowledge of sex and reproductive issues through peers, which can be dangerous, since they might not have been well equipped with the correct knowledge. Teachers also played a useful role in providing reproductive knowledge to respondents (22%). However, fathers did not play a major role in providing reproductive knowledge to respondent as they form only 7.5% of the total respondents. No grandfather offered any knowledge as compared to grandmother's, which had 10% of the total. Aunts also did not play any significant role in the education of respondents on reproductive issues.

### **Carrier Of HIV/AIDS**

For sometime now many people have perceived that healthy looking persons cannot be carriers of the HIV/AIDS disease as slim sickly persons are associated with the disease, which is the later stage of the development of the disease.

One hundred and one (84 %) of the respondents said yes while 7.5% said no. This shows that the majority of the respondents have a fair idea about the knowledge about HIV/AIDS. However 3.3% of the respondents showed little or no idea of the question.

### **Spreading Of HIV/AIDS Through The Same Sex (Lesbians/Homosexuals)**

Lesbianism and homosexuality have been thought to be foreign in our culture. It

is now creeping gradually into our society. Those who have been practicing these might have picked these from a developing country or from our educational institutions. It is known that those who practice lesbianism and homosexuality are the affluent in the society, (UNFPA 1999).

Ninety-four (78%) of the respondents said yes HIV/AIDS is spread through the same sex, while 15.8% of the respondents said no. This shows that a great majority of the respondents have an idea about the mode of transmission of the disease HIV/AIDS.

### **Pregnant Woman And The Spread Of The HIV/AIDS**

Women have been known to bear the brunt of the HIV/AIDS most and are more likely to show the symptoms of the disease than men. Their reproductive functions make them to transfer the disease to the unborn child if they are infected with the disease. However, scientists have developed treatment to reduce mother-to-child transmission.

Similarly, 94.1% of the respondents affirmed that pregnant women could spread HIV/AIDS to their unborn babies and 0.9% had no idea about this issue. This shows that a great majority of the respondents have a fair idea about the mode of transmission of HIV/AIDS.

### **HIV/AIDS And The Sharing Of Meals From The Same Plate**

Though many people are aware that HIV/AIDS cannot be acquired through the sharing of meals from the same plate with HIV/AIDS patients, victims of the disease are usually isolated and ignored. This may be due to the fact that sexual issues are not discussed openly.

A further probe as to whether a person can be infected with HIV/AIDS by eating from the same plate with the person infected with the HIV/AIDS, 86.7% of the respondents said no while 10.8% of the respondents said yes. This shows that a great majority of the respondents have a fair idea about how the disease (HIV/AIDS) is transmitted. However 2.5% of the respondent had no idea about the question.

### **Means By Which HIV/AIDS Was First Transmitted**

With the advance in the communication sector (Information Technology) access to information has been easy and faster but as to whether it is affordable in the developing countries the answer is no especially in the rural areas. However, there has been an improvement in the access to information.

**Table 4:7 Means By Which HIV/AIDS Information Was First Transmitted**

Where did you first hear of HIV/AIDS from?	Frequency	Percentage
Newspaper	8	6.7
Radio	54	45.0
Television	18	15.0
Friends/peers	20	16.7
Medical Practitioners	13	10.8
Others (aunts, mother father, grandfathers)	7	5.8
Total	120	100

From the above table (4:11), it could be seen that radio played a very important role in creating awareness about the disease (HIV/AIDS) as 45% of the respondents first heard of the disease through the radio. Friends/peers also played an important role in the awareness of the disease. This might be due to the fact that issues or topics, which talk about sexual issues, are not discussed openly. Consequently, most of the respondents rely on their peers and friends. Another important source was television. At least 10% of the respondents had the information from medical practitioners. This might be due to the fact that most people do not attend hospitals unless they were ill. Newspaper accounted for 6.7% of the respondents as the educational level of the respondents depict their inability to read and have access (financially) to newspapers.

### **Prevention of HIV/AIDS**

From the discovery of the HIV/AIDS some few decades ago various attempts have been made to find cure to the disease but to no avail, the only known preventing means of acquiring the disease is total abstinence from sex and the use of condoms.

The use of condoms as a means of preventing HIV/AIDS showed a high rate of usage (84%). One hundred and one respondents use condoms as a means to prevent HIV/AIDS while 15.8% of the respondents do not use them. Those who do not use condom as a measure to prevent HIV/AIDS gave the reason that: their partners do not like the use of condoms, which reduce the enjoyment.

### **Awareness Of Female Condoms**

Comparatively female condoms are a new introduction to the male condom. Cost wise, the female condom is expensive compared to the male condom. Much emphasis is not also placed on the female as a mean of preventing HIV/AIDS as compared to the male condom and which is a sure way of empowering the women in the negotiation of sex.

On the issue of their awareness of female condoms, 53.3% of the respondents were not aware while 46.7% of the respondents were aware of the female condoms. This shows that much publicity has not been done on the female

their partners before, with only 3.3% doing so but discontinuing the use of the female condom, because either their partners did not enjoy using it or they did not like it. Though most of the respondents are aware of the female condoms, most of them have not set eyes on one before.

### **Widowhood And Danger Of HIV/AIDS**

In this era of HIV/AIDS, where most causes of deaths are not known, because corpses are not sent to hospitals diseases are easily attributed to spiritual forces. Marriage to widows/widowers where the cause of death of their spouses is not known is dangerous to the spread of HIV/AIDS.

**Table 4:8 Widowhood And Dangers Of HIV/AIDS**

<b>Perception</b>	<b>Frequency</b>	<b>Percentage</b>
<b>Strongly agree</b>	10	8.35
<b>Agree</b>	81	67.5
<b>Do not know</b>	11	9.2
<b>Disagree</b>	18	15.2
<b>Total</b>	120	100.00

Table 4:15 deals with respondents' views about widow/widowers, who move to towns or other places where their past is unknown and remarry. Eighty-one of the respondents (67.5%) agreed that those whose past are unknown and remarry are dangerous in the spread of HIV/AIDS disease with the statement while 10% of the respondents strongly agreed with the statement. However, 15% disagreed while 9.2% had no idea about the statement. The view of the majority of the respondents is supported by Ntozi (1970) that widow/widowers who remarry

might have lost their spouses through AIDS or related cause about which they might be aware.

### **HIV/AIDS Vulnerability To Divorced/Separated Persons**

Divorced and Separated persons are more likely to be prone or at risk to HIV/AIDS infection since there is always the need to satisfy their sexual desire by taking one or two casual sexual partners as a stop gap to finding a new spouse or patching up their former relationships.

**Table 4:9 HIV/AIDS Vulnerability To Divorced/Separated Persons**

<b>Perception</b>	<b>Frequency</b>	<b>Percentage</b>
<b>Strongly agree</b>	6	5.0
<b>Agree</b>	75	62.5
<b>Do not know</b>	13	10.8
<b>Disagree</b>	23	19.2
<b>Strongly disagree</b>	3	2.5
<b>Total</b>	120	100

Seventy-five of the respondents (62.5%) agreed that those who are divorced/separated are more likely to be infected with HIV/AIDS than those in marital unions while 5.0% strongly agreed to the statement. However 19.2% disagreed with 2.5% strongly disagreeing. Wakanaabi and Sekimpi (1997) agreed with the statement by indicating that divorce or separated person are more likely to be infected with HIV than those in marital union since a person may have several sexual partners concurrently or one after the other through divorce and separation.

### **Traditional Circumcision And Its Dangers To HIV/AIDS**

The use of cutting implements like blade and knives that have been used by others without sterilising is a sure way of transmitting HIV/AIDS. Traditional circumcisions are a dominant feature in some parts of Africa and are undertaken by the elderly women who might not know the consequences of the use of nonsterilised implements. Genital mutilations in all forms make women vulnerable to the HIV/AIDS.

**Table4: 10 Traditional Circumcision And Its Dangers To HIV/AIDS.**

<b>Perception</b>	<b>Frequency</b>	<b>Percentage</b>
<b>Strongly agree</b>	5	4.2
<b>Agree</b>	47	39.2
<b>Do not know</b>	31	25.8
<b>Disagree</b>	37	30.8
<b>Total</b>	120	100

Forty-seven of the respondent (39.2%) agreed that women who are traditionally circumcised are more exposed to HIV/AIDS than those not circumcised, while 4.2% strongly agreed. However 30.8% of the respondents disagreed and 25.8% had no views that women who are traditionally circumcised are more exposed to HIV/AIDS than those not circumcised.

Ahmed 1988 supports the above statement when he observed that traditional circumcisions which are performed by traditional birth attendants (T.B.A's) is a sure way of HIV/AIDS transmission since the implements (knives) are not sterilised and also these acts take place in unhygienic places.

### **Exposure Of HIV/AIDS To Regular Travellers**

During the beginning of the HIV/AIDS epidemic, most people who were infected had a history of traveling outside their country. However, this trend has changed and those who travel within their country are now showing an increasing rate of the infection. Movement also brings different groups of people into contact with one another and may thus enhance the possibility of disease transmission. The age and sex composition of most migration streams in Africa make the human contact factor important in the era of HIV/AIDS. Most women and girls who migrate in search of jobs are mostly in casual, part-time, piece rate work, insecure jobs, and often unprotected either by labour laws or work place mechanisms. Their work places outside the home are almost entirely controlled by men; their livelihood and that of their families may depend entirely upon the favour of male managers.

**Table 4:11 Exposure Of HIV/AIDS To Regular Travellers**

<b>Perception</b>	<b>Frequency</b>	<b>Percentage</b>
Strongly agree	13	10.8
Agree	87	72.0
Do not know	6	5.0
Disagree	12	10.0
Strongly disagree	2	1.7
<b>Total</b>	<b>120</b>	<b>100</b>

Eighty-seven of the respondents (72%) agreed with the statement that those who frequently travel within the country and outside are likely to have HIV/AIDS

infection while 10.8% strongly agreed.

Researchers like Ogunjemilua (1982) have identified long distance truck drivers and women who sell goods along the road as playing a role in the spread of the HIV infection. These long distance drivers frequently haul goods from the rural areas to the urban area. Higher levels of infection with HIV have been found among these men and women than among other persons living and working in the same district.

### **Views On Returnees And HIV/AIDS**

With most African countries experiencing economic recession people look for jobs outside their country's borders. The extent and pattern of migration and travel, whether international, inter-urban, urban-rural or rural-rural combined with sexual behaviour and other risk related conditions, determine how quickly HIV spreads. Such fortunate job seekers are a big attraction to women because of their increase in purchasing power.

**Table 4:12 Views On Returnees And HIV/AIDS**

<b>Perception</b>	<b>Frequency</b>	<b>Percentage</b>
Strongly agree	19	15.9
Agree	81	67.5
Do not know	6	5.0
Disagree	12	10.0
Strongly disagree	2	1.6
Total	120	100

Eighty-one of the respondents (67.5%) agreed while 15.9% strongly agreed women who have sexual relationship within the country and outside are more

prone to HIV/AIDS infection than those whose partners are much more stable. However 10% disagreed and 1.6% strongly disagreed. Kishindo (1993) and Chiwa (1992) agree with the above statement when they observed that the money and the domestic goods the migrant brings home make him " a big attraction to women in the village" As a result, migrants maintain multiple sexual partners and this makes migrants particularly susceptible to HIV and other STD's.

### **Female Socialisation And Sexuality**

Gender roles differ, women are socialised to be obedient and submissive, are not part of the decision making. This attitude is mostly time carried to sexual relationships where men take all the decision concerning the partners.

**Table 4:13 Female Socialisation And Sexuality**

<b>Perception</b>	<b>Frequency</b>	<b>Percentage</b>
Strongly agree	5	4.2
Agree	58	48.3
Do not know	11	9.2
Disagree	41	34.1
Strongly disagree	5	4.2
<b>Total</b>	<b>120</b>	<b>100.00</b>

Forty-eight percent of the respondents agreed that socialization given to girls makes them less assertive and therefore could not reject sexual intercourse when she does not feel for it while 4.2% strongly agreed. However 34.1% disagreed. Only 4.2% of the strongly disagreed.

The above statement corroborates Vliet (1974) who observed that gender roles taught in African societies make women submissive and obsequious while men are to be forthright and assertive. These attributes are taken into a sexual relationship where men take all the decisions in a sexual relationship.

### **Perception On Polygamous And Monogamous Marriages And Its Vulnerability To HIV/AIDS**

In polygamous marriages sex and third wives are often much younger than husbands. In such relationship, the men have had more chance to be exposed to HIV/AIDS, both because they are older and because they are likely to have had more sexual relationships. Their women partners are more likely to be exposed to HIV/AIDS than those in monogamous marriage.

**Table 4:14 Perception On Polygamous And Monogamous Marriages And Its Vulnerability To HIV/AIDS**

<b>Perception</b>	<b>Frequency</b>	<b>Percentage</b>
Strongly agree	10	8.3
Agree	78	65.0
Do not know	8	6.7
Disagree	22	18.3
Strongly disagree	2	1.7
<b>Total</b>	<b>120</b>	<b>100.00</b>

Sixty-five percent of the respondents agreed that those in polygamous marriage are more vulnerable to HIV/AIDS than those in monogamous marriage. Combining those who strongly agreed, nearly three quarters agreed to the statement. Orubuloye et al (1994) agreed with the statement when they stated that polygamous unions might lead to the formation of a wide network of

statement. Orubuloye et al (1994) agreed with the statement when they stated that polygamous unions might lead to the formation of a wide network of infection because of extra marital relationship between males and females in such union. In Uganda a study identified polygamous marriage, practiced by about a third of respondents as one of three risk factors prevalent among Uganda's Muslim minority (Kagimu et al 1995).

One interesting issue that came out was that most of the Moslems rejected the view that those in polygamous marriages are more vulnerable to HIV/AIDS than those in monogamous marriages. This might be due to the fact that most Moslems practice polygamous marriages.

An 18 years old Moslem girl had this to say.

‘I don’t think so, you can still be in a monogamous marriage and be more vulnerable to HIV/AIDS than those in polygamous marriages if you are promiscuous’.

### **Perception About Alcohol And Its Vulnerability To Sex**

Alcohol taking forms an integral part of all social gatherings in African societies. It is a known fact that the intake of alcohol makes people susceptible to sex. It has become major feature of social gathering for people to take large amounts of alcohol and to look for sexual partners. Table 4.15 therefore portrayed how vulnerable people take to sex after social gathering.

**Table 4:15 Perception About Alcohol And Its Vulnerability To Sex**

Perception	Frequency	Percentage
Strongly agree	13	10.9
Agree	82	68.3
Do not know	10	8.3
Disagree	13	10.9
Strongly disagree	2	1.6
Total	120	100.00

Eighty-two of the respondents (68.3%) agreed that people who take in alcohol during festive occasions are more vulnerable to sex than those who do not take in alcohol during these occasions while 10.9% strongly agreed. However 10.9% disagreed with 1.6% strongly disagreeing.

#### **Negotiating The Use Of Contraceptives/Condoms**

Negotiating of contraceptives and condoms has been a problem for women because in most African countries women are not part of decision making and this is transmitted to sexual relationship. Economic dependence of women on men also reduces women's participation on decision-making. As a result of this the study tried to find out the extent to which women negotiate with their partners for the use of contraceptives. The result is presented in table 4.16.

**Table 4:16 Negotiating The Use Of Contraceptives/Condoms**

Negotiation on the use of contraceptives/condoms with sexual partner?	Frequency	Percentage
Yes	62	51.7
No	19	15.8
Not always	39	32.5
Total	120	100.00

Sixty-two of the respondents (51.7%) said that, they are able to negotiate the use of contraceptives/condoms, with their sexual partners while 15.8% of the respondents are not able to negotiate the use of contraceptives/condoms. To those 32.5%, they occasionally negotiate the use of the contraceptive particularly when they are available.

### **Knowledge On HIV/AIDS And Its Influence On Sexual Relationship**

The 1997 Demographic and Health Survey (D.H.S.) of Zambia found that nine out of ten women knew that HIV/AIDS can be transmitted sexually and this is true for most African countries. Women have been known to enter into multiple sexual relationships in order to gain economic favours from men. On the other hand most men have multi sexual partners because society sanctions it.

**Table 4:17 Knowledge On HIV/AIDS And Its Influence On Sexual Relationship**

Knowledge on HIV/AIDS and protection in sexual relationship?	Frequency	Percentage
Yes	111	92.5
No	2	1.7
Sometimes	7	5.8
Total	120	100.00

The above table 4:24 depicts that 92.5% of the respondents' think their knowledge on HIV/AIDS had protected them in their sexual relationship by either using condoms or sticking to one partner. However 1.7% of the

respondents said that their knowledge of HIV/AIDS had not protected them in their sexual relationship because of their inability to negotiate the use of condoms. 5.8% of the respondents also said that it had not always protected.

### **Knowledge On HIV/AIDS And Its Protection In Sexual Relationship**

The 1998 Ghana Demography Health Survey (G.D.H.S.) has quoted the knowledge base of HIV/AIDS in Ghana to be 98%. However it has been realized that condom use which is the best known method for prevention was low, which has led to a high incidence of HIV/AIDS prevalence. Respondents were asked about their knowledge on HIV/AIDS and its protection in their sexual relationship.

One hundred and one (92%) of respondents said their knowledge on HIV/AIDS have protected them in their sexual relationship mentioned changes in their behaviour pattern by sticking to one partner, the use of condoms, careful in using blades used by others and to stay away from sex. One respondent even said he has educated his girlfriend to use condom anytime she has a sexual affair outside their relationship. Three of the respondents said their knowledge of HIV/AIDS had made them to stay away from sex until they got married.

Two of the respondents (1.7%) said that the knowledge they had gained on HIV/AIDS did not help them in their sexual relationship and gave the following reason for their answer: Their inability to negotiate the use of condoms was their major reason and financial gains.

Seventeen of the respondents (14.6 %) mentioned that their knowledge on

and the power relationship between partners, especially the women said, refusal may be interpreted as lack of affection to their partners.

### **Target Age Group For HIV/AIDS Campaign**

Since the inception of the HIV/AIDS epidemic, the hardest hit has been the reproductive age group, which is the backbone for any economic growth. There is therefore the need to reverse this trend otherwise families, communities and countries at large will be impoverished. Respondents were asked which age group should be targeted for HIV/AIDS campaign.

**Table4: 18 Target Age Group For HIV/AIDS Campaign**

<b>Age</b>	<b>Frequency</b>	<b>Percentage</b>
9-11 years	37	30.8
12-14 years	42	35.0
15-17 years	29	24.2
18-20 years	12	10.0
<b>Total</b>	<b>120</b>	<b>100.00</b>

Table 4:26 shows that 30.8% of the respondents felt that the age group between 9 to 11 years should be targeted as the age group where the HIV/AIDS campaign should start. Various reasons given for this low age group was that children of today develop much earlier than it used to be. Also children engage in sexual life at an early age. Forty-two respondents (35%) felt HIV/AIDS education should start from the age group between 12-14 years while 24.2% gave the age group as between 15-17 years. Ten percent saw 18 years, as the starting

point to begin HIV/AIDS awareness .The average age to be targeted is 13.8 years which is far less than the average first sexual experience which is 17.6 years of the respondents. However the average age to be targeted for HIV/AIDS campaign falls within the UNICEF 1998 stated first sexual experience for female, which is 12 to 15 years and that of male, which is 16 to 20 years.

### **Targeted Sex For HIV/AIDS Campaign**

During the beginning of the HIV/AIDS epidemic in the developing countries men were more infected, as the disease is early infection was mostly among homosexuals and intravenous drug users, while in many African states it was almost even. Twenty years after the disease was discovered women and the youth are the hardest hit. Respondents were asked which sex should be targeted for HIV/AIDS campaign.

**Table 4:19 Targeted Sex For HIV/AIDS Campaign**

<b>Sex</b>	<b>Frequency</b>	<b>Percentage</b>
<b>Male</b>	38	31.7
<b>Female</b>	58	48.3
<b>Both sexes</b>	24	20.0
<b>Total</b>	120	100.00

Thirty-eight of the respondents (31.7%) said males should be targeted most in the HIV/AIDS campaign and gave the following reasons: males are more aggressive in any relationship and are sexually active; they are more promiscuous; they also have a high desire for sex and find it difficult to control

promiscuous; they also have a high desire for sex and find it difficult to control their sexual desires. Also 48.3% of the respondents said females should be targeted most for the HIV/AIDS campaign and giving the following reasons: females are more vulnerable to the disease because they can transmit the disease easily and even to an unborn child. Females should be targeted because if they have the knowledge they can control themselves. Females are easy to be convince to enter into relationship and sexual act by male for economic gains. However 20% of the respondents said both sexes should be targeted for the HIV/AIDS campaign because they are equally at risk.

### **Target Occupation For HIV/AIDS Campaign**

Commercial sex has featured prominently in HIV/AIDS studies .In Africa prostitutes and their customers were among the first groups to experience high level of HIV infection and were considered to have fuelled the early stages of national epidemics. In the early research on HIV/AIDS the emphasis was on the prostitutes, while little or no attention was paid to their clients. This section was divided into two categories; occupations, which was male and female dominated and which should be targeted for the HIV/AIDS campaign.

However, other occupations have shown their vulnerability to the HIV/AIDS due to social, economic and cultural factors. Respondents where asked which occupation should be targeted for HIV/AIDS campaign

In the male dominated jobs occupations where employees/employers have

enough economic power (lawyers, contractors, bank managers, businessmen, directors, spare part dealers). Forty five percent of the respondents mentioned this group as having multiple sexual partners because of their economic power.

Forty two percent of the respondents mentioned security service as a category that should be targeted. Here particular mention was made of the police service that most respondents attributed to the frequent transfer in the service. The other category of occupation can be said to be those occupations, which are popular or famous in society (radio presenters, actors, musicians and athletes) and 20% of the respondents mentioned this group.

However, there was no clear-cut categorization because a doctor can be in an economic group and at the same time in the prestigious/famous group.

In the female dominated occupations can also be divided into categories. The economic group includes employers or employees who do not make much money (hairdressing, seamstress, hawkers, store keeper, drinking spots attendants, chop bar attendants, hotel attendants, receptionists and waiters). Because these females in these occupations do not earn much they easily give in to men's advances on economic grounds. Eight-six of the respondents (72%) mentioned this category of occupation.

However, one strange occurrence was that prostitutes were hardly mentioned. This might be due to the fact that many of the respondents did not regard it as

work or profession. The second category is the job opportunities which expose females to male clients like secretaries, bar attendants, chop bar attendants, hotel attendants, receptionist, waiters who are exposed to the frequent advances of men. Twenty-eight of the respondents mentioned this category. There is however no clear-cut categorisation. It could be realised that for female dominated occupations the economic power plays an important role in their vulnerability.

#### **Forms HIV/AIDS campaign should take.**

Respondents were asked what form should HIV/AIDS campaign take. Ninety-eight of the respondents suggested a house-to-house campaign, in which churches, community leaders played an active part. Places mentioned, to be targeted, were cinema halls, discotheques, stadia, drinking spots, bus stops, lorry parks and schools. Further, the campaign should be intensified during festive occasions.

Seminars and fora were mentioned by 12.5% of the respondents. These educational programmes should inter- play with drama which catches the attention of the people .If possible infected people should be involved in the campaign but care must be taken for these HIV seropositive patients not be stigmatised and neglected in the community. This can let HIV positive patients to go underground which can be dangerous to the spread of the disease.

Pamphlets and poster used in the HIV/AIDS campaign should also be written in the local dialect for easy understanding. Youth clubs should also be encouraged to take part in the HIV/AIDS campaign. This was mentioned by 5.8%. In all these campaign expert advice should not be ignored.

## CHAPTER FIVE

### **Discussion of Findings And Conclusions**

Though a substantial number (40%) of the respondents did not have education up to Secondary/S.S.S. level it could be realised that knowledge of HIV/AIDS seems to be high even though there was some misunderstanding of some of the issues. Invariably, this shows that the level of education had no bearing on the knowledge on HIV/AIDS.

The average age of first sexual experience of the respondents is 17.6years while the age of first knowledge of sex and reproductive issues is 16.6years; this seems to be too high for both issues. This may not be so as represented by the respondents, as most had some sort of education on, reproduction in Junior Secondary School (J.S.S.) and Senior Secondary School (S.S.S.)

From the findings of those who provided information about knowledge of reproduction issues, mothers played very significant role as against fathers who had for a long time neglected their duty perhaps because traditionally, this aspect of education was left for the mothers to carry out. Though teachers have also played a significant role in these aspects, they seem not to have been well equipped to handle the issue. This might be due to the fact that it is only a topic on the curriculum (Life skills). It is also a common knowledge that there is lack of sufficient role models in the society, as elderly married men frequently engaged young girls, who might qualify to be their daughters, in amorous life.

Not until men and women begin to discuss sexual issues openly can there be joint decision-making concerning sexual issues. Partners can then discuss their perceived risks, their fears, and how they can ensure their protection. Women need no longer feel embarrassed or threatened when they ask men to wear condoms.

Radio played a very important role because of its relative cheap cost to purchase and maintain. However, television can play an important role in the education of HIV/AIDS programmes because of its visual aspect that can make people see the effect the disease is causing to the human race. Drama can also be used on both radio and television to send the HIV/AIDS message across to the people. On radio and television, individuals be made to contribute to the programmes through the phone- in system to ask questions and contribute to the discussion. Hotlines can also be created to answer pertinent questions about HIV/AIDS, which may be bothering people in the society. These radio and television programmes on HIV/AIDS should be done in the local language. Posters on HIV/AIDS should also be in the local languages to enable as many people as people, especially the semi-illiterates to read.

With the upsurge of HIV/AIDS, the use of condom as a measure to prevent HIV/AIDS has increased even though there is much more room for improvement in the use of condoms. This was evident in the West African

Project to Combat AIDS (W.A.P.T.C.A.), which normally sells condoms to the commercial sex workers at a reduced rate. Some of these commercial sex workers also act as vendors in the selling of these condoms for the project. (W.A.P.T.C.A.)

However, female condom is not as popular as the male condoms even in the W.A.P.T.C.A. project, where commercial sex workers are encouraged to use the female condom. It has not been popular because their male clients often reject it and also some of the commercial sex workers themselves reject it

One fact is that the female condoms had not been well advertised. As at now, there is no advert on the radio and the television on female condoms. There is therefore the need for the female condoms to be well advertised, because it is one of the surest ways to empower the women whenever men refuse to use the male condoms. On the whole, contraceptive knowledge is very high among respondents. The main problem lies in negotiating the use of it, especially, the condom. This is where most of the women are weak.

It was evident to most of the respondents that these risk factors were embedded in the traditional customs and beliefs of the people, and thereby making it difficult for the women to free themselves. What is making the situation worse is that campaigns on HIV/AIDS ignore these risks factors, which expose women the more. There is therefore the need for HIV/AIDS campaigns to be gender sensitive so as to make both men and women more aware of female vulnerability

to the disease.

Economic factors also play an important role in making women vulnerable because of their dependence on men. They are weak to negotiate when it comes to sexual decisions. They therefore bargain sex for economic gains. This is reflected in the kind of jobs women engage in. This category of jobs in which women find themselves, exposes them to frequent harassment by men. They become vulnerable because they are not economically strong in comparison with the men. Therefore, there is the need to empower the women economically and make them self sufficient enough to be independent.

The age group that should be the target from where HIV/AIDS campaign should start from is said to be between 9-11 years. This was suggested by 30.8% of the respondents while 35.0% said it should be between 12-14 years. It will however, be noticed that their average age is 13.4 years which is lower than the age group they are suggesting should be targeted for the HIV/AIDS campaign. This could be explained to be that, either the youth of today tend to be more promiscuous, or that they (respondents) were themselves sexually active at the same age.

The HIV/AIDS campaign should emphasise the fact that all persons are at risk.

### **Recommendation**

Open discussion about sex issues must take place in the churches, social clubs and work places. In the churches, such education should not be limited to those who are in for marriage counselling but should be a regular feature of church activity (sex education). This will reduce the effect of peers misinforming their colleagues. Fathers should be encouraged to show interest in educating their children on reproductive issues and not to leave the responsibility to the mothers alone.

Intensive HIV/AIDS education should be on the radio. This should be done in both the local and the English languages. For HIV/AIDS campaign to be more successful, HIV/AIDS campaign should be integrated into other programmes both in the local community and national activities.

HIV/AIDS seropositive patients should be involved in the HIV/AIDS campaign, as it will help to give them some self-esteem because you often see them marginalized in the community in which they live.

HIV/AIDS campaign should be targeted to women of low economic class as most of them give in to sexual relation because of economic reasons, also men

of high economic class turned to have more sexual partners because of their economic power so they should be targeted for the HIV/AIDS campaign.

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## INSTITUTE OF ADULT EDUCATION

## UNIVERSITY OF GHANA

## QUESTIONNAIRE SURVEY FOR STATUS 1,2 AND 3

*Respondents are informed that answers to question below will be treated as confidential and will be used for academic purpose only*

## PERSONAL DATA

1. Age? a) 16-20 years[  ] b) 21-25years[  ] c) 26-30 years[  ] d) 31-35 years [  ] e) 36-40 years[  ] f) 41-45 years[  ] g) 46-50 years[  ].
2. Religion? a) Catholic[  ] b) Protestant[  ] c) Spiritual /Pentecost [  ] c) Traditional [  ] religion[  ]
3. Educational Status? a) No formal education [  ] b) Primary / J.S.S.[  ] c) Secondary /S.S.S.[  ] d) Tertiary[  ]
4. At what age did you have your first sexual experience? a) 1-5 years[  ] b) 6-10 years[  ] c) 11 -15 years [  ] d) 16-20 years[  ] e) 21 -25 years [  ] f) 21 and above [  ]
5. At what age did you first have knowledge of sex and reproductive issues? a) 5-10 years[  ] b) 11-15 years[  ] c) 16-20 years [  ] d) 21-25 years [  ] f) 21 and above [  ]
6. Who gave you that knowledge? a) Father [  ] b) Mother [  ] c) Teacher[  ]

]d) Peers[ ] e) Aunt[ ] f) Grandfather [ ] h) Grandmother[ ].

#### KNOWLEDGE OF HIV/AIDS

7. Can a healthy looking person be a carrier of HIV/AIDS? a) Yes[ ] b) No[ ] c) Do not know[ ]
8. Can HIV/AIDS be spread through same sex -sexual contact for example with lesbians/homosexuals? a) Yes [ ] b) No [ ] c) Do not know [ ]
9. Can a person who is pregnant spread the HIV/AIDS to her unborn foetus? a) Yes [ ] b) No [ ] c) Do not know[ ].
10. Can a person be infected with HIV/AIDS by eating from the same plate with the person infected with the HIV/AIDS? a) Yes[ ] b) No [ ]c) Do not know [ ].

#### SOURCE OF INFORMATION ON HIV/AIDS AND TRANSMISION

11. Where did you first hear of HIV/AIDS from? a) Newspaper[ ] b) Radio [ ] c) Television[ ] d) Friends /Peers [ ] e) Medical practitioners [ ]f) Others[ ]

#### KNOWLEDGE OF CONTRACEPTIVE USE TOWARDS HIV/AIDS PREVENTION

12. Do you use condoms as a measure to prevent HIV/AIDS? a) Yes [ ] b) No [ ] c) Do not know [ ].
13. Are you aware of female condoms? A) Yes [ ] b) No [ ]
14. If yes have ever tried it with your partner before? A) Yes [ ] b) No [ ]

### VIEWS ON FEMALE VULNARABILITY TO HIV/AIDS

Indicate your level of agreement disagreement to the following, where

- Strongly Agree = 01  
 Agree = 02  
 Do not know = 03  
 Disagree = 04  
 Strongly Disagree = 05

15. Widow/Widowers who move to towns or other places where their past is unknown and remarry are dangerous to the spread of HIV/AIDS? 1 2 3 4 5
16. Those who are divorced/separated are more likely to be infected with HIV/AIDS than those in marital unions? 1 2 3 4 5
17. Women who are traditionally circumcised are more exposed to HIV/AIDS than those not circumcised? 1 2 3 4 5
18. People who frequently travel within the country and outside are likely to have HIV/AIDS infection? 1 2 3 4 5
19. Women who have sexual relationship with people who travel a lot both within the country and outside are more prone to HIV/AIDS infection

- than those whose partners are much more stable? 1 2 3 4 5
20. Socialisation given to girls makes them less assertive and therefore could not reject sexual intercourse when she does not feel for it? 1 2 3 4 5
21. Thos in polygamous marriage are more vulnerable to HIV/AIDS infection than those in monogamous marriage? 1 2 3 4 5
22. People who take in alcohol during festive occasions (ie.naming ceremonies and keeping) are vulnerable to sex those who do not take alcohol during these occasions? 1 2 3 4 5

#### EFFECT OF KNOWLEDGE ON THE PRACTICE IN SEXUAL RELATIONS

23. Are you able to negotiate the use of contraceptives /condoms with your sexual partner ? a) Yes [ ] b) No[ ] c) Not always[ ]
24. Do you think that your knowledge on HIV/AIDS make you protect yourself in our sexual relationship. a) Yes [ ] b) No[ ] c) Sometimes[ ]
25. Give reasons for your answer to question 24?

#### FACTORS NECESSARY FOR THE EDUCATION ON HIV/AIDS

26. Which age group should be targeted for the campaign on HIV/AIDS?
27. Which sex should be targeted most for the campaign on HIV/AIDS? a)

Males [ ] b) Females[ ].

28. Give 5 main occupations, which should be targeted of the HIV/AIDS campaign?
29. What form should HIV/AIDS campaign?