

**HIV/AIDS RELATED RISK PERCEPTION AND SEXUAL PRACTICES IN  
OSU KLOTTEY SUB-METROPOLITAN AREA OF ACCRA.**

**BY**

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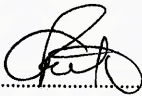
**THIS DISSERTATION IS SUBMITTED TO THE UNIVERSITY OF GHANA,  
LEGON IN PARTIAL FULFILMENT OF THE REQUIREMENT FOR THE  
AWARD OF MASTER OF SCIENCE (MSc) IN APPLIED HEALTH SOCIAL  
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## DECLARATION

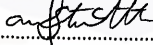
I do hereby declare that except for the acknowledged citations and ideas, this dissertation is an original work produced by me from a study personally undertaken; presentation of findings, discussions and recommendations were all done under the supervision of Dr. Stephen Collins Ahorlu and Dr. Esther Ofei Aboagye; My Academic Supervisors.

This work has not on any previous occasion been presented in part or whole to any Institution or board for any award.



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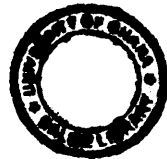


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**DEDICATION**

**I DEDICATE THIS DOCUMENT TO MY HUSBAND, MR. LOVESTONE ELIKPLIM  
MAMATTAH, A TRUE FRIEND AND LIFE PARTNER.**

**THANK YOU AND I LOVE YOU!**



## **LIST OF ACRONYMS**

<b>AIDS</b>	Acquired Immune deficiency Syndrome
<b>ARRM</b>	AIDS Risk Reduction Model
<b>ART</b>	Anti Retroviral Therapy
<b>CNN</b>	Cable News Network
<b>CSW</b>	Commercial Sex Worker
<b>FGD</b>	Focus Group Discussion
<b>CT</b>	Counselling and Testing
<b>FHI</b>	Family Health International
<b>GAC</b>	Ghana AIDS Commission
<b>GHS</b>	Ghana Health Service
<b>GOG</b>	Government of Ghana
<b>HBM</b>	Health Belief Model
<b>HIV</b>	Human Immune deficiency virus
<b>IDI</b>	In-depth Interview
<b>MSM</b>	Men sexing Men
<b>NACP</b>	National AIDS Control Programme
<b>NGOs</b>	Non- Government Organisations
<b>PI</b>	Principal Investigator
<b>PLHA</b>	People Living With HIV/AIDS
<b>PMTCT</b>	Prevention of Mother-to-Child Transmission
<b>POW</b>	Annual Programme of Work
<b>SHARP</b>	Strengthening HIV/AIDS Response Partnerships
<b>STI</b>	Sexually Transmitted Infection
<b>TBA</b>	Traditional Birth Attendants
<b>UNAIDS</b>	United Nations Agency for International Development
<b>WAPCAS</b>	West African Project to Combat AIDS and Sexually Transmitted Infections
<b>WHO</b>	World Health Organization

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## ABSTRACT

An individual's knowledge of HIV transmission and accurate assessment of their own risk is key in adopting safer sexual practices. Evidence suggests prevalence of HIV/AIDS among Ghanaians has seen a steady decline over the years; however there are reports of new infection among various populations despite on-going interventions. Sustaining prevention education among youth and other special groups is very vital in contributing to further decline in the overall prevalence of HIV/AIDS. This study explored HIV/AIDS related risk perception and sexual practices of sero positive persons and those who did not know their status in the Osu Klottey Sub-metropolitan area. The study was exploratory and descriptive in nature and employed both qualitative and quantitative methods in data collection. Tools such as Survey questionnaires, In-depth individual interview and Focus Group Discussion guides were used. Key Informants like caregivers, health care providers as well as PLWHA's were interviewed. Key findings of the study included inconsistent use of preventive measures by sexually active respondents, both sero positive and those who did not know their status. The male and female positive persons had different perceptions about how they got infected, for instance majority of HIV positive females believed they were infected by their husbands and malevolent spirits. HIV/AIDS related risk perception was found to be higher among sero positive persons than respondents who did not know their HIV status while most positive persons and their relations believed that ART was 'cure' and could 'heal' them completely. The study also made the following recommendations among others, the need for expansion of CT services in the community while more research is conducted into the population, their specific needs, and access to needed services created especially for MSM.

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## CHAPTER ONE

### 1.0 INTRODUCTION

In early 1980's doctors in the United States of America noticed an unusual form of pneumonia of which patients were dying due to failure in their immune systems to combat the disease. These victims were later found to be young homosexuals, men having sex with men (MSM) thus, suggesting the early name for the disease Gay Related Immune Deficiency Syndrome (GRIDS). In later years the unusual condition was found in people other than the homosexuals and in 1982, the United States Centre for Disease Control and Prevention (CDC) coined the name AIDS-Acquired Immune Deficiency Syndrome for the illness (WHO, 1988).

Currently, between 30 to 33.2 million people are reported to be infected with HIV/AIDS world-wide most of them living in sub-Saharan Africa (UNAIDS, 2007) and (NACP, 2008). In sub-Saharan Africa and particularly in Ghana, the principal mode of transmission of the disease is by sexual intercourse putting everybody at risk predominantly those involved in transactional and casual sex. Also at risk are monogamous partners who are not faithful to their partners and engage themselves in unprotected sex and so are babies born to HIV positive mothers who get infected either through breast milk or perinatal contaminations. Recipients of unwholesome blood transfusion, use of infected sharps such as needles and razors are some of the other modes of transmission of the infection.

In order to curtail the spread of HIV infection, there was the need to perceive the risk of one getting infected. Risk perception and behaviour are said to be complex issues since they are factors that interact with cultural practices and new technologies to provide an effect (Mackee et al, 2004). Perceived risk of getting oneself infected with

HIV/AIDS may have important implications for health if the perceptions are rational and lead to a willingness to avoid risky behaviour (P Akwara et al, 2003). According to the Ghana AIDS Commission Report (2007), the prevalence rate of HIV/AIDS in Ghana remained below 5%, since the first recorded case in 1986. However the number of persons living with HIV/AIDS continues to rise daily. An estimated 249,145 persons (231,840 adults and 17,305 children) were living with HIV/AIDS in 2007 with a cumulative death of 200,027 (National AIDS Control Programme, 2008). The National Surveillance Report, 2007 also indicated that the menace was slowing down and with the current further decrease in the prevalence rate from 1.9% in 2007 to 1.7% in 2008; stakeholders might be tempted to become complacent as evidenced in the decrease in the 15-19 years and 20-24 years groups (NACP, 2008). However, there is also evidence to the fact that the infection has seen marginal increase in various sub-populations such as was identified in 40-44, 45-49 years groups in urban populations with variations of about 3% especially in Greater Accra, Ashanti and Eastern regions (NACP, 2008). There is therefore the need to sustain preventive education targeted at the youth and other special populations and groups hold good prospects to further contribute to the decline in prevalence rate in the country. HIV/AIDS prevalence in Ghana varies according to geographic area, gender, age, sexual behaviour, and, to some degree, urban-rural residence.

It is worth mentioning that HIV prevention in Ghana continues to receive multi-sectoral response, programmes and interventions. Typical of this is the universal access to prevention, treatment, care and support of positive persons. In 2007, 91 Antiretroviral (ART) treatment sites were opened nationwide; which increased to 117 in 2008 rendering care to about 23,000 people with HIV/AIDS (UNAIDS Fact Sheet, 2008).

Whilst the 30-34 year group records the highest prevalence rate of HIV/AIDS in the Greater Accra Region, the least recorded cases were found in the 10-14 year group. This points to the fact that the 10-14 year group are the 'window of hope' for the nation. It is also interesting to note that within the 2006-2008 periods, the prevalence rates were greater in females than in males. The prevalence of HIV/AIDS among young people and young adults threatens the future development of Ghana, economically and the very basis by which society maintains its continuity.

### 1.1 STATEMENT OF THE PROBLEM

There have been laudable gains in HIV/AIDS prevention in Ghana due to the multi-sectoral level response by the Ministry of Health the Ghana Health Service, the Ghana AIDS Commission, Non-Governmental Organizations (NGO's), religious bodies as well as civil society organization to control the spread of the illness. These concerted efforts have translated into interventions such as the establishment of Anti Retroviral Therapy (ART) centres, support for persons living with the disease, Prevention of Mother-to-Child Transmission (PMTCT) and other related services. Due to PMTCT intervention for example, HIV positive mothers are having children who are HIV negative.

Additionally, as a result of the various HIV/AIDS interventions especially the ART, the gloomy picture of HIV/AIDS positive persons looking sickly, wasted, skeleton-like does not exist any longer. As messages reduce in intensity to motivate individuals on alert regarding HIV/AIDS related risk perception, they are likely to relax about and neither practice nor adherence to safe sexual practices and adaptation of healthy behaviour.

The incidence of HIV/AIDS in Ghana is affected by factors such as gender and geographical factors as well as the changing trends in the distribution of the disease burden and the perceived declining rates. As indicated by Mackee et al. (2004), the problem of HIV/AIDS differs markedly in developed countries from that of developing countries like Ghana.

According to a study by the West African Project to Combat AIDS and STI (WAPCAS) in the Greater Accra Region in 2005, the HIV/AIDS infection was found to be transmitted mainly through unprotected sexual intercourse, multiple sexual partnerships and adoption of high risk sexual behaviours such as observed among female commercial sex workers and men having sex with men through , anal and oral sex (WAPCAS, 2005). Under these circumstances, the questions one is forced to ask is; What is the level of risk perception of the HIV sero positive persons on ART who look and feel alert and healthy, how do they perceive their risk of re-infection and/or secondary infection in the face of the various types of the virus? How do their perceived risks translate into safer sex practices with spouses and other sexual partners?

HIV/AIDS positive persons are 'expected' to adopt sexual behaviours that do not put them at risk of secondary infection, re-infection as well as them not infecting others with the virus. What can be said to be the perceived risk of acquiring HIV/AIDS among persons who do not as yet know their sero status? A study by Adih et al, 2005 found a strong association between perceived self efficacy and related risk perception, safe sexual practices and condom use.

There is also anecdotal information floating among the general population that 'ART is cure for HIV/AIDS' not to mention the numerous herbalists, spiritualists and

traditional healers and other folk healers who claim they can 'cure HIV/AIDS'. With this picture; the question one needs to ask is "How do all these perceptions and wrong information on ART translate into preventive behaviours among HIV/AIDS positive persons and those who do not know their sero status.

One's sexual behaviour can be said to be a determinant of associated risk perceived by the individual and the means by which such perceived risk promotes healthy behaviour or otherwise. Knowledge is key in affecting an individual's HIV/AIDS risk related perception and related preventive behaviour.

Prevention is the most crucial response to the HIV/AIDS epidemic since there is as yet no complete cure. Prevention primarily means behaviour change particularly among those most at risk and most likely to spread the virus to others.

Behaviour change is initiated by the individual and this depends on knowledge acquired by the individual (Ghana AIDS Commission, 2009). Behaviour change is one of the major frameworks/thrusts of the Programme of Work of the Ghana AIDS Commission for the year 2009.

This study therefore is designed to explore HIV/AIDS risk perception and sexual practices among the people of Osu Klotey sub-metropolitan area.

## **1.2 JUSTIFICATION FOR THE STUDY**

A study by Parker, (1987) on AIDS and sexual practice in urban Brazil discovered that models of HIV/AIDS transmission and prevention developed in United States of America and Western Europe were inappropriate to the Brazilian cultural context. He therefore concluded that research on HIV/AIDS prevention should recognize the disease as a socio-cultural and biological phenomenon. Following Parker 1997, the study seeks to investigate sexual practice within urban Accra.

Osu Klottey is an urban part of the Greater Accra Region and can conveniently be referred to as the heart of the city of Accra. This community can boast of numerous tourists, businesses, hotels, brothels etc with an ever changing population of persons who are sexually active. When it comes to risk perception and sexual practices, not much is known about how the people of Osu Klottey sub-metropolitan area perceive their personal risks toward HIV/AIDS and how these relate to their sexual practices; since the levels of risk perceived and sexual practices may be fuelling the spread of the infection.

Anthropological insights are of particular relevance in designing community oriented primary care services. Cultural beliefs and behaviours play important roles in either improving health or causing disease in individuals or the local community.

A study on HIV prevalence and risk factors in women of Accra by Duda et al (2005) also emphasized socio-economic and demographic factors such as age in HIV related risk perception. The same study found significant risk factors for HIV/AIDS to include the locality of residence of the client in the city as well as the existence of STI

For the above reasons, a pragmatic, sensitive, and behavioural research is needed to inform effective strategies for mitigating the spread and negative effects of the HIV/AIDS epidemic, particularly among individuals as well as groups who exhibit high-risk behaviours. The problem of risk perception among both the sero positive and those who did not know their status need to be studied and understood so that a better behavior change education interventions can be designed to enhance protective behavior in the population.

It is anticipated therefore; that the findings of this study on HIV/AIDS related risk perception and sexual practices among sero positive persons and those who do not

**know their sero status** would contribute to the national response in the following ways:

**Policy Formulation** HIV/AIDS policy makers and implementers would have a better insight on issues regarding risk perception in HIV/AIDS positive persons and those who do not know their status; factors that are appropriate for programme designs with local inputs to reduce new infections and mitigate the effect of the epidemic in the country, particularly by identifying beliefs and practices that may have impact on the spread of the infection in the study area.

**Design of Preventive Interventions** The findings of the study could also be used in designing preventive interventions such as HIV/AIDS related Behavior Change Communication tools that would target both sero positive and those who do not know their status. This study would provide possible answers for questions that arise when designing interventions for HIV/AIDS related risks and sexual practices among positive persons and those who do not know their status.

**Advocacy** The study aims at providing the needed information required for HIV/AIDS advocacy in the country. Evidence -based research is a backbone of effective advocacy. This study seeks to provide the relevant scientific information needed for HIV/AIDS advocacy; directed at reducing new infections in Ghana.



### **1.3 CONCEPTUAL FRAMEWORK**

#### **1.3.1 THEORETICAL BASIS OF HIV/AIDS RELATED RISK PERCEPTION**

Many behavioural scientists try to use various theories and models to predict human behaviour and one of the commonly used models is the Health Belief Model (HBM). The Model was formulated by RosenStock et al, (1966) and was used by Hochabum et al, (1975). The model consists originally of four constructs that when present and link chronologically would impact an individual in changing habitual unhealthy behaviour.

The Health Belief Model is a psychological model which works under the assumption that an individual places value on his or her desire to avoid high risk behaviour. Individuals as well as groups that are at risk also believe that any specific safe sexual practice or action taken would result in the desired outcome of behaviour change (HIV/AIDS infection prevention).

The model assumes that a person will take a health-related action, for example, abstinence, use of condom or reduction in number of sexual partners if he or she feels that a negative health condition like the HIV/AIDS infection can be avoided.

Also, if an individual has a positive expectation that by taking a recommended action, he/she can avoid the negative health condition and would therefore go ahead to successfully take the recommended health action.

**Table 1.1 Constructs of the Health Belief Model**

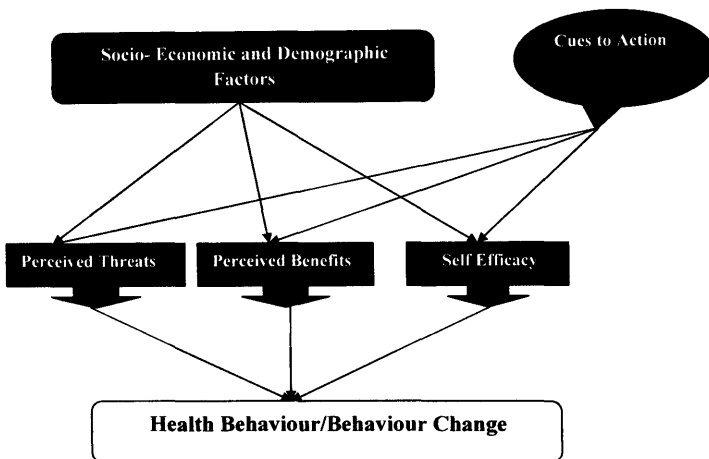
Concept	Definition	Application
Perceived Susceptibility	One's opinion of chances of getting a condition	Define population(s) at risk, risk levels; personalize risk based on a person's features or behaviour; heighten perceived susceptibility if too low.
Perceived Severity	One's opinion of how serious a condition and its consequences are	Specify consequences of the risk and the condition
Perceived Benefits	One's belief in the efficacy of the advised action to reduce risk or seriousness of impact	Define action to take; how, where, when; clarify the positive effects to be expected.
Perceived Barriers	One's opinion of the tangible and psychological costs of the advised action	Identify and reduce barriers through reassurance, incentives, assistance.
Cues to Action	Strategies to activate "readiness"	Provide how-to information, promote awareness, reminders.
Self-Efficacy	Confidence in one's ability to take action	Provide training, guidance in performing action.

**From "Theory at a Glance: A Guide for Health Promotion Practice" (1997)**

The four original constructs, perceived susceptibility, perceived severity, perceived benefits, perceived barriers were proposed as accounting for people's 'readiness to act' or 'avoid negative health behaviour' while Cues to Action; which was later added to the constructs is to help activate the individual's readiness and stimulate overt health behaviour.

In this model, an individual's state of readiness to take a specific preventive action against transmission and or acquisition of the HIV infection is influenced by the constructs shown in figure 1.1.

**Figure 1.1: Diagrammatic representation of factors influencing HIV/AIDS related Risk Perception and Sexual Practices leading to Behaviour Change.**



(Source: Health Behaviour and Health Education by Glanz et al, 2002)

A person must believe that he or she has what it takes to practice safe sex and possesses the necessary skills in negotiating safe sex before its adoption and maintenance. However, a weakness in this model is that it assumes any preventive health endeavour directed towards a person would yield the needed result regardless of the person's beliefs, attitudes, subjective norms and cultural factors that may influence the adoption of low or high risk behaviours. Despite this weakness, this model is preferred to other models such as the AIDS Risk Reduction Model (ARRM) because it reveals the interrelationships that exist among the factors which influence person's risk perception and the needed actions to be taken. For this study on HIV/AIDS related risk and sexual practice at Osu Klottey sub-metropolitan area some of the constructs of the HBM have been adopted in assessing the level of risk perception and sexual behaviour among the study subjects.

The conceptual framework for this study includes some individual background factors, such as sex, age, religious affiliation, educational levels attained and type of occupations, individual or household income levels. Socio-economic and demographic factors such as age and income are essential since the age at onset of sexual intercourse as well as economic status of an individual effects on HIV risk perception. Younger individuals might not perceive the risk as much as adults and also for persons with very low income levels who find it difficult to feed themselves.

It is very critical to understand the context of risk perception in relation to sexual behaviour since this happens to be the first stage towards adoption of health behaviour or avoidance of risk toward safer sex.

Health behaviour models acknowledge the centrality of perceived risk in behavioural change (Becker & Joseph, 1988; Becker, 1974), however, it is not exactly clear how

people's personal risk assessments relate to their sexual behaviour. One can view risky sexual behaviour in the context of the number and types of sexual partnerships, orientation and sexual acts, (Cohen & Trussell, 1996; Dixon Mueller, 1996). Other elements of risky sexual behaviour includes early age at first sexual intercourse, multiple sexual partnerships, unprotected sexual intercourse with 'at risk' sexual partners, and untreated sexually transmitted diseases.

Individuals may perceive their HIV/AIDS related risks to be high or low depending on their previous sexual behaviour or that of their partners. In this case, risky sexual behaviour influences perception of risk. In some cases, a person's perception of risk may be passive, and not necessarily based on his or her previous sexual behaviour.

An individual's high risk perception could lead to modification of sexual behaviour; for example an HIV positive husband who perceives his risk of HIV/AIDS to be high may refuse to have sexual intercourse with his sero-discordant wife (Merge Berer et al, 1995).

### 1.3.1 RESEARCH QUESTIONS

- What are the sexual and behavioral factors that may be contributing to the spread of HIV/AIDS infection in the sub-metro?
- To what extent do HIV/AIDS positive persons and those who did not know their status perceive their risk of infection?
- What are the risk behaviours in the study area which may influence HIV/AIDS infection?

### 1.3.2 GENERAL OBJECTIVES

This study was conducted to explore HIV/AIDS related risk perception and sexual practices of HIV positive persons and those who do not know their sero status in the Osu Klottey Sub-metropolitan area.



### 1.3.3 SPECIFIC OBJECTIVES

- To determine the knowledge and awareness of risk behaviours that may influence HIV/AIDS infection.
- To identify HIV/AIDS related beliefs and practices in the study area.
- To explore sexual behaviours of HIV/AIDS positive persons and those who do not know their sero status in the sub-metro.

## CHAPTER TWO

### 2.0 LITERATURE REVIEW

#### INTRODUCTION

The first AIDS case in Ghana was reported in 1986. By December 2004, 90, 000 AIDS cases had been reported. The number of people currently living with HIV/AIDS globally is estimated to be around 33 million with sub-Saharan Africa bearing the greatest burden with more than two thirds (68%) of all persons infected with HIV. (NACP, 2008, UNAIDS, 2007).The global response to the pandemic is scheduled around treatment, care and support.

According to UNAIDS Executive Director Michel Sidibe; the number of new infections of HIV/AIDS outstrips the number of people put on treatment and until this trend is reversed, countries will have to spend ever-increasing resources on AIDS drugs to keep people alive. An estimated \$25 billion per year according to the UNAIDS Chief is needed to fight the epidemic globally (CNN report February, 2009). The Ghana AIDS Commission estimated 312,030 persons (290,202 adults and 21,828 children) in 2007 to be living with HIV/AIDS in Ghana with a prevalence rate of 1.9% in 2007 (Ghana AIDS Commission, 2008).Projecting from year 2007 to 2012, Dr Nii Addo, the programme Manager of the National AIDS Control Programme(NACP) warned that the number of persons living with HIV/AIDS would increase as well as cumulative deaths from HIV/AIDS(180,899 in 2007 to 266,933 in 2012 ) if the various efforts being marshalled against the disease is not maintained (NACP, 2007).

Ghana has adopted strategies that concern Treatment, Care and Support for persons living with HIV/AIDS by initiating and implementing programmes on Counselling and Testing (CT), Prevention of Mother-to-Child Transmission (PMTCT), and

establishment of Anti Retroviral Therapy Centres nationwide. A total of 174,659 persons were counselled and tested where as for PMTCT a total of 257,575 pregnant women got tested by mid 2008 and 6,944 received antiretroviral prophylaxis to avert paediatric HIV infections. In 2007, 2,896 pregnant women benefited from the same intervention alongside persons on antiretroviral therapies nationwide (MOH 2008, Ghana AIDS Commission POW, 2009).

Despite the concerted efforts by all stakeholders to prevent and curtail the spread of HIV/AIDS in Ghana, the infection continues to spread especially among impoverished communities in Ghana. In 2008 the Greater Accra Region alone recorded 2,280 new cases of HIV/AIDS (Greater Accra Regional Health Directorate, 2008).

Sexual behaviour in Ghana was largely determined and characterized by cultural restrictions but in recent years due to modernization and adoption of foreign cultures; sexuality and sexual behaviour is no longer being determined largely by the Ghanaian culture; since people engage in lifestyles that may not be traditionally Ghanaian which either promote health behaviour or put them at risk of getting illnesses and diseases.

The relationship between perception of risk and that of sexual behaviour is very complex and poorly understood by many. Evidence-based research in different cultures have associated HIV/AIDS related risk perception with a wide range of variables some of which are; number of sexual partners, knowledge of sexual partners' past sexual behaviour, fear of HIV/AIDS, shame associated with having AIDS, the community's perception of AIDS risk, knowing someone with AIDS, discussing HIV/AIDS at home, closeness of parent-child relationships, religious affiliations (Macintyre et al.2004).

## **2.1 Knowledge regarding HIV/AIDS**

In Ghana a well known mode of acquiring HIV/AIDS infection is through sexual intercourse. It is estimated that the rate of HIV/AIDS prevalence is staggering especially amongst young people worldwide. Statistics indicate that more than half of those newly infected with HIV today are between 15 and 24 years old. Frighteningly, however, only a fraction of them know they are infected.

In Somalia for instance, it was reported that only 26 per cent of girls have heard of AIDS and it is only 1 per cent of them who know how to avoid the infection however in Ukraine ,99 per cent of girls in were reported to have heard of HIV/AIDS but again when it comes to primary knowledge on ways of avoiding sexual transmission, only 9 percent could correctly identify the three primary ways of avoiding sexual transmission defined as abstinence, being faithful to one partner and consistently using a condom properly in that country (Zahra Sethna,2002).Worldwide, misconceptions about HIV/AIDS abound and the situation is not different in Ghana. According to survey conducted in 40 countries, it was realised that more than 50 per cent of young people aged 15 to 24 harbour serious misconceptions about how the disease is transmitted. These include the belief that HIV can be transmitted through witchcraft or mosquito bites, or that a healthy-looking person cannot have the AIDS virus (Young people and HIV/AIDS: Opportunity in Crisis).

A study in Sukura (suburb of Accra) revealed that sexual activity in that community starts early. The community youths who are mostly illiterate were found to have serous misconceptions about HIV/AIDS since most of them believed head lice could spread HIV infection (Changing Sukura for Good, October 2001:1).

In promoting sexual behaviours aimed at reducing new infections of HIV/AIDS factors such as personal risk perception and self-efficacy are essential in lowering the current prevalence rate.

## **2.2 HIV/AIDS related risk awareness and perception**

This is the expressed subjective judgment that people make about the characteristics and severity of HIV/ AIDS. The consensus expressed by an individual or community of the likelihood of contracting HIV/AIDS. While the general perception of HIV/AIDS was wide spread even in earlier studies on the subject, mixed results were presented in the area of reported risk perception (Opare, 2001).

Studies on HIV/AIDS related risk in other African countries found many who believe that they are not at risk or that their individual risk of getting infected with HIV is low. In Nigeria for instance, 95 per cent of girls aged 15 to 19 perceived their risk of contracting AIDS to be minimal or non-existent. In Haiti, the figure is as high as 93 per cent and holds for all adolescents, both male and female. A study in Malawi showed that many girls believed they were safe from the risk of infection if they had sexual relations with a boy whose mother knew their family (Sethna, 2002).

A similar study conducted by UNICEF in Accra found awareness of HIV/AIDS to be almost universal however, risk perception was found to be generally low. The low risk perception was said to be reinforced by an individual not knowing or not having seen someone infected and afflicted with HIV/AIDS.

Available information indicates that an understanding of the transmission of HIV/AIDS in Ghana will, to a large extent, depend on knowledge of the behaviour, social and cultural factors that determine the person's risk of HIV infection, particularly the perception and attitude towards the modes of HIV transmission such

as sexual intercourse, sexual practice and the aspects of social networks through which the disease is likely to be transmitted and sexual fulfilment enhanced.

For various reasons sexual intercourse nowadays does not happen between men and women only. Some men prefer having sexual relations with their fellow men while some females also prefer their fellow females. There is no statistics countrywide for persons engaged in the act but the phenomenon exists. Research has shown that men who have sex with their fellow men (MSM) are highly prone to sexually transmitted diseases such as HIV/AIDS, gonorrhoea or syphilis. A study by (Attipoe, 2004) revealed that MSM was 'real' although the practice is culturally reprehensible in Ghana.

It is in this vein that the recent ruling by an Indian Court decriminalizing the act of MSM in that country caught the attention of major players in health such as the Executive Director of UNAIDS, Michel Sidibe and other international media outlets hailed the ruling as a step in the right direction in preventing HIV/AIDS

(Daily Graphic Report, 21st July 2009).

Additionally, research has identified free movement of people, including prostitutes to 'where business is profitable', which in turn is linked to the 'gold rush' to where tourists gravitate and this has been blamed as partly responsible for the high HIV/AIDS incidence in the country. The trend is identified in other African countries such as the ex-British colonies like Uganda, Zambia and Tanzania

(Konotey-Ahulu, 1989).

It has also been identified that civil wars in Liberia, Sierra Leone and Togo had come with it attendant migrant population for Ghana as a whole. The internal conflicts in

the northern regions and part of the Volta region have also contributed to people moving from the north towards the south for settlement and work (Anarfi, 1993).

Apart from these established forms of migration there are short-term movements such as tourist traffic, sailors docking at ports, military and para-military men and women going on peace keeping operations and trips to international meetings (international travel). The high sex ratio (male dominance) at migration destinations implies that females are in demand for casual sexual relations hence the persistence of promiscuity and prostitution in urban areas (Baldo and Cabral, 1990).

All these movements have one thing in common; they expose movers to others with whom they may engage in casual sex and increase their risk of contracting HIV/AIDS infection. According to Brooke G. Schoepf (2001), inequalities of class, poverty and ethnicity are major factors that fuel the spread of HIV/AIDS. This may account for the reason why the Ghana AIDS Commission placed its 2009 Programme of Work within the context of the Ghana Growth and Poverty Reduction Strategy of 2006-2010 (Ghana AIDS Commission, 2009).

Social inequalities such as poverty were found to be responsible for low risk perception when it comes to HIV/AIDS. A study by WAPCAS on Commercial Sex Workers (CSW) in Accra in 2005 found that CSW's who oblige to have transactional sex without condom use were those hard pressed for food and safety. They opt for immediate survival of putting food on the table for themselves and their families above protecting themselves against HIV/AIDS infection (WAPCAS, 2005).

The implementation of various strategic interventions (CT, ART and PMTCT ) on prevention, treatment, care and support of HIV/AIDS positive persons has made the issue of HIV/AIDS control in Ghana more complex than when the infection was first discovered decades ago. With the introduction of ART, thousands of persons who

could have died long ago are now living. It is not unusual to meet HIV and AIDS positive individuals who look 'healthier' and more 'alert' than individuals who are negative. One is now likely to meet HIV/AIDS positive individual who looks healthy and normal without any symptoms or signs of the disease. As shown in picture 1 below, an HIV positive grandmother who was on ART could be seen looking strong and healthy with her family.

**Picture 2. 1: A 54 year old HIV positive grandmother who has been on ART since 2005 in a picture with her family**



(Source: [www.joinmed.com](http://www.joinmed.com))

This study would provide better insight into the factors which may be responsible for the continuous spread of new HIV infections in the country since most at risk persons continue to adopt sexual behaviours that may expose them to contracting the infection as a result of the false assumption that 'HIV/AIDS has a cure' thereby lowering the level of their risk perception of HIV/AIDS.

## CHAPTER THREE

### 3.0 METHODOLOGY

#### 3.1 BACKGROUND OF STUDY LOCATION

The Accra metropolis has six (6) administrative zones (sub-metropolis) one of which is the Osu Klottey sub-metropolitan area. The sub-metro covers a total land surface area of roughly 6,590 square meters with an estimated population of 194,278 and an annual growth rate of 4.4 % (2000 Census). Some important landmarks in the sub-metro are the Holy Spirit Cathedral, the Ridge Hospital, the Osu Castle and Kwame Nkrumah Circle.

**Layout:** The Osu Klottey sub-metro entails suburbs such as Adabraka, Osu, Asylum Down, Tudu and Ridge. Its layout includes part of Kwame Nkrumah circle as well as Tudu, with the southern wing bounded from the Centre for National Culture (The 28<sup>th</sup> February Road) up to the south eastern part of the Fisheries Department.

The eastern wing of the sub-metro is bounded by Kinbu Road through to the Kwame Nkrumah Avenue and the Location Street; whilst the western boundary is outlined by the Klottey Lagoon covering the Okodan Street up to the western end of the Fisheries Department. Osu Klottey sub-metro has well laid out buildings as could be found in Ridge as well as slums as could be found at parts of Tudu.

**Inhabitants:** Various tribes in Ghana and ethnic groups are represented in the Osu Klottey sub-metropolitan area. As a result this community enjoys vibrant commercial activities such as petty trading, commercial sex work as well as fishing/fish mongering and white colour jobs.

**History:** Oral tradition has it that the indigenes of Osu Klottey are descendants of the colonial masters who arrived in Gold Coast for trading. The merchants were said to have landed at the beaches of the study area to do business after which they later settled among the local folks. This phenomenon led to the rapid development of these areas of Accra; a community of Africans and Europeans was thence born.

**Occupation:** The inhabitants of Osu Klottey sub-metro are mainly fishermen and fishmongers; with a sizeable number of the people holding white colour jobs but majority of the people are unemployed. Notwithstanding, the sub-metro sees a lot of petty trading as well as retailing of goods and services which depicts its middle to lower income status. Commercial and casual sexual activities are rampant in the community with sizeable number of nightclubs, pubs, brothels, hotels and discotheques.

**Water and Sanitation:** Water supply in the Osu Klottey sub-metropolis is mainly through pipe borne water which is characterized by perennial shortage. Sanitary condition in the sub-district is one of the worst in the whole of Accra due to its ever increasing and highly unstable population.

**Education and Literacy:** The level of literary in the sub-district was estimated to be high since about 60% of the inhabitants are literates; one of the highest in the country. There are various educational facilities in the sub metro ranging from nurseries to a polytechnic.

**Health Facilities/Services:** There are a total of twenty four (24) health facilities in the sub-metro with the following being government owned institutions; the Ridge Hospital, The Adabraka Polyclinic, Accra Psychiatric Hospital and the Osu Maternity Home. Quasi-government health facilities in the sub-district include the Trust

**Hospital and Police Hospitals.** Some of the privately owned health facilities in the Osu Klottey sub-metro are the North Ridge Clinic and the C&J Medical Centre.

There are two maternity homes in the sub-metro which provide maternal and child health care services. Individual Traditional Birth Attendants (TBAs) also ply the trade. Activities of herbalists, traditional healers as well as and spiritualists also abound in the sub-district with them mostly located at public lorry parks since most of them do not have identifiable premises where they practice their trade. Within the sub-metro are also specialist clinics such for commercial sex workers; located within the Adabraka Polyclinic and Anti Retroviral Therapy (ART) Clinics located within the Ridge Hospital. Various antenatal clinics in the sub-metro also practice the Prevention of Mother-to-Child Transmission (PMPTC) policy; which aims at preventing HIV/AIDS transmission among pregnant women to their unborn children. Also located within the sub-metro are various associations of People Living with HIV/AIDS which act mainly as a support group for their member, some of which were based in the community but operates mostly from the ART centres.

### **3.2 STUDY DESIGN**

This is a descriptive, cross-sectional study designed to explore the risk factors associated with HIV/AIDS. The study employed both qualitative and quantitative techniques for data collection.

### **3.3 STUDY POPULATION**

The study population included the following:

- HIV/AIDS positive persons
- Persons who do not know their sero status

- **Counsellors at ART Centres**
- **Health Services Providers to HIV/AIDS persons**

### **3.4 Variables**

**Dependent Variable:** Safe sexual practice e.g. Condom use, abstinence, late sexual inception.

**Independent Variables:** Knowledge and awareness of HIV/AIDS, Risk perception of HIV/ AIDS and socio-economic and demographic factors such as age, sex, employment status and marital status.

### **3.5 OPERATIONAL DEFINITIONS OF VARIABLES**

#### **3.5.1 Sexual Practice/Behaviour**

**Abstinence, multiple sexual partnership, promiscuity, age at first sexual relations, Whether pre or extra marital sexual relations are encouraged or forbidden, Number of sexual partners, whether recourse to commercial sex work (CSW) or service is socially acceptable, Condom use at every sexual intercourse, whether Men are having Sex with Men (MSM), Tolerance of lesbianism or otherwise, taboos on sexual intercourse during pregnancy, menstruation, lactation or puerperium (Cecil Helman, 2000).**

#### **3.5.3 Safer Sexual Practices**

**Delaying sexual initiation, being faithful to one partner, Saying No to sex (Abstinence), Avoid multiple sexual partners, selecting sexual partner carefully by excluding persons considered to be at high risk such as commercial sex workers (avoidance of casual sex), continual condom use with every sexual partner.**

### 3.6 SAMPLING ISSUES

#### 3.6.1 Sample Size Determination

Using Epi Info Version 3.5.1, 2008 statcal, population of persons who do not know their HIV/AIDS sero status was 194, 278 with prevalence rate of 2.1% and a worst acceptable rate of 5% (95% Confidence Interval). A sample size yield of 94 was generated.

3.6.2 Sampling for HIV/AIDS positive persons (PLHA's): The purposive sampling technique was employed to select PLHA's. Out of the six hundred (600) sero positive members belonging to the Associations of People Living with HIV/AIDS, One Hundred and Twenty (120) were selected through convenience sampling for the study. The support associations were based at the ART Clinic at the Ridge Hospital hence the study subjects were selected from these clinics. Each participant was chosen for the study by virtue of being resident in the sub-metro and willingness to participate. This process offered all those willing to participate in the study an equal chance of inclusion from the various support associations who accessed ART services at the Ridge Hospital. Sample size calculation for people who do not know their sero status: Using Epi Info Version 3.5.1, 2008 statcal, assuming the population of the sub-metro was 194, 278 with the prevalence rate of 2.8% and a worst acceptable rate of 5% (95% Confidence Interval). A sample size of 216 was generated. However, for the purposes of non-response and withdrawal from the study, 5% of the Epi info generated sample size was added to the initial sample size making it approximately 230 respondents.

The total sample size for the study therefore was 350 being those who know their status and those who do not know their status. However 360 respondents participated

in the study. The status known /status unknown percentage representation was 33.3% and 66.7% respectively.

In sampling for persons who do not know their status, simple random sampling method was employed to select two (2) suburbs out of the five in the study area and these were Osu and Tudu. The pre-demarcated enumeration area register for the randomly picked suburbs were accessed from the Statistical Services of Ghana. These communities have 62 and 11 coded enumeration areas respectively with their respective estimated populations.

Proportionally, Tudu's enumeration area to that of Osu yielded a ratio of 1:6. In order to get fair representation of respondents from these two communities, SPSS 16.0 was used in randomising one enumeration area from Tudu and six enumeration areas from Osu. The total population from the sampling frame for Osu and Tudu were then added and divided by the estimated sample size for people who do not know their status (Table 3.1).

**Table 3.1: Table showing various enumeration areas, estimated populations and samples drawn.**

Locality Name	Enumeration Area	Estimated Population	Sample Size	Percentage of Population
Tudu	Caledonian House	700	33	4.71%
Osu	Shamers Club	570	29	5.09%
Osu	Lokko Road Chemists	750	38	5.07%
Osu	Shanghai Chinese Fast Food	500	25	5.00%
Osu	Wulck Pharma Services	630	32	5.08%
Osu	Modern Age Technology	700	36	5.14%
Osu	Watson Services	720	37	5.14%
<b>Total</b>		<b>3,870</b>	<b>230</b>	

### **3.7 DATA COLLECTION TECHNIQUES AND TOOLS**

**3.7.1 Questionnaire:** Data collection was done with a questionnaire. This provided data for statistical analyses to generate frequency distributions and established association between and among various variables of interest. The use of this tool helped maximize the quality of the data collected as well as offered flexibility in type of information that was collected (i.e., knowledge, risk perception and sexual behaviours) from the large number of respondents.

The use of the questionnaire additionally helped provide statistically reliable data which was analysed to identify the HIV/AIDS related beliefs and sexual practices in the study area (Twumasi, 2001). One hundred and twenty (120) questionnaires were administered to PLHA's and two hundred and thirty (230) administered to those who do not know their sero-status.

**3.7.2 Focus Group Discussions (FGDs):** The FGD is a qualitative method of data collection and its purpose in this study was to explore issues on HIV/AIDS risk related and sexual practices in more detail by allowing the PLWHA's to talk freely on the topic and share their perceptions and sexual practice. FGD's were conducted with each group containing 6-10 people purposively selected from PLHA associations. A facilitator moderated the discussions assisted by a note taker. The discussions were tape recorded to maximise data capturing. Males of 15-30 year group formed one group while those 31 years and above also formed another group. The same process was repeated for the females.

The FGD's were more than a question-answer interaction since the facilitator guided the group into increasing levels of focus and depth on the key issues of the research. The discussion generated and explored ideas on HIV/AIDS related risk perception

and sexual practices in the study area. In all, four FGDs were conducted with the participants from the ART centres. FGDs provided the researcher with some preliminary guidance concerning the topic and helped to identify key issues for further follow-up. This further granted the researcher the opportunity to gain useful insight into HIV/AIDS related risk perception and sexual practices in the study area (Cecil Helman, 2000; Twumasi; 2001).

**3.7.3 Key-informant In-depth interview:** This is a face-to-face conversation with a key individual with the intent of exploring issues and opinions in detail by use of an interview guide. These key informants included HIV/AIDS positive persons, Counsellors and care providers. The questions were open-ended and this helped elicit qualitative narrative accounts of the individual. Additionally, the open-ended questions enabled us to probe further issues that were raised during focus group discussions. In all, ten in-depth interviews were conducted to explore views and perceptions on HIV/AIDS.

Research assistants helped the Principal Investigator in conducting the interviews. The in-depth interviews were tape recorded and notes taken to complement the information obtained. The recorded tapes were transcribed and compared with notes taken during the interview for completeness and accuracy.

### **3.8.4 DATA QUALITY CONTROL**

**3.8.1 Recruitment and Training of Research Assistants:** Research Assistants were recruited from the sub-metro. They have had prior skills in data collection. They were trained for two days to understand the questions to be posed and how to translate from English to the Ga and Twi languages appropriately to respondents. A role play on

translation was undertaken by the Research Assistants. The personnel also received training on various methods of data collection and questionnaire administration.

**3.8.2 Pretesting:** The data collection tools and techniques were pre-tested at the ART Clinic at the Tema General Hospital since the sub-metro has similar features as that of Tema. This was to assess the acceptability, appropriateness and suitability of the questions posed. The pre-testing also helped assess the willingness of respondents to answer questions on the research topic due to its sensitive nature. The reliability or otherwise of the tools such as the in-depth interview guide and questionnaire for data collection was revealed and the needed steps taken to address issues that were raised. After pretesting, the tools were finalised and printed.

### **3.9 DATA PROCESSING**

**3.9.1 Cleaning and Double Entry:** Whilst collecting data on the field, daily checks were done on data collected for internal consistency, correctness and appropriateness. Any inconsistencies that were detected were promptly corrected before the questionnaires were taken away. Quantitative data collected was cleaned, coded and double entry was made into SPSS 16.0. Software.

**3.9.2 Verbatim Transcription:** Focus Group Discussions and In-depth interviews were transcribed verbatim on daily basis and compared with hand written notes taken during data collection. Gaps that were identified were filled. Peer review of data collected and transcription were equally pursued.

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### **3.10 DATA ANALYSIS**

The analysis took a step by step look at HIV/AIDS risk perception among persons who were positive as well as those who did not know their sero status, assessment of issues such as the modes of transmission, perceptions about risk of infection, perceptions about treatment as well as and cure, preventive methods. The findings in both groups are discussed concurrently to complement each another.

Quantitative data analysis was done using SPSS 16.0. Frequency tables, contingency tables and graphs were drawn and cross tabulations performed to establish associations for HIV/AIDS related risk perception and sexual behaviour. Chi-Square was used to test the level of associations between risk perception and HIV status among others. Additionally, logistic regression was used to assess whether the predictor variable significantly predicted whether or not a person has tested positive to HIV.

Qualitative data were analysed by transcribing verbatim recorded tapes of Focus Group Discussions and individual in-depth Interviews conducted. The transcripts were cross -checked with notes taken after which major opinions expressed by discussants in line with the study were identified. Coding of the data was done; themes as well as sub-themes formed to further digest the data. Master sheets were developed to contain summarized information of the dominant and strongly held opinions of the participants. Patterns in responses provided supportive information for the various issues that came up during discussion. The qualitative and quantitative data were triangulated to complement each other.

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### **3.11 ETHICAL CONSIDERATIONS**

Ethical clearance to conduct the study at Osu Klottey sub-metropolitan area was sought from the Ghana Health Service Ethical Review Committee.

Secondly, the Accra Metropolitan Health Director and the Osu Klottey sub-metro Head were duly informed about the study in their jurisdiction. The Queen Mothers and Ethnic Leaders in the communities were also contacted for their permission to enter the various communities where data collection was conducted. The Medical Superintendent of the Ridge Hospital where the various Support Associations for HIV/AIDS persons were located and the Association Heads were duly informed of the study and their consents obtained.

Verbal and written consents were obtained from persons living with HIV/AIDS and the other respondents in the communities. Those who were not literate were made to thumbprint the consent forms as evidence of their willingness without harassment, coercion or duress to participate in the research. Participants for In-depth interviews and Focus Group Discussions also participated on their own volition, during the course of the Focus Group Discussions, those who left did so with no restriction.

Finally, confidentiality and anonymity of information given by the respondents and discussants relating to their sexual practices, sero status and HIV/AIDS related risk perceptions were strictly maintained.

### **3.12 LIMITATIONS OF THE STUDY**

A major limitation that the Principal Researcher faced was that she does not speak the predominant Ga and Twi dialects therefore translation assistants were utilized. The second limitation to the study was financial constraints. It was very difficult getting



willing study participants without them demanding monies for various engagements such as granting interviews, filling of survey questionnaires and participating in Focus Group Discussions. As one of the PLHA's put it and I quote; '*madam, as for HIV it is money, my people would not talk to you without money*'.

Persistent rainfall greatly disrupted data collection activities (field work) for several days and prolonged the data collection period and further constrained the study period.

## **CHAPTER FOUR**

### **4.0 FINDINGS**

This chapter presents the analysis of data collected from the Osu Klottey Sub-Metropolitan area. Structured questionnaires were used to collect quantitative data from three hundred and sixty (360) respondents while in-depth interviews and focus group discussions were used to collect qualitative data.

The presentation of the research findings is structured in the following format:

- Socio-demographic information on respondents and related issues
- Knowledge, Awareness and Risk Perception on HIV/AIDS
- HIV/AIDS related beliefs and practices in the study area.
- Exploration of sexual behaviours and practices of HIV/AIDS positive persons and those who do not know their sero status.

#### **4.1 Demographic Information on Respondents**

Respondents consisted of both males and females from fifteen (15) years and above based on the premise that people become sexually active from fifteen years on the average. About 224 (62.2%) of the respondents were females whilst 136 (37.8%) were males; the issue of more females being sampled was not deliberate since the questionnaire was administered to persons who were willing to participate in the study. Furthermore, of the 120 positive respondents selected, females constituted 75.5%. Also, out of the 240 respondents who did not know their HIV status, 53.3% of them were women.

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However, for the Focus Group Discussions equal numbers of male and females participated in the discussions. The asymmetric nature of the sample however posed no threat to the findings of the research since the research topic is not a gender-sensitive one and data was presented proportionally.

#### **Age distribution of Respondents**

Majority of the participants were within the age bracket of 20 - 29 years. They constituted about 159 (44.2%) of the respondents. Few of the participants were within the age group of 70-79 years and formed about 1(0.3%) of the respondents. A further probe revealed that about 356 (98.8%) of the respondents were not more than the age 59 years (Table 4.1).

**Table 4.1:** Age distribution of Respondents

<b>Age</b>	<b>Frequency</b>	<b>Percentage</b>
15-19	46	12.7%
20-29	159	44.2%
30-39	95	26.4%
40-49	35	9.7%
50-59	21	5.8%
60+	4	1.2%
<b>Total</b>	<b>360</b>	<b>100.0%</b>

#### **Religious affiliation of Respondents**

The research covered respondents with diverse religious backgrounds. Christians formed the largest percentage of respondents 333 (92.5%). About 25 (6.9%) of the

respondents belonged to the Islamic Faith and only two 2 (0.6%) of the study participants profess to have belonged to the traditional religious faith. The study however did not find any association between protective behaviour particularly condom use and religion.

### **Ethnicity of Study Participants**

Like religion, ethnicity also plays a major role in the kind of behaviour people adopt, their values and actions they take. Ethnicity may present diverse views on similar issues; what someone may regard to be 'right' or acceptable may within another ethnic group or setting be seen as otherwise. The Osu Klottey Sub-metro is traditionally a Ga community, however, Akans 154 (42.8%) dominated the respondents with Gas constituting 94 (26.1%) of the 360 respondents.

Table 2: 2 Ethnicities of Respondents

Ethnicity	Frequency	Percentage
Akan	154	42.8%
Ga	94	26.1%
Ewe	56	15.6%
Northerner	25	6.9%
Ga-Adangbe	31	8.6%
Total	360	100.0%

### **Educational Attainments of Respondents**

Osu Klottey sub-metropolitan area can be said to have one of the highest rates of literacy in the country since 335 (93.1%) of the respondents had at least basic education. Only 25 (6.9%) of the respondents never had any formal education. It is

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worth reporting that about 247 (68.6%) of respondents had secondary school or higher educational levels (Table 4.3).

**Table 4.3: Educational Level of Respondents**

Education	Frequency	Percent
None	25	6.9%
Basic	88	24.5%
Secondary	170	47.2%
Tertiary	77	21.4%
Total	360	100.0%

#### **Occupation of Respondents**

Analysis revealed that the majority of the participants 108 (30.0%) were into trading whilst 80 (22.2%) were artisans. Participants who were in school came up to about 73 (20.3%) whilst sixty 60 (16.7%) of the participants said they were unemployed with about 16 (4.4%) working in the public sector. It is known that having financial access to healthcare improves service utilization and adherence to treatment protocols. However, the study found that most of the PLHA's default in their treatment due to financial difficulties they face in paying for transportation to and from the clinic and also the subsidized treatment cost. This position was vividly captured in the following narrative:

*I think some people have problems paying the five Ghana cedis for the ART drugs, lab etc. some default and say that they don't have even transportation fee to and from the clinic let alone paying for the service, some of them really don't have anything (HIV/AIDS Counsellor at Ridge Hospital).*

**Table 4.4: Occupation of Respondents**

Occupation	Frequency	Percentage
Trading	108	30.0%
Teaching	7	1.9%
Public Service	16	4.4%
Security Service	3	0.8%
Artisans	80	22.2%
Banking	1	0.4%
Labourer	12	3.3%
Schooling	73	20.3%
Unemployed	60	16.7%
<b>Total</b>	<b>360</b>	<b>100.0%</b>

### Marital Status of Respondents

Marital status of respondents was assessed in order to better situate the HIV/AIDS related risk perception and sexual practices in appropriate contexts.

The result show that 193 (53.6%) of the respondents were single (table 4.4 ). Out of the 360 respondents interviewed, 195 (54.2%) have children. Of persons living with HIV/AIDS, some also have positive children whilst others said they got infected after having their children. These positions were represented in the following narratives:

*I have been diagnosed for the past five years but am not on ART as at now, I have a 10 year old son who is with my parents because am unemployed, I sleep in the Adabraka market; I don't have money to pay for rent advance. My son is negative (A 35- year old HIV positive woman).*

**Table 4.5: Marital status of Respondents**

Marital Status	Frequency (%)	Percentage
Single	193	53.6%
Married	124	34.4%
Divorced	20	5.6%
Separated	9	2.5%
Widowed	14	3.9%
<b>Total</b>	<b>360</b>	<b>100.0%</b>

**Table 4.6: Comparative analysis of marital status of Respondents**

HIV/AIDS Status	Marital status of Respondents					Total
	Married	Divorced	Separated	Single	Widowed	
Positive	55 (45.8%)	14 (11.7%)	8 (6.7%)	34(28.3%)	9 (7.5%)	120 (100.0%)
Do not know status	68(28.3%)	8 (3.3%)	3 (1.2%)	154(64.2%)	7 (2.9%)	240 (100.0%)
<b>Total</b>	<b>123 (34.2%)</b>	<b>22 (6.1%)</b>	<b>11 (3.1%)</b>	<b>188(52.2%)</b>	<b>16 (4.4%)</b>	<b>360 (100.0%)</b>

$$X^2_{0.05} = 47.395 \quad X^2_{0.05, 2} = 9.49 \quad p\text{-value} = 0.000$$

The result shows a significant association between HIV/AIDS status and the marital status of the respondents.

#### 4.2 Knowledge, Awareness and Risk Perception on HIV/AIDS

In assessing the knowledge, awareness and risk perception of HIV/AIDS among study participants, (97.2%) know and were aware of the condition.

**Table 4.5: Marital status of Respondents**

Marital Status	Frequency (%)	Percentage
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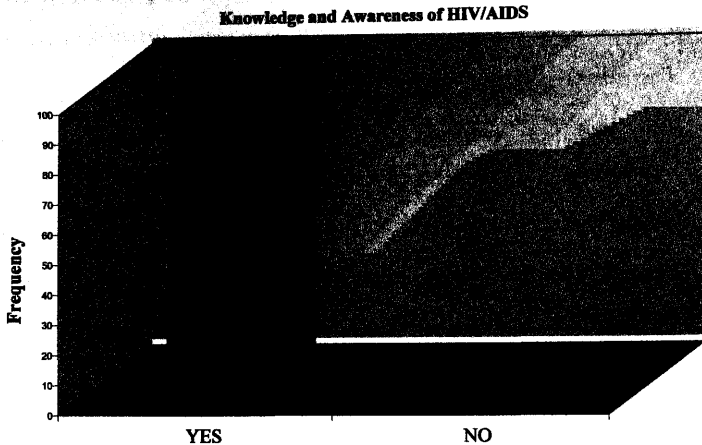
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#### 4.2 Knowledge, Awareness and Risk Perception on HIV/AIDS

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**Figure 4.1: Knowledge and Awareness of HIV/AIDS**



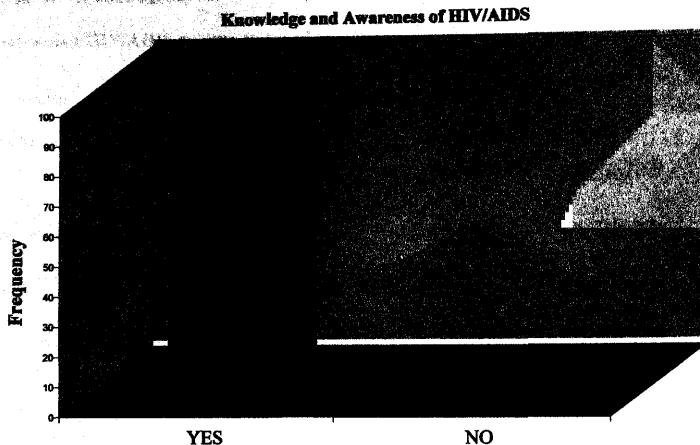
From the findings one might be tempted to draw the conclusion that almost everybody in the study area had adequate knowledge on HIV/AIDS. However, the following revelation points to the fact that more needs to be done.

*Mati nso menim adekro I have heard of HIV/AIDS but I don't know what it is (37 year old newly diagnosed HIV positive patient from Tudu).*

#### **4.3 Perceived risk of community members contracting HIV/AIDS infection**

An individual's state of readiness to take a specific preventive action against contracting or infecting others with the HIV/AIDS is influenced by the level of risk perceived either by the individual or significant others. As depicted in table 10, ordinarily, people would take and abide by a particular health action if they perceive they are at risk or others residing in the same community with them stand the risk of contracting the condition.

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**Table 4.7: A contingency table showing Risk assessment of community members contracting HIV/AIDS against status of respondents**

HIV/AIDS status	Likelihood of community members contracting HIV/AIDS			Total
	Yes	No	Don't know	
Positive	101 (84.2%)	4 (3.3%)	15 (12.5%)	120 (100.0%)
Do not know status	201 (83.7%)	22 (9.2%)	17 (7.1%)	240 (100.0%)
Total	302 (83.9%)	26 (7.2%)	32 (8.9%)	360 (100.0%)

$\chi^2_{0.05} = 6.412$      $\chi^2_{0.05, 2} = 5.99$     p-value = 0.041

The study however revealed that of the 120 positive participants, 101(84.2%) see their community members as being at risk of contract the virus as against 201 (83.0%) of those who do not know their status. As the following comments demonstrate, persons who were positive had higher HIV/AIDS related risk perception.

*My friends out there, the disease has come ooooooh, you'll be there walking kim kim kim thinking there is nothing wrong with you but one day you'll go to the hospital and you'll be tested and told you're positive' (47 years old HIV positive person).*

In all, 26 (7.2%) of the 360 respondents said they could not see their community members being at risk of contracting HIV/AIDS whilst 32 (8.9%) of the participants could not tell whether or not people in their communities were at risk of contracting the disease. This finding demonstrates that those who do not know their status tend to have relatively lower risk perception of the condition than those who know their positive status. Thus those with the virus associate higher perceived risk of contracting the infection than those who do not know their status.

The following comments also attest to that: *As for me before I was diagnosed I used to telling my friends that HIV is better than cholera because if cholera catches you,*

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The following comments also attest to that: *As for me before I was diagnosed I used to telling my friends that HIV is better than cholera because if cholera catches you,*

*you'll die in 3 days but for HIV ;10 years before you'll die, even akpeteshie can kill it; but when this disease attacked me, it's then that I know that it is not easy; I can't tell them am positive but I always let all of them know that the disease exists and it is dangerous (by a 24 year old HIV positive male).*

The results showed ( $X^2_{0.05} = 6.412$ ,  $p < 0.05$ ) a significant relationship between HIV/AIDS status and perceived risk of people contracting the HIV/AIDS infection.

#### **4.4 Perceived ways of Contracting HIV/AIDS in the Community**

As shown in figure 4.2 the two most important mode of HIV/AIDS transmission in Osu Klottey sub-Metropolis were through sexual intercourse (94.4%) and sharing of contaminated sharp instruments (70.0%). Mother -to- child transmission during birth (55.6%) also featured prominently. However; the following narratives indicated that other causes of the infection were also known in the metropolis. The following comments depict the respondents perceived ways of contracting HIV/AIDS.

*I think it is the evil spirits which put the illness on me'-(Female Church labourer).*

*I had HIV through transfused blood. I became positive after eight months of blood transfusion; in fact in this hospital. I am not married (by 30 year old positive male).*

*You can get HIV if somebody uses blade and you use it; you can get it. If you use somebody's toothbrush you can get it. You can get it from towels and sponge as well (by a 34 -year old trader).*

*I think it is the evil spirits which put the illness on me (by 39 year old positive female).*

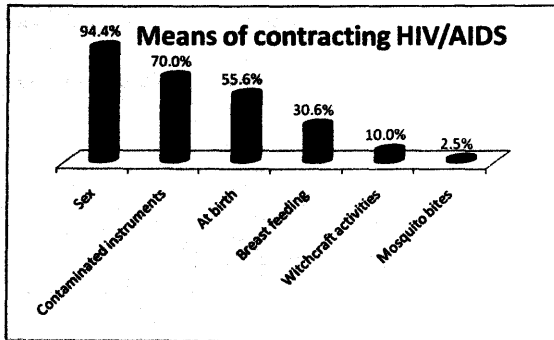
The following narratives also supported the position that sexual intercourse was the most widely known mode of transmission:

*Looking at the patients after counselling and risk assessment, most of the patients get the infection through sexual intercourse (PNO in-charge of ART Clinic).*

*I had it (HIV/AIDS) through sex; I had a partner who was getting ill almost always and she eventually died ;yes the one who gave it to me is dead, she died (by 51-year old sero positive male).*

Personal care service providers such as hairdressing saloons and barbering shops were reported during FGD's and IDI's to be some of the conduits by which HIV/AIDS infection was transferred in the community due to unhygienic practices.

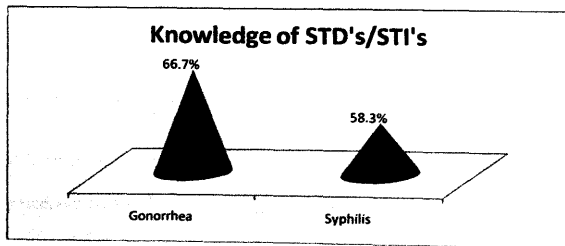
**Figure 4.2: Means by which the respondents believe one can contract HIV/AIDS**



**Knowledge on Sexually Transmitted Diseases**

The respondents were aware of the two main Sexually Transmitted Diseases (STD) aside HIV/AIDS.

**Figure 2.3: Knowledge on STD's/STI's**

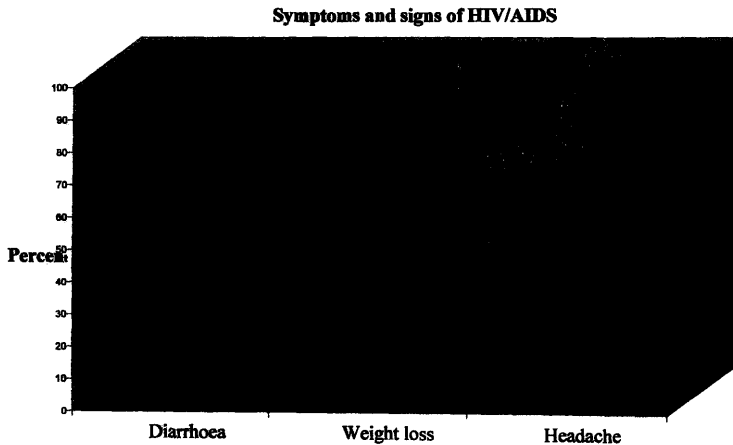


**Gonorrhoea** was the most common and most known STD among the study population. As shown in figure 4.3, gonorrhoea represented (66.7%) of respondent's knowledge on Sexually Transmitted Infections (STI's) and their belief that one can contract it through sexual intercourse followed by Syphilis (58.3%).

#### **Signs and Symptoms of HIV/AIDS**

The most commonly reported symptoms of HIV/AIDS by respondents were diarrhoea, weight loss and headache (figure 4.4).

**Figure 3.4: Symptoms and signs of HIV/AIDS**



#### **Perception about the likelihood of contracting HIV/AIDS**

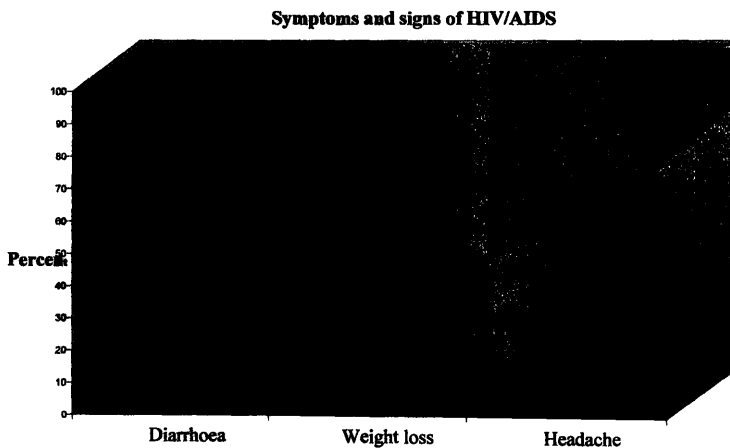
The table below describes how likely the respondents who do not know their status perceived their risk of contracting the infection.

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Figure 3.4: Symptoms and signs of HIV/AIDS



#### Perception about the likelihood of contracting HIV/AIDS

The table below describes how likely the respondents who do not know their status perceived their risk of contracting the infection.

**Table 4.8: Likelihood of contracting the disease among those who do not know their status**

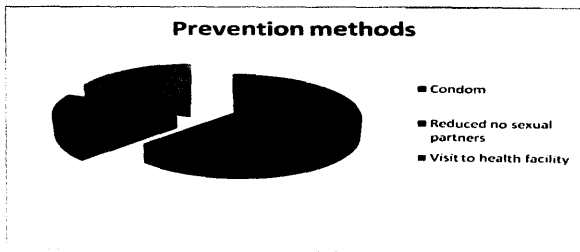
Likelihood	Percentage
Not likely	200(83.3%)
Likely	30(12.5%)
Very likely	10(4.2%)
Total	240(100.0 %)

Most 200 (83.3%) of them (those who do not know their HIV/AIDS status) suggested they were not likely to contract the infection.

**Means by which those who do not know their status protect themselves against HIV/AIDS infection**

An individual's chances of contracting HIV/AIDS depend greatly on the individual's lifestyle and most especially the adherence to preventive protocols. In finding out why the majority of the respondents were confident of not getting infected with HIV/AIDS, their preferred modes of preventing the infection were assessed.

**Figure 4.5: Preventive methods**



The most widely reported mode of preventing HIV/AIDS reported by respondents who do not know their HIV/AIDS status was condom use (figure 4.5).

All those interviewed (360)100.0% including those who knew their sero status stated the use of condoms as their main means of protecting themselves against the HIV/AIDS infection. Of the 360 respondents, (108) 30.0% hinted that they have reduced the number of sexual partners they had as a way of protecting themselves from getting the disease.

#### Sources of getting HIV/AIDS related information:

Most 301 (83.6 %) of the study participants reported that radio was a major channel through which they get HIV/AIDS related information and education followed by posters 283 (78.6%), whilst 69.4 (69.4%) stated that they get information on HIV/AIDS from health personnel (table 4.9).

**Table 4.9: Sources of HIV/AIDS related information**

Sources	Frequency	Percentage
Radio	301	83.6%
News paper	6	1.7%
Television	216	60.0%
Posters	283	78.6%
Sexual partners	10	2.8%
Religious leaders	16	4.4%
Traditional leader	11	3.1%
Hhealth personnel	250	69.4%



Generally, the HIV/AIDS positive persons wanted educational messages on the condition to be 'polished', the messages on prevention they said should reach every segment of society. The following comments substantiate the above.

*Media messages on HIV/AIDS must be polished; messages should not be in the negative must give hope to people. HIV must be likened to fever.*

According to them, this would make persons who may be positive stop hiding their status from others but come out to seek care and change their lifestyles; thereby not infecting innocent people.

#### **Knowledge on CT Centres in the study community**

HIV/AIDS control in the Osu Klottey sub-metropolitan area has seen multi-sectoral level response in preventing the spread of the infection and in treating and caring for people living with the disease. One of the strategies being used in curbing the spread of this condition is Counselling and Testing (CT), a process by which one gets to know his or her HIV/AIDS status whether positive or negative.

Most 285 (79.2%) of the participants said they were aware of where HIV/AIDS testing was done in the community. Among the respondents who are positive to HIV/AIDS 8 (6.7%) also did not know where CT was done in the community while 67 (27.9%) of respondents who do not know their status also did not know where CT was being conducted (Table 4.10).

In assessing the knowledge in those who were positive to the HIV virus, 112<sup>\*</sup> (93.3%) had knowledge on CT centres and 173 (72.1%) representing those who do not know their status.

A chi-square test showing the relationship between the HIV/AIDS status of the respondents and their knowledge about venues for HIV testing showed

( $\chi^2_{0.05} = 21.903$ ,  $p < 0.000$ ) a significant relationship.

**Table 4.10: Contingency table showing Knowledge of CT Centres in the Community.**

HIV/AIDS status	Knowledge of CT Centres		Total
	Yes	No	
Positive	112 (93.3%)	8 (6.7%)	120 (100.0%)
Do not know status	173 (72.1%)	67 (27.9%)	240 (100.0%)
Total	285 (79.2%)	75 (20.8%)	360 (100.0%)

$\chi^2_{0.05} = 21.903$       p-value = 0.000

This means that to a large extent, a person's knowledge of the place of testing for HIV/AIDS is influenced by the person's sero status. More of positive persons tend to know where CT was being conducted in the community than those who do not know their status (Table 4.10).

#### **Knowledge of HIV/AIDS positive person(s)**

The risk perception of HIV/AIDS in the community was assessed by use of friendship with a positive person(s), the responses are presented in Table 4.11. About 188 (52.2%) of the respondents know people who are infected with HIV. A further probe indicated that 104 (86.7%) of the positive persons knew others who are infected with the HIV virus whilst 84 (35.0%) of those who do not know their status said they knew persons who were positive to the virus. A chi-square test of the relationship between respondents' HIV/AIDS status and knowledge of an HIV/AIDS person showed

( $\chi^2_{0.05} = 85.591$ ,  $p < 0.05$ ) a significant association between them. This means that, those with the virus tend to know more people with the disease than those who do not know their status.

**Table 4.11: Contingency table showing the relationship between sero status and knowledge of persons living with HIV/AIDS**

HIV/AIDS Status	Knowledge of HIV/AIDS persons		Total
	Yes	No	
Positive	104 (86.7%)	16 (13.3%)	120 (100.0%)
Do not Know Status	84 (35.0%)	156 (65.0%)	240 (100.0%)
<b>Total</b>	<b>188 (52.2%)</b>	<b>172 (47.8%)</b>	<b>360 (100.0%)</b>

$\chi^2_{0.05} = 85.591$       p-value = 0.000

#### **Knowing of an HIV/AIDS patient**

Not every interviewed person knows someone who has contracted HIV or ADIDS. The result of the research depicts that about 172 (47.8%) of the respondents do not know anybody who has been afflicted with HIV/AIDS. The majority of respondents 160 (86.0%) who knew HIV/AIDS afflicted individuals also know people who died as a result of the condition.

#### **Perceived risk of friends getting HIV/AIDS infection**

More than half (60.0%) of the respondents felt their friends were at risk of contracting the HIV/AIDS infection. However, 144 (40.0%) of the respondents did not perceive their friends in the community to be at risk of contracting the HIV condition. The majority 133 (55.4%) of the respondents who stated that their friends were not at risk of contracting the HIV/AIDS infection were those who do not know their status,

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whilst 109 (90.8%) of positive persons believed their friends in the community stand the risk of getting infected. A chi square test showed ( $X^2_{0.05} = 71.302$ ,  $p < 0.05$ ) a significant relationship between the respondents' HIV/AIDS status and the associated risk of their friends getting the HIV/AIDS infection (Table 4.12).

This means that respondents' who are positive to HIV/AIDS have a higher perceived risk of their friends getting the infection than those who do not know their HIV/AIDS status.

**Table 4.12: Contingency table showing the relationship between respondents' HIV/AIDS status and their perceived risk of their friends contracting the virus.**

HIV/AIDS Status	Perceived risk of friends getting HIV/AIDS infection		Total
	Yes	No	
Positive	109 (90.8%)	11 (9.2%)	120 (100.0%)
Do not Know Status	107 (44.6%)	133 (55.4%)	240 (100.0%)
<b>Total</b>	<b>216 (60.0%)</b>	<b>144 (40.0%)</b>	<b>360 (100.0%)</b>
$X^2_{0.05} = 71.302$		p-value = 0.000	

#### **Respondents HIV/AIDS status and impact on their social relationships.**

Most (250) 69.4% of respondents reported that knowing a person's status would not negatively affect their relationship, however 54 (15%) of them said their relationships would be negatively affected by a person's HIV/AIDS status. Of the persons who are positive, 12 (10.0%) also said that their relationship would be affected while 87(72.5%) said a person's status would have no effect on their relationship (Table 4.13).

**Table 4.13: Contingency table of respondents' HIV/AIDS status and the impact on social relationships.**

HIV/AIDS Status	Impact of an HIV/AIDS persons status on relationships			Total
	Yes	No	Can't be bothered	
Positive	12 (10.0%)	87 (72.5%)	21 (17.5%)	120 (100.0%)
Do not Know Status	42 (17.5%)	163 (67.9%)	35 (14.6%)	240 (100.0%)
<b>Total</b>	<b>54 (15.0%)</b>	<b>250 (69.4%)</b>	<b>56 (15.6%)</b>	<b>360 (100.0%)</b>

$$\chi^2_{0.05} = 3.680 \quad \chi^2_{0.05, 2} = 5.99 \quad p\text{-value} = 0.159$$

A chi square test showed ( $\chi^2_{0.05} = 3.680, p > 0.05$ ) an insignificant relationship between knowing one's positive status and impact on their relationship with others. The way people relate to an HIV/AIDS person does not depend solely on the person's sero status as captured in the following narratives:

*Yeah, I told my boyfriend am HIV positive but he still can't be bothered, even there are times that he insists we have sex without condoms; actually, I don't know how he understands this whole HIV business (by a 21 year old HIV positive University student).*

### HIV/AIDS Testing

In this study, 173 (48.0%) have never screened for HIV/AIDS. Out of this group, 115 (66.5%) of them indicated their willingness to do so should they be presented with the opportunity. However, comparatively small number of them stressed that they will never do HIV testing. The issue of discrimination and stigmatization might keep people from testing to know their status.

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**Beliefs and Practices Concerning HIV/AIDS**

This section outlines the beliefs and practices of the people in the community in relation to HIV/AIDS. These beliefs and practices relating to HIV/AIDS span from their sexual practices, cause of the illness, treatment, care and support for the patients.

**Table 4.14: Contingency table showing respondents sero status and their closeness to HIV/AIDS persons**

HIV/AIDS Status	Would you be able to take care of HIV/AIDS persons			Total
	Yes	No	Never	
Positive	81 (67.5%)	21 (17.5%)	18 (15.0%)	120 (100.0%)
Do not know status	147 (61.2%)	78 (32.5%)	15 (6.2%)	240 (100.0%)
<b>Total</b>	<b>228 (63.3%)</b>	<b>99 (27.5%)</b>	<b>33 (9.2%)</b>	<b>360 (100.0%)</b>
$\chi^2_{0.05} = 13.721$ $\chi^2_{0.05, 2} = 5.99$ p-value = 0.001				

The study found that 228 (63.3%) of the participants were willing to be friends with HIV/AIDS positive persons and take care of them without worries. However, 99 (27.5%) of the participants stated that they would not be close to positive persons and let alone take care of them. Respondents who said they would never take care of HIV/AIDS persons were 33 (9.2%). Among the respondents who have tested positive to the disease, 81 (67.5%) hinted that they can take care of HIV/AIDS person without any worries as against 147 (61.2%) of those who do not know their status. Of the positive persons, 21(17.5 %) stated that they cannot take care of other HIV/AIDS positive persons whilst 18 (15.0 %) stated categorically that they will never do that. However, among the respondents who do not know their HIV/AIDS status, 78

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HIV/AIDS Status	Would you be able to take care of			Total
	HIV/AIDS persons			
	Yes	No	Never	
Positive	81 (67.5%)	21 (17.5%)	18 (15.0%)	120 (100.0%)
Do not know status	147 (61.2%)	78 (32.5%)	15 (6.2%)	240 (100.0%)
<b>Total</b>	<b>228 (63.3%)</b>	<b>99 (27.5%)</b>	<b>33 (9.2%)</b>	<b>360 (100.0%)</b>
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(32.5%) also stated that they cannot take care of positive persons with about 15 (6.2%) indicating that they will never do that.

A chi square test of relationship shows ( $X^2_{0.05} = 13.721$ ,  $p < 0.05$ ) a statistically significant relationship between the two variables. This indicates that a person's HIV/AIDS status influences whether or not he or she is willing to take care of an HIV/AIDS person.

**Table 4.15: Contingency table of knowing a sero status vis-à-vis visitation to an HIV/AIDS person.**

HIV/AIDS Status	Visiting HIV/AIDS persons			Total
	Yes	No	Don't know	
Positive	118 (98.3%)	2 (1.7%)	0 (0.0%)	120 (100.0%)
Do not Know status	204 (85.8%)	30 (12.5%)	6 (1.7%)	240 (100.0%)
<b>Total</b>	<b>322 (83.9%)</b>	<b>32 (7.2%)</b>	<b>6 (8.9%)</b>	<b>360 (100.0%)</b>

$X^2_{0.05} = 13.951$      $X^2_{0.05, 2} = 5.99$      $p\text{-value} = 0.001$

A small proportion 2 (1.7%) of the HIV/AIDS positive respondents reported that they could not visit others with the virus thus, almost all (98.3%) of the respondents with the virus stated that they can visit other HIV/AIDS persons. However, in the case of those who do not know their status, majority 204 (85.8%) of them will visit people with HIV/AIDS infection, leaving only about 30 (12.5%) of them who will not visit persons who have been diagnosed with HIV/AIDS. A chi square test of association shows ( $X^2_{0.05} = 13.951$ ,  $p < 0.05$ ) a significant relationship between the respondents' HIV/AIDS status and visitation to HIV/AIDS friends. This indicates that more of people with the virus are able to visit people who have been diagnosed with the disease than people who do not know their HIV/AIDS status.

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A chi square test of relationship shows ( $X^2_{0.05} = 13.721$ ,  $p < 0.05$ ) a statistically significant relationship between the two variables. This indicates that a person's HIV/AIDS status influences whether or not he or she is willing to take care of an HIV/AIDS person.

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HIV/AIDS Status	Visiting HIV/AIDS persons			Total
	Yes	No	Don't know	
Positive	118 (98.3%)	2 (1.7%)	0 (0.0%)	120 (100.0%)
Do not Know status	204 (85.8%)	30 (12.5%)	6 (1.7%)	240 (100.0%)
<b>Total</b>	<b>322 (83.9%)</b>	<b>32 (7.2%)</b>	<b>6 (8.9%)</b>	<b>360 (100.0%)</b>

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### Sexual Practice/Behaviours

This section describes the sexual behaviour or sexual practices of the respondents in the Osu Klotey sub-metropolitan area.

Alcohol is said to have an effect on one's sexual practice, the result of the analysis summarized in the contingency table 4.16 below describes the use of alcohol by the respondents.

**Table 4.16: Use of alcohol by Respondents**

HIV/AIDS status	Use of alcohol		Total
	Yes	No	
Positive	34 (28.3%)	86 (71.7%)	120 (100.0%)
Do not know status	80 (33.3%)	160 (66.7%)	240 (100.0%)
Total	114 (31.7%)	246 (68.3%)	360 (100.0%)

$\chi^2_{0.05} = 0.924$       p-value = 0.336

The majority (68.7%) of respondents said that they do not take alcohol (table 4.16). A chi square test shows ( $\chi^2_{0.05} = 0.924$ ,  $p > 0.05$ ) no significant relationship between respondents' HIV/AIDS status and the use of alcohol. This indicates that, on average, the respondents with positive HIV/AIDS status and those who do not know their status behave the same so far as alcohol intake is concerned.

### Habit of Smoking

Those who have tested positive to the disease and those who do not know their status have the same attitude towards smoking. A chi square test showed ( $\chi^2_{0.05} = 910$ ,  $p > 0.340$ ) no significant relationship between the two variables. This means that,

respondents' smoking behaviour is not dependent on their HIV/AIDS status. The results of the analysis indicated that in total, only 5.8% of the respondents smoke.

**Table 4.17: Contingency table of respondents' HIV/AIDS status and smoking**

HIV/AIDS status	Smoking		Total
	Yes	No	
Positive	5 (4.2%)	115 (95.8%)	120 (100.0%)
Do not Know	16 (6.7%)	224 (93.3%)	240 (100.0%)
<b>Total</b>	<b>21 (5.8%)</b>	<b>339 (94.2%)</b>	<b>360 (100.0%)</b>

$X^2_{0.05} = 0.910$       p-value = 0.340

#### Use of brothels and Discotheques

Generally, society expects HIV/AIDS positive persons are expected to adopt sexual behaviours that do not put them at risk of secondary infection or re-infection and not -

**Table 4.18: Contingency table of respondents' HIV/AIDS status and patronage of brothels/Discotheques**

HIV/AIDS status	Visit to brothels/Discotheques		Total
	Yes	No	
Positive	17 (14.2%)	103 (85.8%)	120 (100.0%)
Do not know status	36 (15.0%)	204 (85.0%)	240 (100.0%)
<b>Total</b>	<b>53 (14.7%)</b>	<b>307 (85.3%)</b>	<b>360 (100.0%)</b>

$X^2_{0.05} = 0.044$       p-value = 0.833

infecting others. The study found that majority 307 (85.3%) of the respondents do not visit brothels or discotheques. Among the positive persons, 103 (85.8%) of them did not patronize the services of brothels and discotheques (table 4.18). A chi square test indicates ( $\chi^2_{0.05} = 0.044$ ,  $p > 0.05$ ) no significant association between respondents' HIV/AIDS status and their visit to brothels.

#### **Sexual activity of Respondents**

The majority (103 (85.8%)) of the respondents who are HIV/AIDS positive were sexually active. However, 190 (79.2%) of those who do not know their status were sexually active (table 4.19). A chi square test showed ( $\chi^2_{0.05} = 2.347$ ,  $p > 0.05$ ) an insignificant relationship between respondents' HIV/AIDS status and sexual activity. This indicates that, a person's sexual activity has nothing to do with his or her HIV/AIDS status.

**Table 4.19: Contingency table of Respondents' HIV/AIDS status and their state of sexual activity**

HIV/AIDS status	Sexually active		Total
	Yes	No	
Positive	103 (85.8%)	17 (14.2%)	120 (100.0%)
Do not Know	190 (79.2%)	50 (20.8%)	240 (100.0%)
<b>Total</b>	<b>293 (81.4%)</b>	<b>67 (18.6%)</b>	<b>360 (100.0%)</b>
$\chi^2_{0.05} = 2.347$		p-value = 0.125	

**Table 4.20: Contingency table of the HIV/AIDS status of respondents and the number of Sexual partners' respondents are engaged with.**

HIV/AIDS Status	Number of sexual partners				Total
	None	One	Two	Multiple	
Positive (n=98)	13 (13.3%)	83(84.7%)	0 (2.0%)	2 (2.0%)	98 (100.0%)
Do not Know (n=195)	19(9.7%)	146(74.9%)	15(12.5%)	15(7.9%)	195 (100.0%)
	32 (10.9%)	229 (78.2%)	15(5.1%)	17 (5.8%)	293 (100.0%)
$\chi^2_{0.05} = 14.710$ $\chi^2_{0.05, 2} =$ p-value = 0.012					

Some 32 (10.9%) of the respondents indicated that they have no sexual partners (table 4.20). The 13 (13.3%) of the respondents who have the virus and have no sexual partner explained their reasons for not engaging in sex in the following narratives:

*Just avoid this sex thing, even if you use condom, it can burst at anytime and the sperm would pour on you and the woman, then you get more of the disease (by 59 years old HIV positive male).*

*As for me I don't want to have sex with anybody, for about one year now. My brothers have been saying I should get married, but I just don't mind them because I don't understand how I got this diseases, I don't want to give it to any body's son (by Female HIV positive respondent).*

Some of the respondents who do not know their status indicated that they were not yet ready to engage in sexual relationship.

A chi square test showed ( $\chi^2_{0.05} = 14.710$ ,  $p < 0.05$ ) a significant association between the HIV/AIDS status of the respondents and the number of sexual partners they have. This means that one's HIV/AIDS status largely depends on the number of sexual partners one is involved with.

### **Reasons for engaging with multiple/several sexual partners**

Interestingly, most 21 (70%) of the people who reported that they were engaged in multiple sexual relationships have indicated that they would have preferred having only one sexual partner. However, 9 (30%) of the respondents indicated their unwillingness to stick to one sexual partner.

The following narratives explained why some people continue to have multiple sexual partners:

*Eih Sister!, if I stop this work what would I eat? I need to feed myself, I have nobody; I need to pay the bills (by An HIV positive sex worker).*

*As for me, it is basically boring not to have more than one sexual partner; it is boring to have a sexual relationship with only one person. Once you protect yourself, you can have as many sexual partners as you desire (by Male respondent)*

### **Habit of Casual Sex**

It is hypothesized that, persons who have sexual intercourse with anonymous people stand at a higher risk of contracting the HIV virus. Some of the respondents indicated that they have had sexual intercourse with anonymous persons. 71 (59.2%) of them were positive to HIV/AIDS while the remaining 49 (20.4%) who do not know their status said otherwise. This could mean that casual sex actually exposes one to the risk of acquiring the HIV/AIDS virus (Table 4.21).

**Table 4.21: Contingency table of respondents' HIV/AIDS status and their sexual lifestyles (casual sex/ sexual intercourse with anonymous partners).**

HIV/AIDS status	Sexual intercourse with anonymous partners(casual)		Total
	Yes	No	
Positive	71 (59.2%)	49 (40.8%)	120 (100.0%)
Do not know status	49 (20.4%)	191 (79.6%)	240 (100.0%)
Total	120 (33.3%)	240 (66.7%)	360 (100.0%)

$\chi^2_{0.05} = 54.056$       p-value = 0.000

**Table 4.22: Gender of respondents' sexual partners**

Respondent		Male partners	Female partners	Total
Male	Positive	5 (18.5%)	22 (81.5.0%)	27(100.0%)
	Don't know status	12 (11.0%)	97 (89.0%)	109(100.0%)
Female	Positive	88 (94.6%)	5 (5.4%)	93(100.0%)
	Don't know status	110 (84.0%)	21 (16.0%)	131(100.0%)
Total		215(59.7%)	145(40.3%)	360(100.0%)

### Sexual preference of Respondents

It can be observed from the (table 24) that sexual intercourse does not happen between males and females only. 5 (18.5.0%) out of 27 of the male respondents who are HIV/AIDS positive have sexual relation with men while (22) 81.5% have sexual relation with women.

A further probe indicated that 17 (12.5%) out of the 136 men studied have sexual intercourse with their fellow men and out of this population,5 (29.4% ) are HIV positive.

Also, 5 (5.4%) out of 93 of the female respondents who are HIV positive have sexual relation with their fellow females while 88 (94.6%) have sexual relation with men. A further probe reveals that 26 (11.6%) out of the 224 females studied have sexual intercourse with fellow females and out of this group, 5 (19.2%) are HIV positive.

*The population of MSM's in this clinic is about 25% of the total population of over 5,000 clients, some of them are married with children but their wives don't know (PNO in-charge of ART clinic).*

*In dealing with my clients, I have realized that most of them had the HIV infection through heterosexual sex and few of them, and very few of them had it through MSM (by the Medical Officer in-charge of ART clinic at Ridge Hospital).*

However the most common sexual preference in the community was heterosexual sex representing 317 (88.1%) as the following qualitative narrative depicts:

*It is God who ordained that sex should be between man and woman and not man and man or woman and woman (Response from FGD, male group 30 years and above).*

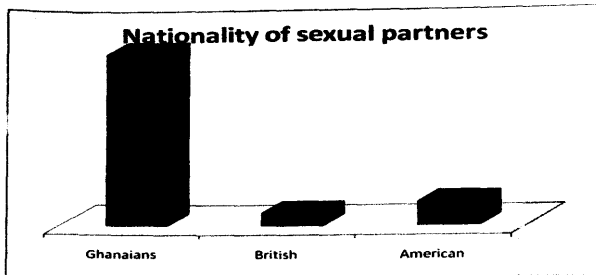
#### **Nationality of Sexual Partners**

In analysing the nationality of sexual partners of respondents, Ghanaians were found to be in the majority (97.2%). However, some British nationals were also involved sexually with Ghanaians as the following narrative suggests.

*My guy is a British; I met him when I was in SHS and have a four year old son with him (by 21 years old HIV positive woman).*



**Figure 4.6: Nationality of sexual partners**



### **Sexual preference and risk of contracting HIV/AIDS**

For behaviour change to take place one must perceive the risk associated with an unhealthy behaviour especially, the perceived susceptibility and severity of the risk behaviour and the needed clues to action for behaviour change to take place. In preferring a particular sexual orientation, the perceived risk of contracting HIV/AIDS was assessed in the study population.

Logistic regression was used to compare the probability of HIV/AIDS positive persons' risk perception to that of those who did not know their status.

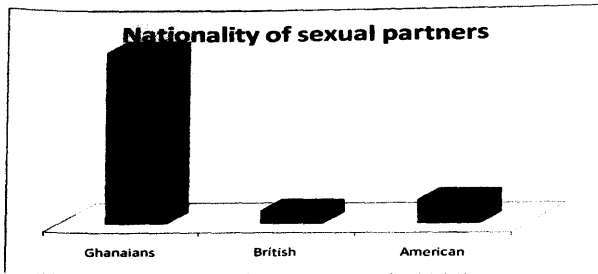
A predictor variable was considered, it significantly predicted sero status of respondents  $X^2_{0.05} = 6.814$ ,  $df=2$ ,  $p<0.05$ . The regression model is as follows:

$$R(x) = e^{\beta_0 + \beta_1 x_1}$$

$$R(x) = e^{0.125 + 1.58 x_1}$$

Where  $\beta_0$  and  $\beta_1$  are the regression coefficients,  $x_1$  is the predictor variable. This model was further transformed into a probability function which predicted the

**Figure 4.6: Nationality of sexual partners**



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Where  $\beta_0$  and  $\beta_1$  are the regression coefficients,  $x_1$  is the predictor variable. This model was further transformed into a probability function which predicted the

chances of a person's HIV/AIDS related risk perception conditional on their HIV/AIDS status.  $P(x) = \frac{e^{0.125+1.58x_1}}{1+e^{0.125+1.58x_1}}$

Example let us consider an HIV/AIDS patient where  $x_1 = 1$ .

$$\begin{aligned} \text{Therefore, } P(x) &= \frac{e^{0.125+1.58(1)}}{1+e^{0.125+1.58(1)}} \\ &= 5.5014/6.5014 = 0.8462 \end{aligned}$$

This means that, out of every 10 people in Osu Klottey sub-metro who have tested positive to HIV/AIDS, about 8 of them may have high HIV/AIDS related risk perception. Also, for persons who did not know their status in the study area  $x_1=0, P(x) = \frac{e^{0.125+1.58(0)}}{1+e^{0.125+1.58(0)}} = 1.1331/2.1331 = 0.5312$

This means that, out of every 10 people in Osu Klottey who do not know their HIV/AIDS status, about 5 of them were shown to have had high HIV/AIDS related risk perception.

Furthermore, the logistic regression when conducted assessed whether the predictor variable, (respondents) felt their friends were at risk of contracting HIV infection. When this predictor was considered, it significantly predicted sero status of respondents  $X^2_{0.05} = 6.814, df=2, p<0.05$ . The regression model predicted who HIV positive person was; based on their HIV/AIDS related risk perception.

In estimating the risk of persons in Osu Klottey who did not know their HIV status in contracting the infection, an odd ratio of 1.49 and a P-value of 0.04 were arrived at. The function showed a significant association and suggested that, the odds of estimating correctly who contracts HIV infection improves by 49.0% if one is made aware of the associated risk perception of the condition.

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This means that, out of every 10 people in Osu Klotey who do not know their HIV/AIDS status, about 5 of them were shown to have had high HIV/AIDS related risk perception.

Furthermore, the logistic regression when conducted assessed whether the predictor variable, (respondents) felt their friends were at risk of contracting HIV infection. When this predictor was considered, it significantly predicted sero status of respondents  $X^2_{0.05} = 6.814, df=2, p<0.05$ . The regression model predicted who HIV positive person was; based on their HIV/AIDS related risk perception.

In estimating the risk of persons in Osu Klotey who did not know their HIV status in contracting the infection, an odd ratio of 1.49 and a P-value of 0.04 were arrived at. The function showed a significant association and suggested that, the odds of estimating correctly who contracts HIV infection improves by 49.0% if one is made aware of the associated risk perception of the condition.

## **CHAPTER FIVE**

### **5.0 DISCUSSION**

**INTRODUCTION** This study explored and described HIV/AIDS related risk perception and sexual practices in Osu Klotey sub-metropolitan area of Accra and this chapter presents the discussion of the result.

The study found knowledge and awareness of HIV/AIDS to be about 97.2% among the study participants. This confirms earlier studies that reported a very high level of knowledge and awareness of HIV/AIDS within the population ((Wagbatsoma et al, 2006, Nyanzeh et al, 2004). The signs and symptoms of the illness as well as the modes of transmission were well understood by the participants. Community members were also aware of availability of medicine for treating HIV/AIDS patients.

However, this did not reflect in the health seeking behaviour of the community since most of the PLHA's visited several places other than health facilities for 'cure' before finally attending a health facility. Health facilities remained their second point of call only after consultation with herbalists, spiritualists and other alternative healthcare providers. For HIV positive persons this may result in deterioration of their health status before reporting at a clinic.

The recognition of ill health was done mainly in the community within the popular sector and the main arena of healthcare is the family where the main healthcare providers for HIV/AIDS positive persons were mothers, daughters, women and grandmothers. They aided the patients to and from the health facilities

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effects such as sponges and towels. Various levels of fear and anxiety exist in the community and these were expressed in words such as 'scary illness,' 'disease that kills easily' etc; expressions that promotes stigmatization against PLHA's. Sexual intercourse was identified as the main means by which the condition was contracted in the community confirming similar findings in Uganda (Ntozi et al, 2003).

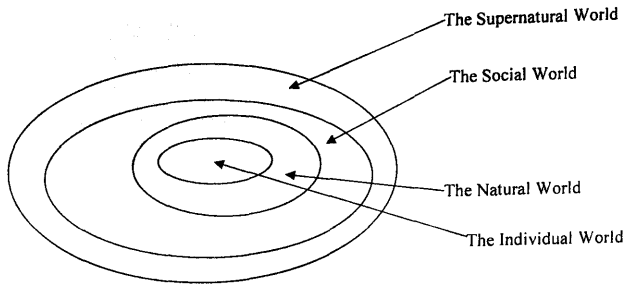
While majority of males perceived they contracted the infection through sexual intercourse, the female group thought otherwise. They thought their HIV infection was caused by malevolent spirits as some also thought they got infected through their male sexual partners. The females however believed that the ART drugs have the potency to 'cure' them of HIV/AIDS.

The World Health Organization defined health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' (Cecil Helman, 2001). Definition of what constitute 'health' and 'illness' vary from community to community, between families, cultural groups and among individuals. At the individual level the process of defining oneself to be 'ill' can be based on different perceptions in the community or the individual's own perception. Illness definition follows a number of subjective experiences which may include amongst others perceived changes in bodily appearance such as weight loss, changes in skin colour or even behavioural changes in relation to others such as marital or work disharmony (Cecil Helman, 2001).

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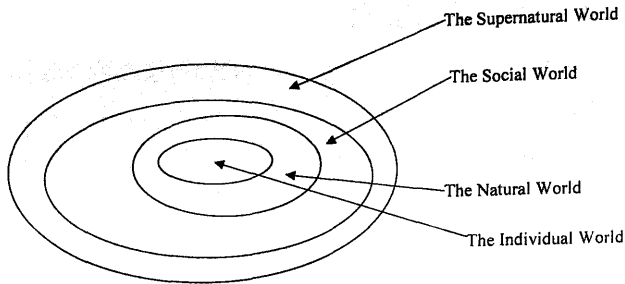


**Figure 5.1: Sites of illness aetiology (Cecil Helman, 2001)**

The explanatory model of the causes of HIV/AIDS in the community was based on both the scientific and folk/lay theories. The nature of the illness determines where treatment should be sought or may influence the decision of care seeking. Causes, treatment path and illness behaviour of the participants was greatly influenced by their explanatory models of HIV/AIDS in the study area. Although, the majority of the participants asserted to the fact that HIV was transmitted mainly through sexual intercourse, they also believed that malevolent spirits were responsible in most cases. As a result, the people of Osu Klottey sought treatment from churches, herbalist, pastors and other alternative healthcare providers with most of the patients having the belief that “God can heal them of the illness”.

The findings corroborated what Twumasi, 2005 reported; that in Ghana, patients shuffle among the folk sector, the popular sector and the professional scientific sector in the course of treating the same episode of illness. The consequences of such health seeking behaviour may not only lead to delayed health seeking at a health facility but may affect compliance with treatment prescribed at the hospital.

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Sexuality and sexual behaviour has become a very dicey issue the world over. Sexual behaviour for that matter has become a personalized issue rather than what society

approves or what is culture specific. The risk perceived by an individual before getting involved in any kind of sexual lifestyle is a factor of the susceptibility to, or severity of, the perceived danger. Sexual behaviour and risk perception therefore cannot be said to be culture specific, therefore views expressed by the participants on sexual behaviours and risk perceptions varied. The participants identified lifestyles such as having unprotected sexual intercourse, drug and alcohol abuse, promiscuity and engagement in multiple sexual relations either homosexually or heterosexually as risky lifestyles, which may lead to HIV infection.

According to Helman (2000), metaphors that were used in the past years particularly in lurid media headlines portrayed AIDS as a moral punishment with 'guilty' being homosexuals, bisexuals, promiscuous people, prostitutes and intravenous drug users whilst the 'innocents' were the accidental recipients of blood transfusions, children and spouses of bisexuals who engaged in extramarital sex. Since this perception generally weakens family and social ties or relationships, generally, PLHA therefore try to avoid this societal stigmatization by keeping their status secret from others including spouses, religious leaders as well as sexual partners.

This study identified the sexual preference of MSM in the community. Due to societal disapproval of the practice, discrimination and stigmatization, this population is not able to access needed healthcare and information that would help stop the spread of infections such as HIV in the population.

Whether the practice is acceptable culturally in Ghana or not, the reality for health policy makers and implementers is that, the earlier we confront this phenomenon the better; since it is a hidden 'canker' or 'reality' which might eventually destroy the fabric of our society.

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A statement attributable to Michel Sidibe, the Executive Director of UNAIDS indicated there is evidence that countries which protect men who have sex with men from discrimination and stigmatization double their access to HIV prevention services (Daily Graphic, July 17<sup>th</sup>,2009).

Stigmatization of HIV/AIDS clients in the community was evident with descriptions such as 'scary illnesses, 'the disease that kills' 'ghost illness'. With this kind of mindset in the community about HIV/AIDS, the way the health staff relate and treat HIV/AIDS patients and their relations may be either a key factor in correcting the wrong notion or in promoting stigma in the community.

Non-disclosure of one's sero status was identified as a key factor in the spread of the infection in the study area. Positive couples were keeping their status from one another thereby having unprotected sex and exposing the other partner to the risk of HIV infection. Most of these persons were those who mostly refused to accept their status and even when they did accept the diagnosis, they continue to hide the fact from others including their spouses or sexual partners.

A wife who for fear of being literally thrown out of her marital home kept her HIV status from the husband for over four years and continued to have unprotected sexual intercourse with him; some married men with children engaged in same sex relationships with positive male partners thereby infecting their wives. Should this deliberate act of omission and commission be made punishable by law?.

Calls by policy makers and stakeholders for all to undergo Counselling and Testing (CT) cannot be overemphasized. Dr. Sylvia Anie, the Director of Policy Planning of the Ghana AIDS Commission urged all in the Thursday July 23, 2009 edition of the

Daily Graphic stated that 'it is better for people to know their HIV status through CT to be able to guard against contracting or transmitting the virus.

Counselling and Testing was identified by participants as key in the fight against HIV/AIDS. The recent 'Know your status campaign' organized by the NACP in collaboration with other stakeholders was a laudable fight against HIV/AIDS in Ghana.

Reduction of Stigma and non-discriminatory attitude towards positive persons would lead the way forward in the prevention effort.

*Society must learn to accept HIV/AIDS positive persons and must empathize with them. When HIV positive persons are discriminated against; it hurts them since they are human. It is argued that if people feel they are being stigmatized; they may feel peeved and may decide to go out there and deliberately infect others with the virus. Families must learn to accept HIV/AIDS relations and society must accept them. Patients reported being stigmatized most by close relations such as husbands, uncles and aunts (Medical Doctor in-charge of ART Clinic).*

This study however identified some sero-discordant couples attending ART clinic with their partners. A practice which needs to be encouraged to support HIV/AIDS persons. Currently the focus of the Ghana Health Service is to re-orient its customer care services and outlook, it is therefore imperative for HIV positive persons who decide to volunteer at the facilities to have their minds re-focused in the strategic direction of the service, since it is not easy for an outsider to readily distinguish those with negative attitude to clients from that of personnel of the Ghana Health Service.

The researcher observed that doctors, nurses and pharmacists at the ART clinic relate excellently and professionally with patients and their relations.

However, of a great concern was the attitude of volunteer PLHA's who voluntarily assisted the health professionals at the ART clinic. Some virtually insult clients and their relations. They yell at the patients and their relations bringing some of them to a near tears level, a practice which needs to be discouraged.

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## CHAPTER SIX

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**Introduction** The findings of the study re-echoed similar findings in Ghana particularly within the past few years (Nyanzeh et al, 2004).

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Assessment of knowledge and awareness of HIV/AIDS in the community revealed a high level of awareness and knowledge about the condition. The vast majority of community members knew about HIV/AIDS and perceived persons in the community are at risk of getting themselves infected. As many as 200 (83.3%) of those who did not know their status believed they were not likely to be infected with HIV. Could this assertion be wrong or could it be hopefully explained that they are practicing safer sex by wearing condoms anytime they had sex or were abstaining (secondary virginity).

Traditional and religious leaders were seen as playing a very key role in informing the community about HIV/AIDS and this must be encouraged. The study however did not find any cultural practices in the study area that might be fuelling the HIV infection. In as much as HIV/AIDS related risk perception was high in HIV positive persons as against those who do not know their status, some of the PLHA's were engaged in multiple sexual relationships putting themselves and their sexual partners at risk. The findings of this study also revealed PLHA's were involved in Commercial Sex Work and MSM. The study also revealed that some sero-discordant partners were forcing their partners to have unprotected sexual intercourse with them.

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exists however, a window of golden opportunity for receptiveness of behaviour change strategies and preventive interventions in the community.

## 6.2 RECOMMENDATIONS

On the basis of the strength of the findings and existing literature on HIV/AIDS prevention, care, treatment and support as well as observations made on the field, it is recommended that,

- i. The Osu Klotey sub-metropolitan Health Directorate should strengthen existing partnership and collaboration with other stakeholders to sustain HIV/AIDS awareness campaigns and establish more CT services in the community.
- ii. Current policy of HIV positive persons bringing their relations prior to ART treatment commencement needs revision to accommodate person's confidants other than personal relations.
- iii. Ghana Education Service through the School Health Programme must commence the teaching and learning about HIV/AIDS from primary schools through to tertiary institutions.
- iv. NACP with its partners should design Behaviour Change Communications tools that reinforce health behaviour in the community.
- v. Further research should be conducted by the NACP, Ghana Health Service, Ghana AIDS Commission and other stakeholders into the insurgence of MSM in the community.

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I

**CONSENT FORM**

**HIV/AIDS Related Risk Perception and Sexual Practices in Osu Klottey Sub-Metropolitan Area**

Good morning/afternoon, Madam/Sir. My name is \_\_\_\_\_ a student of School of Public Health, University of Ghana Legon. I am here to collect information for a study on HIV/AIDS related risk perception and sexual practices in the Osu Klottey Sub-metropolitan area. The study is in partial fulfilment of a Master of Science Degree in Applied Health Social Sciences; and also with the overall aim of contributing to evidence based research on HIV/AIDS prevention, care and support.

Since the discovery of HIV/AIDS in the early 1980's, the disease continues to be the most daunting health problem the world over. According to the UNAIDS and WHO, the pandemic has had its most profound impact to date in Sub-Saharan Africa.

1. We are therefore investigating this topic in order to further our understanding of the factors that may be responsible for the continual spread of HIV/AIDS in the Osu Klottey sub-metropolitan area.
2. We are targeting persons who are HIV/AIDS positive and have come to accept their status as such. We also intend assessing HIV/AIDS related risk perception in persons who do not know their status.
3. This is a research project, and the findings may be used to design and plan appropriate policies for better health services at a national level in the future.
4. Your participation in the research study is voluntary. Before agreeing to be part of this study, please read and/or listen to the following information carefully. Feel free to ask questions if you do not understand something.
5. If you participate in this study, you may be asked to disclose your HIV/AIDS status, your knowledge and awareness of HIV/AIDS related issues, your sexual practices or behavior and your background information such as your

age and occupation. The interaction would be question -answer based with discussions on HIV/AIDS.

6. Be assured that this study would not in any way embarrass you by disclosing your HIV/AIDS status to any persons whatsoever. Your sexual practice issues would receive the necessary confidentiality and would not be divulged. There is a possibility that some of the questions in the interviews may make you feel uncomfortable. We will be asking you about personal things and you may feel embarrassed at times when talking about your personal risk perception of HIV/AIDS and your sexual practice.
7. This rarely happens though, but if you do feel uncomfortable, you can do any of the following: you can choose not to answer certain questions; you can take a break and continue later, you can choose to stop the interview, or even withdraw. If you wish you can call your sexual partner or someone else of your choosing that you feel comfortable that he/she can talk about your feelings.
8. This study was not designed to benefit you directly, however, there is some possibility that you may learn about sexual practices and HIV/AIDS related risks if you are negative to the virus. You may also benefit in knowing risks of HIV/AIDS such as secondary/ re-infection through your participation.
9. In addition, what we learn from the study may help us to better understand the socio-economic and socio-cultural contexts of HIV/AIDS infection prevention. As a participant, you benefit by gaining a better understanding of the advantages of primary and secondary prevention as well as re-infection.

Finally, you would be served with snack and lunch for participating in this study.

10. All information obtained from you during the study will be confidential. Your privacy will be protected at all times. You will not be identified individually in any way as a result of your participation in this research. The data collected however, may be used as part of publications and papers related to HIV/AIDS risk perception and sexual practice in Osu Klottey sub-metropolitan area. Your participation is anonymous and your identity would never be disclosed.
11. Your participation in this study is entirely voluntary. You may refuse to participate in this research. Your refusal will not have any negative consequences for you. If you begin to participate in this research, you may at any time, for any reason, discontinue your participation without any negative consequences to you or to your family
12. Please feel free to ask any questions about anything that seems unclear to you before you consider to participate in this research and to sign the consent form.

### **Authorization**

If you agree to participate, you will be guaranteed your privacy fully. The interview process will take about **10-15 minutes** to complete. If you have any further questions, during the study or in the future, please do not hesitate to contact the research team using the telephone numbers below.

I have carefully read or listened to the above information and I have decided that I will participate in this study on HIV/AIDS related risk and sexual practices.

The researcher has explained the study to me and answered all my questions.

I have full understanding of what would be asked of me and have also understood the purpose of the study. If I do not participate there would be no

penalty or loss of my rights and that of my dependants. I can stop participation or withdraw from this study anytime even after I have started.

May we proceed? Verbal Consent: YES: \_\_\_ NO: \_\_\_

**I hereby agree to participate in the study. My signature/thumb print below also indicates that I have received a copy of this consent form.**

Participation's Signature \_\_\_\_\_

Name of Participant \_\_\_\_\_

Date \_\_\_\_\_

Name and Signature of Witness \_\_\_\_\_

If you have any further questions regarding this research, please contact the Principal Investigator, Mrs. Patience Ami Mamattah at School of Public Health, Social and Behavioural Science Department, University of Ghana-Legon. E-mail address: [yesuvi@yahoo.com](mailto:yesuvi@yahoo.com), Mobile phone: 0244378400

**Thank you very much.**

II

**SURVEY QUESTIONNAIRE**

<b>HIV/AIDS RELATED RISK PERCEPTION AND SEXUAL PRACTICES IN OSU KLOTTEY SUB- METROPOLITAN AREA</b>	<b>CODE.</b>
--	--------------

Date of Survey.....Site.....Questionnaire

No.....

**BACKGROUND OF RESPONDENTS**

1. Respondent's ID.....

2. How old are you? (Age in completed years)

3. Sex 1. Male  2. Female

4. What is your Religion? 1. Charismatic  Pentecostal

3. Orthodox  4. Pagan  None of the above  others, specify

5. What ethnic group do you belong? 1. Akan  2. Ewe  3. Ga  4. Tusa

4. Ga -Adangbe  5. Fante

6. Mole-Dagbani  7. Others, specify

6. What is the highest educational level you have attained?

1. Primary

2. Middle

3. JSS

4. SSS

5. Voc/commercial

6. Tertiary

7. None

7. What occupation are you engaged in?.....

8. What is your current marital status?

1. Married

2. Divorced

3. Separated

4. Single

5. Widow/Widower

9. How many living Children do you have? 1. Yes  2. No

### KNOWLEDGE, AWARENESS AND RISK PERCEPTION ON HIV/AIDS

10. Do you know of the condition known as HIV/AIDS?

1. Yes  2. No

11. Do you think people in this community are at risk of contracting HIV/AIDS?

1. Yes  2. No  3. I don't know.

12. What do you believe are the various ways by which a person can get HIV/AIDS in this community? (Tick/check all the options that apply).

1. Sexual Intercourse

2. Sharing of contaminated needle/instruments

3. Mother to Child during birth

4. Breast milk from infected mother

5. Witchcraft, Juju, Charms

6. Mosquito bite

13. What are the diseases that can be contracted through sexual intercourse?

(Tick/check all the options that apply).

1. Gonorrhoea

2. Syphilis

3. HIV/AIDS

4. Don't Know

5. Other,  
(specify).....

.....

14. What are the signs and symptoms of HIV/AIDS? (Tick/check all the options that apply).

1. Discharge from vagina/penis

2. Diarrhoea

3. Swelling of groin

4 Weight loss

5. Headache

6. Don't Know

Others(specify).....

.....

15. What is your HIV/AIDS status? 1. Positive  2.Negative  3.I don't Know

If Positive, skip to question 19.

16. How likely do you think you can contract HIV/AIDS?

1.Likely

2.Very likely

3.Not likely

Give reasons for your answer to the above.....  
.....  
.....

17. What are the ways by which you protect yourself from getting HIV/AIDS infection?

- 1. Use of condoms
- 2. Reduce number of sexual partners
- 3. Regular checkups/health facility visits
- 4. Douching or cleaning vagina and penis with detergents after sex
- 5. Using herbs and concoctions
- 6. Nothing

18. How often do you use your preferred mode of prevention?

- 1. Occasionally
- 2. Always
- 3. Not applicable

19. What are the sources from which you get HIV/AIDS related information? (Please tick as appropriate).

- 1. Radio
- 2. News Paper
- 3. Television
- 4. Posters
- 5. Sexual Partner (s)
- 6. Religious Leader
- 7. Traditional Leaders
- 8. Health Personnel

20. Do you know where HIV/AIDS Testing is done? 1. Yes  2. No

21. Do you know anybody who has contracted HIV/AIDS? 1. Yes  2. No

If yes, do you know somebody who died of HIV/AIDS? 1. Yes  2. No

22. Are your friends at risk of getting HIV/AIDS infection? 1. Yes  2.No

23. Has knowing a person's status negatively affected your relationship with him or her?

1. Yes

2. No

3. Can't be bothered

Not applicable

24. Have you ever had HIV/AIDS Test done?

1. Yes

2. No

3. Other

If 'No', are you prepared to test the HIV status of your blood?

1. Yes

2. No

3. Never

If yes, what was your test result?

1. Negative

2. Positive

**BELIEFS AND PRACTICES CONCERNING HIV/AIDS**

25. Why do you think people get infected with HIV/AIDS.....  
.....

26. Can you take care of HIV/AIDS person without worries?

1. Yes  2. No  3. Never

27. Can you visit and be a friend to HIV/AIDS positive person?

1. Yes

2. No

3. Never

**SEXUAL BEHAVIOUR/PATTERNS**

28. Do you drink alcohol? 1. Yes  2. No

29. Do you smoke? 1. Yes  2. No

30. Do you attend discotheques/brothels? 1. Yes  2. No

31. Are you sexually active? 1. Yes  2. No

If yes, how many sexual partners do you have? 1. One  2. Two or more

3. Multiple/several

32. Why do you have the number of sexual partners stated above?

.....  
.....

If you have more than one sexual partner, would you have preferred to stick to one partner instead?

1. Yes  2. No

33. Have you had sexual intercourse with an anonymous partner before? (Casual sex).

1. Yes  2. No

34. What are the sexes of your sexual partners? 1. Male  2. Female

35. What sexual preference do you have? Please tick as appropriate.

1. Men having sex with men

2. Women having sex with women

3. Men having sex with women

36. Why do you prefer the above sexual orientation?

.....

37. What is the nationality of persons you engage in the sexual activities with as mentioned above?

1. Ghanaian

2. British

3. American

4. German

5. Others specify

38. Do you think your sexual behaviour preferences put you at risk of getting HIV/AIDS?

1. Yes  2. No  3. Never  4. I don't Know

**THANK YOU**

### III

#### **FOCUS GROUP DISCUSSION GUIDE FOR HIV/AIDS POSITIVE PERSONS**

Hello. My name is Patience Ami Mamattah student from School of Public Health, University of Ghana, and Legon. I am part of a team doing research on HIV/AIDS related risk perception and sexual practices in this area; our aim is to help people with the illness and prevent others from becoming infected with the virus.

We want to hear your opinion about the issue. What you say will help us understand the condition better and to better meet the needs of people in this or similar situations by providing useful information to the necessary authorities through this research.

We would be discussing issues that pertain to HIV/AIDS and it will take about an hour to complete. We want you to share your opinions both positive and negative. Everything that you say today will be kept confidential.

I will be taking notes during the discussion. The research team will be the only ones to read my notes. Just in case I can't write everything down on paper, I would like to tape record this session. No one except me and the research team will listen to the tape.

Kindly ask me for any explanation or clarification before we proceed. What questions do you have? May I turn on the tape recorder?

First, I'd like to ask you a few questions about yourselves and your work.

1. What have you heard about HIV/AIDS?
2. How does one acquire HIV/AIDS?
3. Who can be infected with HIV/AIDS? 3b. Why?
4. What in your opinion might have made you contract the disease?
5. How can one avoid getting HIV/AIDS?
6. Do you think multiple sexual partners influence one's chances of contracting HIV/AIDS?
7. How many sexual partner(s) one should have? (The ideal number of sexual partner(s).
- 8.a . Would you be willing to have sex with a person if you knew she has an STI

8. b. Why?

.....

9. What should be the sexual lifestyle of persons living with HIV/AIDS?
10. What kinds of lifestyles expose people to the risk of contracting HIV/AIDS?
11. What is your opinion on this statement “all die be die”?
12. What in your opinion is responsible for people still getting infected with the virus?
13. What will be your word on HIV/AIDS prevention?

#### IV

### IN-DEPTH INTERVIEW GUIDE FOR KEY INFORMANTS

Hello. My name is Patience Ami Mamattah student from School of Public Health, University of Ghana, and Legon. I am part of a team doing research on HIV/AIDS related risk perception and sexual practices in this area; our aim is to help people with the illness and prevent others from becoming infected with the virus.

We want to hear your opinion about the issue. What you say will help us understand the condition better and to better meet the needs of people in this or similar situations by providing useful information to the necessary authorities through this research.

The interview will take about 30 minutes to complete and you can stop the interview at any point if you'd like. We want you to share your opinions both positive and negative. Everything that you say today will be kept confidential.

I will be taking notes during the interview. The research team will be the only ones to read my notes. Just in case I can't write everything down on paper, I would like to tape record this session. No one except me and the research team will listen to the tape.

Kindly ask me for any explanation or clarification before we proceed. What questions do you have? May I turn on the tape recorder?

First, I'd like to ask you a few questions about yourself and your work.

1. How long have you been providing care for this person(s)?
  2. What do you think is wrong with him/her?
  3. What do you know about HIV/AIDS?
  4. What do you think is responsible for the cause of this illness in your relation?
  5. What would you say is the reason why he/she contracted the HIV/AIDS?
- b. What was his/her lifestyle before contracting the illness?
- c. what kind of lifestyle is he/she leading now?

Would you say there has been a change in his/her sexual practices? Why?  
Please give reasons.

6. a. Would you say your relation/client worry about getting secondary/re-infection?
  - b. What about transmitting the HIV/AIDS infection to others? Why?
7. a. What would you say is the level of his/her risk perceptions about HIV/AIDS?
  - b. Would you say it is low or high? Why?
8. a. Have you observed any positive change in his/her lifestyle since diagnosis?
  - b. Was it positive or negative, why?
9. What will be your word on HIV/AIDS prevention in this community?

**THANK YOU!**

Ghana Enumeration Area Information System  
[ GEA INFO ]  
STATISTICAL SERVICE

SPECIAL REPORT ON RURAL ENUMERATION AREAS  
(Single Locality EAs)

District: ACCRA METROPOLITAN  
Region: GREATER ACCRA

EA Code: 0301303002

District Code 0301

Locality Code: 303

EA Number: 002

Locality Name: OSU

Category: URBAN

EA Name: WATSON SERVICES  
OSU

Estimated Population: 720

Boundary Description: Start from the Crystal Ice Company (excl) and the Watson services (incl) and follow the South Anorhor street to the Seashpre. Turn left and follow the shore to meet the concrete drain from the Police Barracks. Turn left and follow the drain past the Police Staff Barracks C and B (both incl), continue to meet the La - Osu road at the Elyons Stationery shop (excl). Turn left and follow the La-Osu road past the shell Filling station and Plan International (both excl) and also Citi Loans and Savings Company (incl) to the Watson Services (incl) and the Crystal Ice Company (excl), your starting point.

Ghana Enumeration Area Information System  
[ GEA-INFO ]  
STATISTICAL SERVICE

PHC 2

SPECIAL REPORT ON RURAL ENUMERATION AREAS  
(Single Locality EAs)

District: ACCRA METROPOLITAN

Region: GREATER ACCRA

EA Code: 0301301009

District Code 0301

Locality Code: 301

EA Number: 009

Locality Name: ADABRAKA/TUDU

Category: URBAN

EA Name: CALEDONIA HOUSE  
OSU

Estimated Population: 700

Boundary Description: Start from the Caledonia house (incl) and follow the Kojo Thompson road to the Traffic light on the South Liberia road. Turn right and follow the South Liberia road by-passing the Goil Filling Station (excl) to meet the Jones Nelson Street from the street in front of Rainbow Motors to meet the Official street. Follow the official street by-passing official town Presby Church, Edifroco Lodge, and Ebenezer hse (all incl) to meet Ahenakwa street. Turn left and follow the Ahenakwa street by-passing Solilla stores (excl), to meet Tonyeviadzi Fitting Workshop (Home of fiat) (incl), at its junction. Turn left and follow the tarred road for about 30 meters to meet untarred road continue on the untarred road to cross a wooden bridge to enter the street in front of Rainbow Motors. Follow the street in front of the Rainbow Motors to enter the Official street, your starting point.

Ghana Enumeration Area Information System  
[ GEA INFO ]  
STATISTICAL SERVICE

SPECIAL REPORT ON RURAL ENUMERATION AREAS  
(Single Locality EAs)

District: ACCRA METROPOLITAN  
Region: GREATER ACCRA

EA Code: 0301303022  
District Code: 0301  
Locality Code: 303  
KA Number: 022  
Locality Name: OSU Category: URBAN  
EA Name: SHAMERS CLUB  
OSU  
Estimated Population: 570

Boundary Description: Start from the junction of the Nmetsobu street and Sai Kojo street. Follow the latter to meet Anumanso street. Turn left and follow this street past the Aklerh Villa (incl) to meet the concrete drain. Turn left again and follow this drain to meet Nmetsobu street. Turn left finally and follow this street past Shamers Club (incl) back to your starting point.

Ghana Enumeration Area Information System  
{ GEA-INFO }  
STATISTICAL SERVICE

PHC

SPECIAL REPORT ON RURAL ENUMERATION AREAS  
(Single Locality EAs)

District: ACCRA METROPOLITAN  
Region: GREATER ACCRA

EA Code: 0301303056

District Code: 0301

Locality Code: 303

EA Number: 056

Locality Name: OSU Category: URBAN

EA Name: SHANGHAI CHINESE FAST FOOD  
OSU

Estimated Population: 500

Boundary Description: Start from the Junction of the Eighth lane and the First street and follow the Eighth lane along the earth drain past Enviro Techelec Contractors (incl) to meet the Sixth street. Turn right and follow the street to H/No F553/1 (incl). Turn right again and follow the road past the Shanghai Chinese Fast Food (incl) to meet a junction. Turn left and follow the Sixth lane past the Sam Bus Company (excl) to meet the First street. Turn right finally to the Eighth lane, where you started.

Ghana Enumeration Area Information System  
[ GEA-INFO ]  
STATISTICAL SERVICE

PHC

SPECIAL REPORT ON RURAL ENUMERATION AREAS  
(Single Locality EAs)

District: ACCRA METROPOLITAN  
Region: GREATER ACCRA

EA Code: 0301303010  
District Code 0301  
Locality Code: 303  
EA Number: 010  
Locality Name: OSU Category: URBAN  
EA Name: MODERN AGE TECHNOLOGY  
OSU  
Estimated Population: 700

Boundary Description: Start from Modern Age Technologies (incl) at the junction where the Labadi road meets an untarred road. Follow the untarred road past the Dadebu shrine (incl) to meet a rough road. Turn left and follow the rough road past the Mosque (incl) to meet the Sir Charles Quist street. Turn left and follow the Sir Charles Quist street past the Brazz and Petro Commodity Service Ltd (incl) to meet the Labadi road. Turn left finally and continue along Labadi road to meet the untarred road near the Modern Age Technologies, where you started.

