REPRODUCTIVE DECISION-MAKING IN THE CONTEXT OF HIV/AIDS

A CASE STUDY OF THE "GYIDIM" COMMUNITY IN THE AGOGO SUB-DISTRICT

This dissertation is submitted to the School of Public Health, University of Ghana, Legon in partial fulfilment of the requirement for the award of Master of Public Health Degree

By

Gladys Tetteh-Yeboah

(MPH Resident, School of Public Health)

University of Ghana

Legon

SEPTEMBER 2003

DECLARATION

I declare that this dissertation is an original work produced by me from research undertaken under supervision. This work has never on any occasion been submitted in part or whole to any Institution or Board for the award of any degree.

.....

GLADYS ELMA NAA ADJELEY TETTEH-YEBOAH

ACADEMIC SUPERVISORS

.....

DR PHYLLIS ANTWI

.....

NAA PROF JOHN S. NABILA

DEDICATION

This dissertation is dedicated to my loving husband, Ernest, my parents, Titus and Gladys Laryea and my sweet children- Clara, Fedora and Ebenezer.

ACKNOWLEDGEMENTS

I thank the Almighty God for giving me the strength, grace and wisdom to go about my studies and for sustaining me through out the period of this study.

I am most grateful to the School of Public Health for giving me the opportunity to undertake this course and the support given me in diverse ways by its staff.

My profound gratitude goes to my academic supervisors, Dr Phyllis Antwi and Naa Prof. John S. Nabila, without whose guidance and support this work could never have been what it is and to my field supervisor, Dr C Dodoo, and the entire DHMT of the Ashanti-Akim North District and Agogo sub-district, for their bountiful support.

My gratitude also goes to David Sefa-Boakye, Edmund Oduro, David Kwabena Asare, Acheampomaa Owoahene , Lydia Ampadu-Kwakuwah and Mr. Brobbey for devoting their time and efforts to collecting data for this work and to Miss Angela Bannerman (Research Manager, PPAG) and her team for their assistance.

I acknowledge the role played by the Pastor and the entire members of the Gyidim community, without which this project could never have been possible.

Finally, my appreciation goes to Mr and Dr (Mrs) Bismarck Nerquaye-Tetteh, Mrs Mercy Anim, (Ashanti Akim North ADP manager), the National Director and Management of World Vision Ghana for their profound contribution and support towards this award.

ABSTRACT

The study was undertaken in the Gyidim community of the Agogo sub-district of the Ashanti-Akim North district of the Ashanti region. The overall objective of the study was to acquire empirical data aimed at understanding the impact of HIV/AIDS on reproductive decision-making for programme strategizing and policy decisions.

The Gyidim community is largely governed by their strong religious beliefs that favour large family size, promote polygynous marriages and strongly oppose contraceptive use including condoms and pre-marital sex. The community also has negative perceptions on HIV/AIDS transmission and infection.

A cross-sectional descriptive study design was used in this study to assess the knowledge, attitudes, belief and practices on HIV/AIDS of this community and to explore its impact on the reproductive decision-making of the men and women in the reproductive age group. Both quantitative and qualitative data collection methods were used in acquiring the relevant information on the study variables. A total of 249 individuals (92 males and 157 females) were interviewed in a household survey using structured questionnaires. In addition Focus Group discussion guide was used in seeking in-depth information from six (6) unmarried and married groups of men (15-60years), and women (15-49years), in the community.

The study findings show that the knowledge, Attitude and perceptions of the Gyidim community, on HIV/AIDS, did not influence their reproductive decision-making. However, the findings on this community show the strong influence of religious beliefs on their reproductive decisions such as marital status, childbearing, condom use, and sexual behaviour.

Though the study findings indicates that their knowledge and attitude level to HIV/AIDS is high, and though the majority of the study population are aware that the main mode of HIV transmission is through heterosexual intercourse, they do not perceive themselves at risk of HIV and as such lack knowledge and skills on the use of the condom as a means of protection against STD/HIV/AIDS and unwanted pregnancy.

The community, although polygynous, do not attach polygamous behaviour to the risks of HIV/AIDS. They believe that premarital sex, fornication or sex outside marriage, and contraceptive use including condom use to prevent pregnancy or HIV infection is against the law of God.

As to decisions on marital status and sexual behaviour, when one partner is infected, majority of respondents indicated that they would divorce when test results reveal that one partner is discordant but continue to live together as couples without sexual intercourse if both partners were infected. The issue of divorce stems from the negative perception that HIV is contracted through promiscuity and therefore it is a punishment from God for immorality. The avoidance of sex within marriage when couples find that they are both HIV positive appears only as a proposition; probably the decision would change when the reality dawns on the community.

It further revealed that knowledge of a woman's HIV positive status is likely to influence a couple's child bearing decision but unlikely to influence contraceptive use especially condom.

Although the religion frowns on premarital sex and has stringent sanctions for those who flout the law, the study findings show that a number of unmarried youth are sexually active. However, the youth are in favour of condom use and are prepared to protect themselves against HIV/AIDS.

In view of the findings of this study, it is recommended that strictly confidential and youth-friendly services be made accessible to the sexually active youth

within the Gyidim community. . It will be necessary to empower such young people with life skills as well as information to enable them avoid unwanted sex. It is strongly recommended that education on the relation between HIV and STDs should be provided for the people of the Gyidim community.

The fight to reduce the spread of HIV infection is likely to be successful if they are implemented within the general framework of reducing individuals' vulnerability to infection. Thus the Gyidim community's stand against premarital sex should be considered in HIV/AIDS intervention programmes and messages on condom use and keeping to one partner should be tactfully introduced and explained, particularly where the community is polygynous. Again, risks involved in polygynous relationships could be a useful strategy for intervention programmes

It is also believed that the use of life testimonies of HIV infected persons could go a long way in changing perceptions held about People Living with HIV/AIDS. Promoting Voluntary Counselling and Testing (VCT) services could also go a long way in helping people identify their status and seek the needed counselling to prevent the spread of HIV/AIDS.

An effort should be made to educate and motivate religious leaders to engage their followers in discussions that will lead to a better understanding of the consequences of HIV/AIDS.

To conclude, we believe that the DHMT and District Assembly could use these findings to intensify education among the people in the Gyidim community towards changing the negative perception and behaviour on sexuality and Reproductive Health and making reproductive health decisions based on their knowledge, and perceptions on HIV/AIDS

LIST OF ABBREVIATIONS

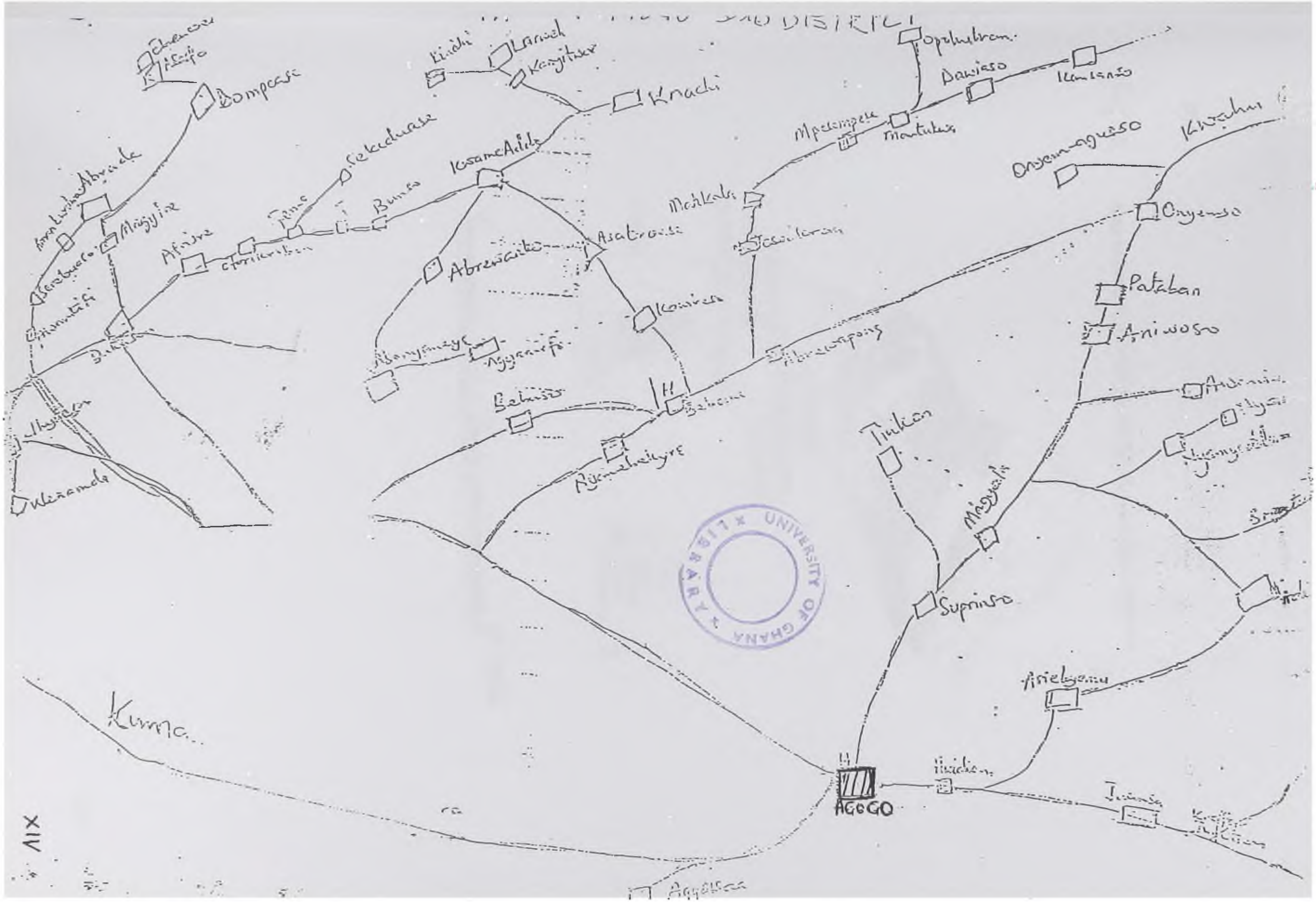
ADF		African Development Forum
ADP	-	Area Development Project
AIDS		Acquired Immune Deficiency Syndrome
CBS	-	Community Based Surveillance
CHPS	-	Community Health Providers
CPHN		Community Public Health Nurse
DHA	-	District Health Administration
DHMT	-	District Health Management Team
DHS	-	District Health Service
FHI		Family Health International
GDHS		Ghana Demographic Health Survey
HIV		Human Immuno-Deficiency Virus
ICPD		International Conference and Population Development
JSS	-	Junior Secondary School
KABP		Knowledge Attitude Beliefs and Perceptions
KVIP	-	Kumasi Ventilated Improved Pit
LA	-	Local Authority
MTCT		Mother to Child Transmission
NACP		National AIDS Control Programme
PLWHA		People Living With HIV/AIDS
PPAG		Planned Parenthood Association of Ghana
SSS		Senior Secondary School

STDs		Sexually Transmitted Diseases
TBA	-	Traditional Births Attendants
UNAIDS		Joint United Nations Program on HIV/AIDS
VCT		Voluntary Counseling and Testing
WHO		World Health Organization
WIFA	-	Women in Fertile Age
WVG	-	World Vision Ghana

TABLE OF CONTENTS

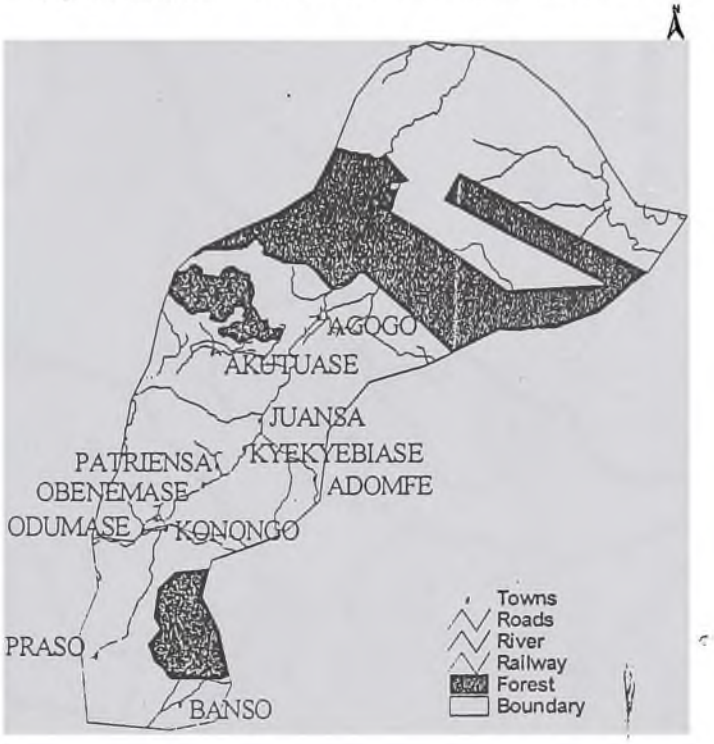
FIGURES

APPENDICES



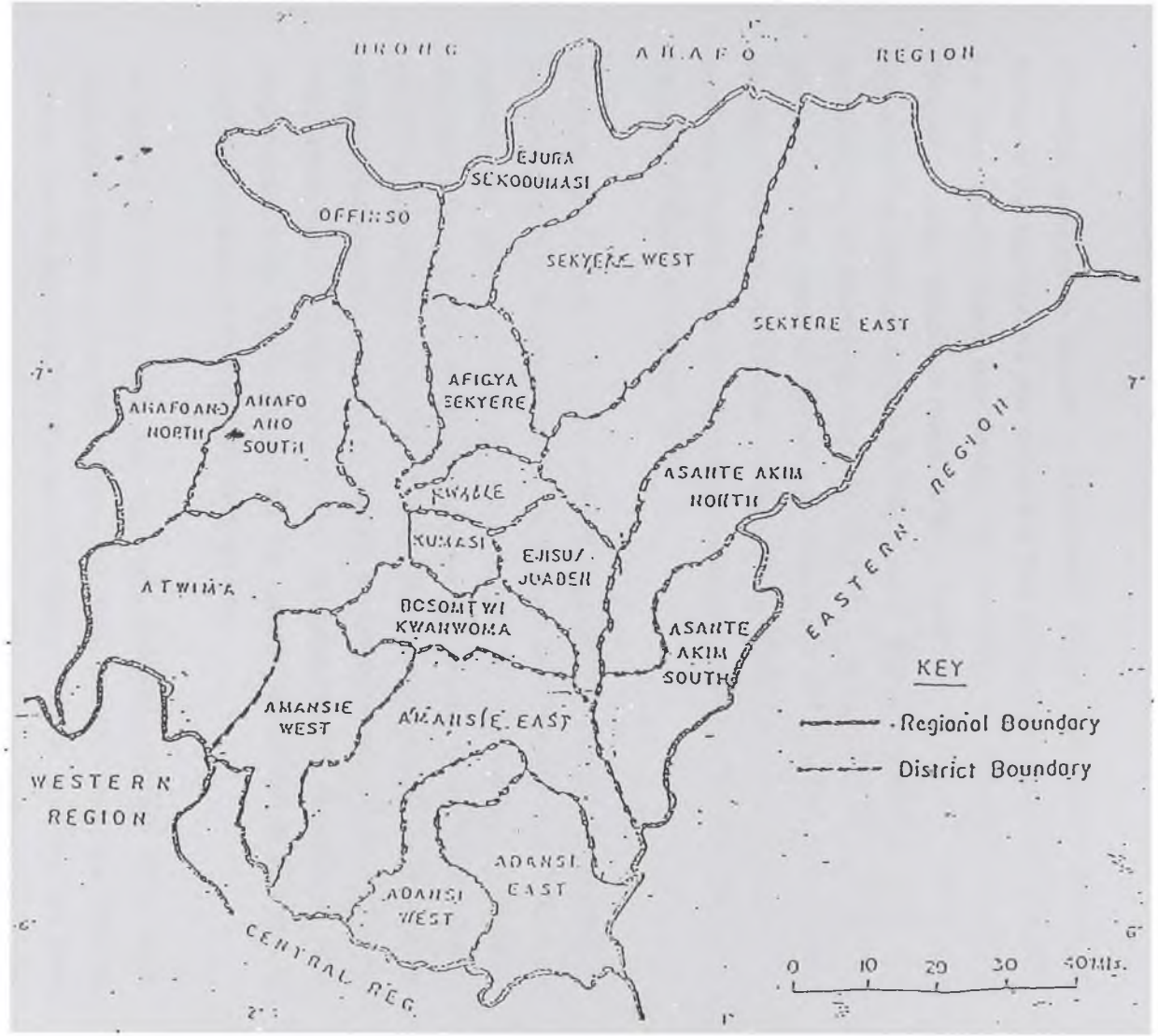
Slide 1

FIG. 2 **Map of Ashanti Akim North District showing basic features**



10 0 10 Miles

MAP OF ASHANTI REGION



CHAPTER ONE

1.0 INTRODUCTION:

HIV/AIDS continue to spread in Sub-Sahara Africa. Increased numbers of women in the reproductive age group and their partners are being infected with the virus. Fertility rates also remain high in many countries most severely affected by AIDS. Hence, a major mode of transmission of AIDS virus in the region is from infected mothers to their children during pregnancy, delivery or breastfeeding. In developing countries, 25-35% of infants born to HIV-infected women become infected themselves. Moreover, the children who escape infection from their HIV-positive mothers are likely to join the rapidly growing number of children orphaned by parents who have died of AIDS. [UNAIDS and WHO, AIDS Epidemic Update 1998].

In Ghana, the current rate of the HIV/AIDS spread is potentially threatening to increasing number of women of childbearing age and their partners. This is so because the main modes of HIV transmission are heterosexual intercourse accounting for over 80% of all transmissions and mother to child transmission (MTCT) accounting for 15 %.(NACP, 2002) This notwithstanding, family planning programmes have the potential to prevent heterosexual as well as mother-to-child transmission through condom use. Nevertheless, the success of such programmes would largely depend on how perceptions of risk of infection of HIV/AIDS influence reproductive decision-making.

At present for instance, early marriage, early childbirth and high fertility rates continue to feature prominently in many Sub-Saharan Africa countries including Ghana. Due to pronatalist tendencies, the uptake of family planning has been quite slow in many parts of the country and especially the rural areas. (Awusabo-Asare and Anarfi, 1995). Contraceptive prevalence rate for women (15-49), in Ghana is 22% and less than 10% for Nigeria and Sudan (Blanc, 2000). All this

factors certainly contribute to the poor reproductive health status of women in the sub continent.

At the International Conference on Population and Development (ICPD) held in Cairo in 1994, reproductive health was defined as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters related to the reproductive system and to its functions and processes. The definition of reproductive health therefore includes many components, among which are family planning, maternal and child health, prevention of harmful practices, reduction of the spread of reproductive tract infections and other sexually transmitted diseases (STDs), including HIV/AIDS, and provision of treatment for STDs and their complications.

The right reproductive choices are essential to one's reproductive health, particularly in this era of HIV spread. However, few studies have explored reproductive decision-making among people who live in a location with a high prevalence of HIV and who generally do not know their HIV status (due to the absence of voluntary HIV testing). In addition, other studies, which explored the relationship between an HIV-positive diagnosis and subsequent fertility behaviour, have found that known HIV-status has little association with childbearing. Women use pregnancy to demonstrate the absence of HIV infection and continuing good health, and frequently cite fear of abandonment and stigmatization (Rutenberg et. al., 2000).

Regardless of women's own desired reproductive response to HIV infection, many lack the ability to negotiate openly with their partners about reproductive decisions and contraceptive use. In a study in Kinshasa, Zaire, more than 97% of 238 women infected with HIV-1 were unwilling to inform their sexual partners of their HIV status because of fear of divorce, physical harm or public scorn [Ryder et. al., 1999)]. This does not necessarily mean that the men have the final say; some women may find it easier to practice contraception secretly than to obtain the agreement of their partners. Thus, more research is needed to understand if and

how the AIDS epidemic influences reproductive decision-making. Research is needed not only on how women and men make decisions but on which, if any, interventions would assist them in making better choices about childbearing and contraceptive use and empower them to act on those choices which will reduce the risks of HIV/AIDS.

This research aimed at identifying the perceptions of risk among women and men who live in a faith-based community setting but with a high risk of HIV/AIDS and how these perceptions are related to reproductive decisions such as childbearing and condom use.

1.1 RESEARCH PROBLEM

Since the HIV virus was first detected, it has engaged the attention of both governments and non-governmental organizations all over the world. In spite of this, global evidence shows that HIV/AIDS cases are on the increase and in many parts of Sub-Saharan Africa; epidemic proportions have been recorded (African Development Forum, 2000).

The rate of the HIV/AIDS spread in Ghana is alarming, with a current rate of 200 infections per day and a national prevalence rate of 3.6 % (NACP, 2002). The economically active and reproductive age group (15-49years) remains the worst hit by the disease. No cure is available for AIDS, and the disease is becoming one of the most serious development issues in the country. Thus, HIV/AIDS is demolishing the economic resources, particularly human resources. The human resource bases of some communities are beginning to deplete through deaths and frequent illness by those infected by HIV.

In addition the number of orphans resulting from the death of HIV/AIDS- infected parents has also increased. Both the affected and infected require time and care

and thus need the time of other non-infected relations or community persons, which could otherwise be used in other economic activities.

Like other regions of Ghana, the Ashanti region is not exempted from the HIV menace. The Ashanti-region has a prevalence rate of 2.7% [HIV/AIDS in Ghana 2001]. In the Asante-Akim North district of the same region the prevalence rate is even higher (4.2%) [District Health reports 2002]. Even believed to be higher is the prevalence rate of the Agogo sub- district where the Gyidim faith community is based (Agogo hospital reports, 2002).

In the light of the growing epidemic, the question of how HIV will affect the reproductive decisions of people in the sub-district has been raised in many settings. The concern has been whether HIV-infected men and women may consider certain reproductive decisions and behaviours. Awareness of AIDS is expected to bring about changes in some aspects of their sexual life, and influence their choices about reproduction. For HIV-positive women in sub-Sahara African who are trying to have children, higher rates of stillbirth, spontaneous abortion, or infant and neonatal mortality will eliminate culturally prescribed periods of abstinence. This is one way in which HIV can play an indirect role in reproductive decisions among infected persons (Setel, 1995).

Thus, appropriate reproductive decision-making is a very important factor in HIV/AIDS prevention. Against this backdrop and from the family perspective, the first step in a rational process of fertility decision-making involves communication between both spouses (Lasee and Becker, 1997). However, in the case of the Gyidim community, largely the church influences reproductive decision-making, with couples having limited input. In addition, the men are allowed or expected to marry more than one woman, thus the transmission of HIV/AIDS through multiple

sexual intercourse in polygynous marriages is likely to occur. (Personal Communication, 2003)

Another important factor influencing decision-making by husbands and wives is the leadership of this faith-based community, often the priests. It is a general belief among the community that children are a gift from God and therefore contraceptive use as part of the reproductive decision may be against God's laws. Further to this, anecdotal evidence from key personnel such as the District Health Management Team (DHMT) and the Community Public Health Nurse (CPHN) reveals that the community does not practice Family Planning and places value on large families. This is evident in their large family sizes of about 10 children per woman.

Thus condom use to prevent pregnancy is abhorred by the community as against the laws of God. Condom use is associated with illicit sex and so people who use this method are seen to be those who engage in casual sex and/or have sexual contact with persons other than their regular partners. Because of this, the use of condom in marriage is almost non-existent. It was also evident that men do not use the condom because of their belief that it reduces sensitivity, which is crucial in sexual gratification and thus against the laws of God, thus ignoring the issue of HIV/AIDS.

Like other communities, in Agogo, the average age for first sexual intercourse for most females is 15 years and in many cases childbirth starts immediately afterwards. Quite often they are not in a position to make sound reproductive decisions. Also childbearing during adolescence (10-19 years) has adverse consequences on the health of the mother, not to mention the social constraints on young women's ability to pursue educational and employment opportunities and their vulnerability to risky sexual behaviours.

However, although premarital sex is a taboo in such a religious community, with limited access to further education and limited job prospects, sex as an economic gain and benefit may be common among the young women and men. Also like other adolescents their motivation for being sexually active is complex, with social, romance, adventure and economic dimensions. However, fear of societal and parental disapproval of premarital sexual activity limit adolescence's access to much-needed accurate information and services and place them at risk to STI's and HIV/AIDS infections.

In the advent of HIV/AIDS however, one is not certain what impact knowledge of the menace could have on their choices. Besides, no study has been conducted in this community to ascertain the knowledge levels, attitudes, and perceptions of HIV/AIDS among the members of the Gyidim community.

1.2 RATIONALE OF THE STUDY

The risk of HIV/AIDS infection remains a central concern. HIV/AIDS is a threat in any community and it is a number one priority in the Ministry of Health second 5-year program of work. Strategies for prevention of HIV spread and the provision of care and support for those with HIV/AIDS becomes an issue. However we do not know how men, and women and couples, especially pronatalist of a generally polygynous society (as the Gyidim community) perceive the seriousness of the HIV menace. Neither do we know the strategies they consider appropriate to cope with these risks, nor the difficulties they face trying to adopt appropriate sexual behaviours to minimize them. This study seeks to provide insights into perceptions, strategies and constraints in the reproductive decisions of the people in Gyidim community in the Agogo sub-district of the Ashanti -Akim North district in this era of up surging HIV/AIDS.

In this study there will be the need to identify the socio- cultural factors such as marital status, early marriage, gender differences, child bearing/ large family size, religious beliefs and economic factors that influence Reproductive health decision-making in the context of HIV/AIDS.

The fact that HIV/AIDS education takes place is confirmed by literature, which shows that knowledge of the modes of HIV transmission among Ghanaians is very high (GDHS1998). However, available data show that HIV is on the increase in Ghana and the spread is mainly among the men and women in the reproductive age.

Unfortunately in Ghana today, there is an apparent dearth of information about the reproductive decision making of couples. The relevance of this study therefore is to understand how people's knowledge, attitudes and perceptions of HIV/AIDS can influence their reproductive decision-making.

The DHMT and other implementing partners in the Agogo sub-district will use the findings of this study to plan HIV/AIDS intervention and management programmes in the future among the Gyidim communities in the Agogo sub-district of the Ashanti Akim North district. Finally, it is hoped that this study will contribute to programme implementation and evaluation in the district.

1.3 STUDY OBJECTIVES

The overall objective of the study was to acquire empirical data aimed at understanding the impact of HIV/AIDS on reproductive decision-making for programme strategizing and policy decisions.

The main objectives of the study were:

- To assess the knowledge, attitudes, beliefs and practices (KABP) among men and women of the reproductive age group in the Gyidim community with respect to HIV/AIDS;

- To explore reproductive decision-making among men and women of the reproductive age group in the Gyidim community with respect to sexual behaviour, marriage, childbearing, number of children, and condom use;

- Explore the relationship between potential HIV-positive diagnosis and subsequent likely fertility behaviour; and

- Identify community-based strategies/initiatives for HIV/AIDS prevention and management.

CHAPTER TWO

2.0 LITERATURE REVIEW

This section gives information on the HIV/AIDS situation and issues concerning reproductive decision-making. A background of the Ashanti-Akim North district, the occupation, health and HIV/AIDS status of the district and the Gyidim community in which the study was conducted is also given. Thus it is very important that one becomes familiar with the context within which the study was conducted

2.1. HIV/AIDS SITUATION

Each day, 14,000 people become infected with HIV. By 2001, at least 5 percent of adults in nearly every sub-Saharan country were infected with HIV. Prevalence rates have reached alarming levels in most African countries. But Uganda stands out as a success story in the fight to stem the epidemic. The Ugandan government, along with religious groups launched programmes such as abstinence for adolescents, monogamy for adults and safe sex, including condom use, for all sexually active people more people died of AIDS than in any previous year (Lamptey et al., 2002). According to a WHO prediction, by the year 2004, up to 40 million people could be infected with HIV. However, a history of STDs in both sexes is related to risk of HIV infection and HIV itself may increase susceptibility to certain STDs (Germain et al., 1992; Grosskurth et al. 1995). It is therefore likely that vulnerability to AIDS is shown to rest on the high levels of STD infection in the world.

However the epidemic in Africa is fuelled by ignorance of the disease, lack of access to prevention, inadequate treatment and care services, and stigma and discrimination. Other factors are the high incidence of STI's, large refugee and migration activities, and cultural and religious practices that allow for multiple sexual partners [Lamptey et al., 2002].

In Ghana, as in the rest of Africa, two transmission mechanisms account for most new HIV infections in the country: heterosexual contact and mother-to-child [MTCT] transmission [HIV/AIDS in Ghana, 2001]. From the Ghana Demographic and Health Survey 1998, although awareness of HIV/AIDS is high in Ghana [97% of women and 99% of men have heard about AIDS], majority of Ghanaians still believe that they are not personally at risk of contracting the HIV virus. However, if people can perceive themselves at risk of contracting HIV/AIDS, they are likely to change their reproductive behaviour.

Also more than half of all new HIV infections occur among people under age 25 Young people are vulnerable to HIV because they are more likely to engage in high-risk behaviour, such as unprotected sex with multiple partners. Further more they tend to lack information about the risks of infection and how to protect themselves from it. Adolescents, especially female adolescents, and women are particularly vulnerable because of lack of information and services, and sociocultural barriers that prevent them from taking measures to protect themselves. Should they be provided with information, young people are able to take decisions to change their behaviour to reduce their risk.

In areas where there is social demand for large family sizes, HIV infection is also high. Some individuals are likely to be put at risk in an effort to achieve their reproductive goals. Available evidence also shows that when couples talk and share responsibility for their reproductive health decisions, it helps produce life-saving changes in their sexual behaviour. Therefore, inter-spousal communication and shared reproductive decisions are viewed as essential to HIV/AIDS prevention strategies [Rao et. al., 1994]. Ignorance and fatalism have denied some people this valuable benefit. For instance, a study in Uganda showed that open discussions about reproductive matters were discouraged by the belief that fertility should be left to God or to male partners, many of whom were opposed to contraception [Blanc, 2001].

2.2. REPRODUCTIVE DECISION-MAKING ISSUES

- *Marital status and Early marriages*

In a society where 50% of married women are in polygynous marriages, spousal emotional links are often weak. Women are not supposed to be concerned with, or about their husbands' sexual activities outside the marriage. There is little discussion of sex between spouses, and most women know that the greatest danger of infection is likely to come from their husbands. Yet wives are not supposed to discuss sexuality issues with their husbands. Such discussions might be misconstrued. Infact a request for condom use might suggest that the woman suspects the man of extra-marital affairs or as having a sexually infected disease.

Ankrah (1991) in his study stated that in Uganda wives had practically no power to negotiate that their husbands should practice safer sex outside the home, or to refuse sex or demand the use of condoms within the home. However, Family Health International (FHI) researcher Dr. Patricia Bailey stated that many women are living in a context where they are not making unilateral decisions about their reproductive health (although some women are using contraceptives without their husbands' consent). Therefore regardless of women's own desired reproductive response to HIV infection, many lack the ability to negotiate openly with their partners about reproductive decisions and contraceptive use.

In most rural settings, marriages occur at an early age, particularly for females most marry soon after puberty or after basic education. The early age at marriage does not only increase their risks at childbearing, but reduces their ability to make reproductive decisions (Sakyi et al., 1995).

- *Childbearing*

Another observation relates to the general love for children among Ghanaians. It is importantly upheld that the reason for marriage is for reproduction and the

- Socio-cultural factors

The cultural and the socio economic roles of women in most societies make women aspire to fulfil the wishes of their spouses. It is for these reasons that the barren in the Ghanaian society are "forced" to go to great lengths to seek for help to become biological mothers. Thus social and cultural factors strongly influence the reproductive health decisions of women in many settings. Religious prohibitions, expectations that women prove their fertility, a woman's knowledge and beliefs about contraception, self esteem, relationships with friends and family members, and freedom of movement all influence her decisions [Khan, 1999]. This implies that reproductive decision-making in relation to marital status, childbearing, sexual behaviour and condom use, are largely dependent on socio-cultural factors such as, economic and the religious beliefs of the people.

➢ *Economic factors*

Gender differences in access to economic opportunities reinforced by cultural practices impacts on reproductive decision-making by creating a situation of high dependence of women on men. This situation endangers the lives of most women who get involved in unprotected sex especially with multiple partners for financial gains and thereby promotes the transmission of HIV/AIDS (NACP, 2001). Findings have shown that economic factors could affect one's reproductive decision such as the need to use a contraceptive.

Most young women with lower socio-economic status often become vulnerable to sexual exploitation, commercial sex and forced marriages and are prone to sexually transmitted infections and HIV/AIDS. Deteriorating economic conditions also make it difficult for women to make decisions on access to health and social services (NACP, 2001).

➢ *Religious beliefs*

One other important socio- cultural factor, which tends to influence reproductive behavior, is the religious beliefs people hold. For example, adherents of the

Catholic faith do not accept the use of any modern contraception to regulate ones fertility (Ministry of Finance and Economic Planning Report, 1992). The Islamic religion limits its followers only to the use on non- permanent contraceptive methods (Jad and Haq et al., 1992).

Traditional religion, which is practiced in most parts of Ghana, though has no documentation disapproving of its adherents to use any modern method, generally favour pro-natalism. Like any other religion, the adherents of African traditional religion believe that children are blessings from God. In view of the fact that religious beliefs are usually deeply seated, they largely regulate the actions (including that of contraceptive practice) of followers. However, a study by Bossman in 1995 among protestant Christians in the Eastern region of Ghana showed differences in attitudes of respondents towards contraception.

In the light of the above, there is therefore the need to understand some of the socio-cultural factors that hinder or promote reproductive health decisions in the spread of HIV/AIDS, society's perception of the disease and the attitudes towards individuals suffering from it. Research on such health-related issues assist in the development of appropriate intervention programmes and provides input into policies on the reproductive and social dimensions of HIV/AIDS infections in Ghana.

2.3 Background Information on Ashanti-Akim North District

The Ashanti- Akim North District is one of the 18 districts in the Ashanti Region. The district covers about 5.6% of the total land area of the Ashanti Region. The district shares boundaries with Ejisu-Juaben district on the west, Sekyere East district on the north, Kwahu South district on the east and Ashanti- Akim South on the south. The district covers an area of 1361 sq.km with an estimated population of 139,821 (projection from 2000 population census). There are 115 communities

in the district and the district is divided into five sub-districts. (About 40% of these communities are covered by the Afram Plains.)

The Agogo sub-district is one of the five sub-districts in the Ashanti- Akim North District. The Agogo sub-district has an estimated population of 49,637 i.e. 35.5 % of the entire district with 23.2% of this population consisting of Women in Fertile Age (WIFA). The Gyidim community is one of sixty-four (64) communities in the Agogo sub-district.

The Gyidim community is a small community made up of members of a religious group, known as the Saviour church or the Faith church with an estimated population of 1,841. Because of the dogmatic beliefs of the church, the members of the congregation have isolated themselves forming the community. The majority of the people in this community, as with the Ashanti-Akim North District, belong to the Akan ethnic group.

The vegetation of the Ashanti-Akim-north district is mainly tropical rainforest and savannah grassland. Frequent bush fires have destroyed some of the forest vegetation and are threatening to turn the district into grassland. Due to logging activities of the timber industry, legal and illegal, the virgin forest is being depleted. There are two main rainy seasons in the district between mid- March and late June and between September and November. The first dry season is from December to February with the North Easterly winds (The harmattan dry winds from the Sahara desert) and the second and shorter dry season from the end of June until August.

Occupation

The majority of the people depend on small-scale farming. Crops produced include tomatoes, cassava, plantain, maize, cocoyam, groundnuts, and yam. Appropriate period for farming during the year is between March and September. Commercial

farming is practised on a small scale and crops planted include cocoa and oil palm tomatoes, maize, and yams. Fishing on a small scale and Charcoal production is the main occupation of the Sissala in the Afram Plains. However, this activity is degrading the environment on a large scale. Trading takes place all year round but peaks between August and December. The Obenemase Gold Mine used to be a major avenue of job opportunities but it has folded up. Sand winning, galamsey and chain saw operators operate in the district. Trading in general goods is also a major economic activity.

Health

The Ashanti-Akim-north District Health Administration is managed by a management team headed by the District Director of Health Services [DDHS], supported by units' heads and sub-district leaders. There are seven (7) government, one (1) mission and five (5) registered private health facilities in the district. The Agogo Presbyterian Mission Hospital, which is the district hospital, is located in the Agogo sub-district. The Konongo –Odumasi hospital, which is the government hospital for the district, is yet to be upgraded into a district hospital. There are estimated 150 unorthodox health providers in the district. The providers are mainly herbalists and spiritualist (DHMT report, 2003).

The District recorded 56,627 attendances in the hospitals and health centres. Malaria recorded the highest, which is about 31.3% of the total attendance. Pregnancy-related complications, the tenth in descending order, recorded 1.3% of the total attendance. Two hundred and seventy-five (275) deaths were recorded with malaria, being the major cause recording 24.7%. Teenage pregnancies are also high with 2% of this group aged between 10 – 14 years of age [District Health Annual Report, 2002]. Meanwhile, the HIV/AIDS menace in the district is on the increase with 142 HIV/AIDS cases recorded in the year 2002 (Table 1).

Table 1: HIV/AIDS cases in the Ashanti-Akim North District recorded from 1996 to 2002

YEAR	NO OF HIV/AIDS CASES								
	MALE				FEMALE				
	<15	15-49	>49	Subtotal	<15	15-49	>49	subtotal	TOTAL
1996	2	71	8	81	0	80	14	94	175
1997	0	86	10	96	0	68	17	85	181
1998	1	60	18	79	3	90	22	115	194
1999	0	74	12	86	1	78	16	95	181
2000	0	38	16	54	0	40	18	58	112
2001	0	16	7	23	2	52	20	74	97
	<15	15-25	>25	subtotal	<15	15-25	>25	Subtotal	Total
2002	0	13	50	63	2	22	55	79	142

(Source: District Health Report, 2002)

2.4. STUDY AREA

The study community consists of members of the Saviour Church, which has its headquarters in Osiem, in the Eastern Region of Ghana. The church has other branches in Ghana, and the Agogo branch is located in the Gyidim community. The history of this branch church stems from when two members of the church in Osiem moved to settle in this community. The land belongs to the church and the church has acquired more hectares of land for farming. As part of the rules of the church, members are supposed to live close to the church's location and so any one who becomes a member of the church automatically moves into the community. The name"Gyidim" was acquired as a result of their beliefs and doctrines.

According to the leader, 80% of the community members have low educational standards and the basic occupation of mostly the men, is farming and women, is trading. The pastor is among the few who have completed secondary education and works as an Accounts clerk with the Agogo Training College.

As part of the church's doctrine, they worship on Saturday, which is a Sabbath day for the members, and every member is not to work or travel on that day. The head of the church is also the assemblyman for the community and the community leader. He lives in the church's mission house and is married with two (2) wives and 15 children.

The church allows, a man to marry as many wives as he could cater for and have as many children as God gives to him. The marriageable age for a girl in this community is 18 years and one is not supposed to be living together until the church marries them. Thus premarital sex is against the laws of the church and this is held strongly by the members of the church. Most families live together in households, with each family consisting of the man, wife and his children. A man, who has more than one wife, acquires a separate apartment for each wife who stays with their respective children in their apartment.

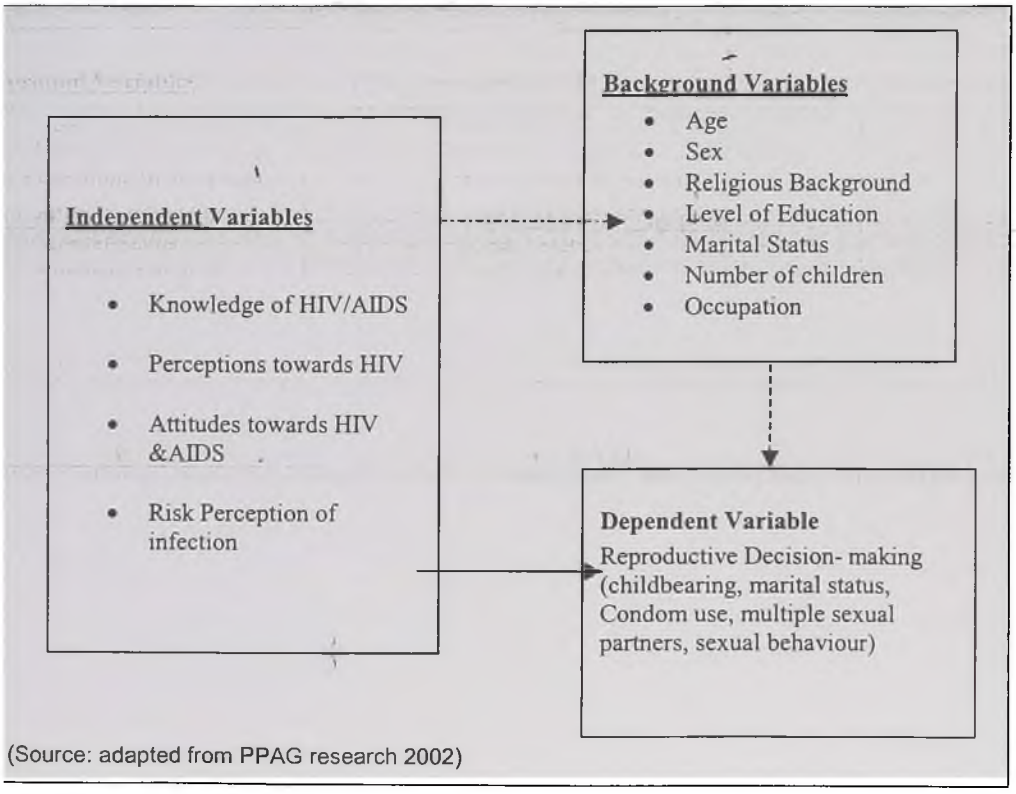
Childbearing is considered a very important aspect of marriage and so it is against the church doctrines to use any contraceptive method, with strong emphasizes against the condom. Most people interviewed vehemently frowned upon condom use and it was likened to the sin of murder, committed by Onan in the bible [Genesis 38 verse 9]. Another aspect of their religion is their doctrine against circumcision. As in other cultures, the religion frowns on male circumcision, regarding it as against the laws of God for Christians. One peculiar thing about this community also was their close-knit ness and their strong belief that it is not possible to have HIV/AIDS in the community.

2.5. STUDY VARIABLES AND PROPOSITIONS

Three groups of variables were used in this study. The first is the background variable, which gives the general characteristics such as age, religion, education and marital status of the men and women participating in the study of the Gyidim community. The independent variables constitute the second group of variables: Knowledge, perception, and attitude about HIV/AIDS. The personal risk

perception of the sample is also assessed. These variables are presumed to influence the reproductive decision making of those within the reproductive age group of the study community. Under the third group is the dependent variable, which considers reproductive decision-making (the main subject of the study) with regards to child bearing, marital status, and age at marriage, condom use and sexual behaviour and assumed to be influenced by the independent variables. (Fig 2)

Figure 2: Group of variables and their relationships



(Source: adapted from PPAG research 2002)

In the light of the above, it was proposed that:

1. Knowledge of AIDS will influence decisions regarding reproductive behaviour
2. Knowledge and perceptions on HIV/AIDS is likely to influence communities' acceptance and use of condoms.
3. Perceived risks of getting AIDS is likely to influence reproductive decision-making
4. Association with an HIV positive person will influence perceived risk and reproductive- decisions on child bearing.

CHAPTER THREE

3.0 RESEARCH METHODOLOGY

Provided in detail is the methodology used for the research.

3 1 RESEARCH METHODOLOGY

3.1.1 *Type of study*:

This was a cross-sectional descriptive study, using both primary and secondary data. The primary data was obtained from collecting information from the field using both one to one interviews with structured questionnaires and Focus group discussions (FGDs) using a guide. The secondary data was obtained from literature reviews of journals, research reports, DHMT reports, and anecdotal reports from service providers and the community members.

3.1.2 *Study design*

The study was conducted in the Gyidim community in the Agogo sub-district of the Ashanti-Akim North District (AAND). Convenient sampling of four participants per each household was used as basis for selection to provide variety in the study sample. The selection of participants for study was based on their availability in the household at the times of study. Participants were also selected from the reproductive age group: 12-49 for females and 15-60 for males. Female participants who were 12 to 14 years were included in the study to capture the many young people who begin child bearing soon after their menarche. Table 2 shows the study households in the community. Each household consists of four or more families with one family head. (Appendix 1)

3.1.3 *Data Collection/ Sampling techniques*

Both qualitative and quantitative methods of data collection were used. The qualitative approach was used because it gives room to collect in-depth

information, as probes are used to clarify issues and to seek additional information to support the quantitative data collected. (Susan Adamchak et al, 2000). The qualitative research consisted of an in-depth interview with the community leader, who is also the pastor of the Saviour church (Gyidim) and six (6) focus group discussions. The focus group discussion consisted of 2 unmarried male and female groups (15-24years), 2 married male and female young adult groups (20-34 years), and married male (40-55years) and female (35-49years) adult groups. In all 74 individuals, (42 males and 34 females) were involved in the focus group discussion.

For the quantitative data, a structured questionnaire was used for the house-to-house interviewing. A total of two hundred and forty-nine (249) people (12-49years for females and 15-60years for males) were interviewed.

Procedures

Six (6) research assistants were selected and trained on the data collection tools. They were also taught basic concepts in HIV/AIDS and sexuality. They went through practice in the use of probing questions to elicit responses and the use of the local language in conducting the study. They were involved in pretesting the FGD and the questionnaires as part of the training. Collection of data took 10 days.

3.1.4 *Data Processing and Analysis*

The FGD were transcribed from the Akan to English and issues raised were analyzed. The completed questionnaires were edited and open-ended questions coded. Data entry and analysis were done using EPI INFO 6 and SPSS software packages respectively.

3.1.5 Limitations

Because the community was mainly farmers who went to their farms every day except Saturday, which was their Sabbath, the FGD was conducted on Saturday

immediately after their church meeting. In addition, because most men were not reached for the interviews, more men were involved in the FGD. Only one in-depth interview was conducted since the pastor of the Gyidim church was the sole leader of the community and the final authority but one community service provider acted as a Key Informant to the exercise.

CHAPTER FOUR

4.0 RESULTS

This chapter looks at the results of the research findings of the study on the Gyidim community. The findings consist of the background of the study respondents such as their sex, age, religious background, educational level, occupation, marital status and reproductive decision-making behaviour. The knowledge, attitude, perceptions of the study respondents, their personal risk perception of HIV/AIDS (independent variable), and its relation to their reproductive decision-making (dependent variable) has been well highlighted in these findings.

4.1 Social demographic characteristics of the Respondents

(Tables 4.1a-4.1e and figure 4.1)

Age of respondents

A total of 249 respondents comprising 92 males and 157 females participated in the quantitative study. Over two out of every five respondents (40.6%) were aged between 15-24 years. Close to 40% were between the ages 25 and 39 years whilst the remaining 20% were 40 years and above (Table 4.1a).

Table 4.1a: Age distribution of respondents according to Sex

	Male		Female		Total	
Age	(%)	Freq	(%)	Freq	(%)	Freq
15-19	19.8	18	18.7	29	19.1	47
20-24	25.3	23	19.4	30	21.5	53
25-29	9.9	9	18.1	28	15.0	37
30-34	15.4	14	12.9	20	13.8	34
35-39	8.8	8	11.6	18	10.6	36
40-44	1.1	1	9.0	14	6.1	15
45-49	4.4	4	10.3	16	8.4	19
50+	15.4	14	0.0	0	5.5	14
Total	100	92	100	157	100	249

Source: Field survey, Gyidim 2003

Marital status

Close to 63% (72% females and 47% males) of the sample were married. Almost 2% of respondents were cohabiting and a little over a third were single people who had never been married. A total of 1.2% were either divorced or widowed. Amongst the married males, about half of them had more than one wife. (Table 4.1b)

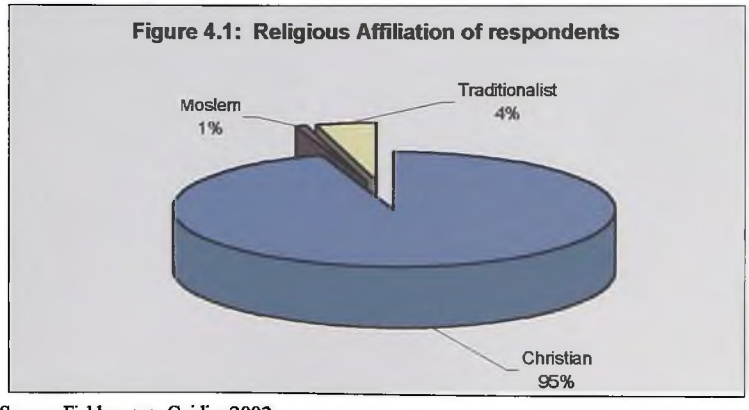
Table 4.1b: Marital status of Respondents according to Sex

	Male		Female		Total	
	%	Freq.	%	Freq.	%	Freq.
Marital Status						
Married	46.7	43	72	113	62.7	156
Cohabiting		-	2.5	4	1.6	4
Single never married	53.3	49	23.6	37	34.5	86
Divorced/separated		-	0.6	1	0.4	1
Widowed		-	1.3	2	0.8	2
Total	100	92	100	157	100	249

Source: Field survey, Gyidim 2003

Religion of respondents

Almost all the respondents (95.2%) were Christians, with majority (90%) of them belonging to the Gyidim/Saviour church. The others were traditionalists (4%) or Moslems (1%). (Fig.4.1)



Source: Field survey, Gyidim 2003

Educational status of respondents

With regards to educational status the majority (58.6%) had attained middle or Junior Secondary School (JSS) level. Close to a quarter (24%) had completed primary school whilst a few, about 7.2%, had attained Senior Secondary School (SSS) or tertiary level education. However, 10% of the respondents had never been to school at all. (Table 4.1c)

Table 4.1.c: Educational level of respondents according to sex

	Male		Female		Total	
Educational Level	(%)	Freq	(%)	Freq	(%)	Freq
Primary	16.3	15	28.7	21	24.1	36
Middle/JSS	66.3	61	54.1	45	58.6	106
Secondary/SSS	8.7	8	3.2	5	5.2	13
Vocational/Tech	4.3	4	0.6	1	2.0	5
Never been to school	4.3	4	13.4	21	10	25
Total	100	92	100	157	100	249

Source: Field survey, Gyidim 2003

Main occupation of respondents

The main occupation (44%) of the respondents was farming. Close to 22% female respondents were traders, whilst 21% were not engaged in any job/occupation. At least, over one out of every ten males was an artisan or in an apprenticeship. More females (21.2%) than males (9.8%) said they had no occupation.(Table 4.1d)

Table 4.1d: Occupation of respondents according to Sex

	Male		Female		Total	
Occupation	(%)	Freq	(%)	Freq	(%)	Freq
Farmer	46.7	43	41.7	65	43.5	108
Trader	3.3	3	21.8	34	14.9	37
Artisan	12.0	11	7.7	12	9.3	23
Driver/mate	6.5	6	0.0	0	2.4	6
Apprentice	13.0	12	5.1	8	8.1	20
None	9.8	9	21.2	33	16.9	42
Other	8.7	8	26.0	4	4.8	12
Total	100	92	100	157	100	249

Source: Field survey, Gyidim 2003

Number of children/family size of respondents

On the issue of children, 18.2% males and 32% female respondents who were married mentioned having between one and three children. About 17% of married respondents had between four and six children. Out of the female respondents who were married, 31.8% had more than one child, 50% had more than 3 children, and 10.1% had more than ten (10) children. More than a third of both male and female respondents had no child at all. (Table 4.1e)

Table 4.1e: Number of children of respondents according to sex

	Male		Female		Total	
Number of Children	(%)	Freq	(%)	Freq	(%)	Freq
None	44.2	34	25.7	38	32.0	72
1-3	18.2	14	31.8	47	27.1	61
4-6	11.7	9	19.6	29	16.9	38
7-9	11.7	9	12.8	19	12.4	28
>10	14.3	11	10.1	15	11.6	26
Total	100	92	100	157	100	249

Source: Field survey, Gyidim 2003

4.2 REPRODUCTIVE DECISION-MAKING BEHAVIOUR

The study sought to assess the reproductive decision- making of the people concerning premarital sex, sexual behaviour, condom use, and child bearing. As shown in Table 4.2a, more than half (75.8% females and 51.1% males) of the respondents had ever had sex. About 36% and 12% of the females and males respectively had their first sexual intercourse when they were between 15-19 years. The majority of males (42%) had their first sex between ages 20 and 24 years. Findings also show the mean age at first sex for both sexes to be 20 years.

Table 4.2a: Sexual Behaviour of respondents according to sex

	Male		Female		Total	
Sexual Behaviour	**(%)**	**Freq**	**(%)**	**Freq**	**(%)**	**Freq**
Ever had sex						
Yes	51.1	47	75.8	119	66.7	166
No	48.9	45	24.2	38	33.3	83
Total	100	92	100	157	100	249
Age at first sexual intercourse						
10-14	0.0	0	2.6	4	1.8	4
15-19	12.8	6	35.9	43	29.3	49
20-24	42.6	20	50.4	59	48.2	79
>25	44.7	21	11.1	13	20.7	34
Total	100	47	75.8	119	1h00	166

Source: Field survey, Gyidim 2003

Sexual relationships

As expected, most respondents mentioned their wife (68%) or their husbands (77%) as their first sexual partners. Only about 19% mentioned their first sex as being with a boy or girl friend. (Table 4.2b)

Table 4.2b: Sexual Relations of respondents according to sex

Responses	Male		Female		Total	
	(%)	Freq	(%)	Freq	(%)	Freq
Relationship to person with whom first sex occurred						
Wife	68.1	32	-	-	20.0	32
Husband	-	-	77.1	92	57.6	92
Friend	19.2	10	19.5	23	19.4	33
Someone	2.2	2	1.7	2	1.8	4
Can't remember	2.2	2	0.8	1	0.6	3
Don't know	2.0	1	0.8	1	0.6	2
Total	100	47	100	119	100	166

When asked whether they planned for their first sex, only a few, 11% males and 27% females mentioned that their first sex was unplanned whilst 89% males and 73% females stated that they decided to have sex the first time they did because they were married.

Table 4.2c: Sexual decisions of respondents according to sex

Responses	Male		Female		Total	
	(%)	Freq	(%)	Freq	(%)	Freq
Was sex planned?						
Yes	89.1	42	73.1	87	77.6	129
No	10.9	5	26.9	32	22.4	37
Total	100	47	100	119	100	166

Source: Field survey, Gyidim 2003

Sexual partners

As to the issue of number of sexual partners they have had since their first sexual experience, 20% had had more than one sexual partner, whilst most respondents agreed to having had one sexual partner since then. When asked whether they have regular partners, 95% responded in the affirmative. One in every five males mentioned having more than one spouse whilst 5% of female and their partners had more than one spouse (Table 4.2c).

Table 4.2c: Number of Multiple sexual partners according to sex

Responses	Male		Female		Total	
	(%)	Freq	(%)	Freq	(%)	Freq
Number of sexual partners since then						
None	4.3	2	5.3	6	5.0	8
One	76.6	36	74.6	85	75.2	121
Two	14.9	7	8.8	10	10.6	17
Three	2.1	1	7.0	8	5.6	9
Four/more	2.1	1	4.4	5	3.7	6
Total	100	47	100	119	100	166
Have regular partner						
Yes	90.3	42	96.6	115	94.9	157
No	9.7	5	3.4	4	5.1	9
Total	100	47	100	119	100	166
Have more than one spouse						
Yes	20.5	8	5.1	4	10.3	12
No	79.5	39	94.9	115	89.7	154
Total	100	47	100	119	100	166

Source: Field survey, Gyidim 2003

Condom use and faithfulness of partner

Respondents were further asked whether they ever used condom with their sexual partner(s). Significantly for this study, most respondents (90% males and 90% females) could vouch for their partners that they were faithful. Just a few, about 7% were not sure of their partners. Most respondents (96%) said they never used a condom with their partner(s) (Table 4.2d).

Table 4.2d: Condom use in relation to sexual partner according to sex

Responses	Male		Female		Total	
	(%)	Freq	(%)	Freq	(%)	Freq
Do you consider regular partner to be falthful						
Yes	90.7	42	90.5	108	90.6	150
No	2.3	1	2.6	3	2.5	6
Not sure	7.0	4	6.9	8	6.9	12
Total	100	47	100	119	100	166
Ever Used of condom with partners						
Ever Used	4.3	2	4.2	5	4.2	7
Never Used	95.7	45	95.8	114	95.8	159
Total	100	47	100	119	100	166

Source: Field survey, Gyidim 2003

Decisions on Childbirth and number of children

On decisions concerning childbirth and number of children to have, 54% of the respondents stated that the decision on childbearing should be God's. Others (23%) expressed the view that both the man and the woman must have an input in the decision.

About 25% respondents mentioned the desire to have a maximum of five (5) children whilst 42% said as many as God gives. (Table 4.2e)

Table 4.2e: Decision on childbearing according to sex of respondents

Respondents	Male		Female		Total	
	(%)	Freq	(%)	Freq	(%)	Freq
Decision to have children						
The man	16.5	13	7.3	11	10.4	24
The woman	1.4	1	11.2	17	7.8	18
The church	3.9	3	2.0	3	2.6	6
God	51.6	41	55.0	83	53.9	124
Both man and woman	26.6	21	20.5	31	22.6	52
No one	0.0	0	4.0	6	2.6	6
Total	100	79	100	151	100	230
Number of children desired						
Less than 3	4.0	4	6.7	10	5.7	14
2 to 5	22.7	17	25.5	38	24.6	55
6 to 10	13.3	10	6.0	9	8.2	19
More than 10	4.0	4	16.1	24	12.1	28
As many as God gives	49.3	37	37.6	56	41.5	93
None	2.7	3	0.0	0	0.9	3
Don't know	4.0	4	8.1	14	7.0	18
Total	100	79	100	151	100	230

Source: Field survey, Gyidim 2003

4.3 KNOWLEDGE, ATTITUDE AND PERCEPTIONS ON HIV/AIDS

4.3.1 Knowledge of STDS (Table 4.3a)

Respondents' knowledge was assessed on Sexually Transmitted Infections (STI's) in general. The greater majority of respondents who have heard about any disease one can get through sex knew about HIV (91.2%) and Gonorrhea (47%). A fair proportion of the sample appeared to be knowledgeable about symptoms of STIs. For instance, 21% and 39% respectively mentioned discharge and burning sensations in the penis/vagina However, most respondents (98%) said they did nothing to avoid having an STD and the few (2%) that did something used the condom.

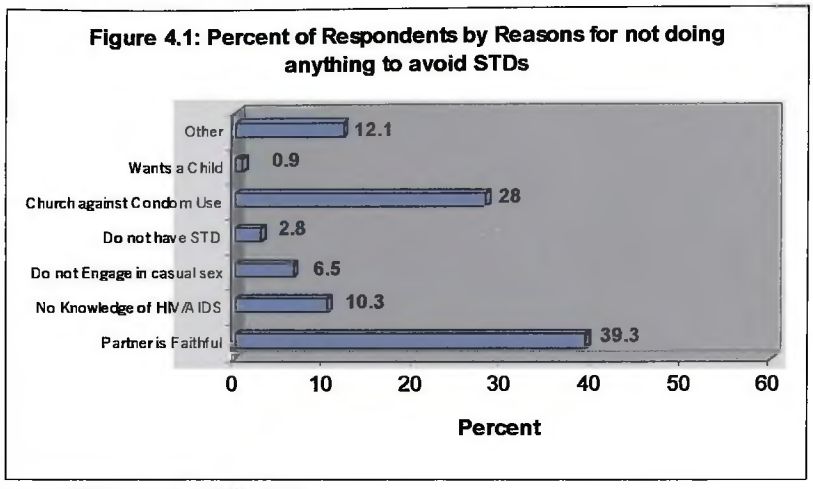
But only few (2% males and 5% females) respondents mentioned that they had had an STD before.

Table 4.3a: Respondents knowledge of STD according to sex

	Male		Female		Total	
STDs	**%**	**Freq (n=92)**	**%**	**Freq (n=187)**	**%**	**Freq (n=249)**
Types of STDs Known						
HIV	83.6	71	96.2	127	91.2	198
Gonorrhea	57.6	49	40.2	53	47.0	102
Syphilis	10.6	9	8.3	11	9.2	20
Others	4.7	4	0.8	1	2.3	5
No idea	0	0	1.5	2	0.9	2
Total*						
Symptoms of STDs known						
Discharge from penis/vagina	21.6	11	21.0	13	21.2	24
Burning pain/ sores on penis/vagina	47.1	24	32.3	20	38.9	44
Itching on genitals	2.0	1	6.5	4	3.5	5
No idea/don't know	45.1	23	54.8	34	30.1	57
Total*						
Did you do anything to avoid getting STD/HIV/AIDS						
Yes	3.9	3	1.0	1	2.0	3
No	96.1	49	99.0	98	98	147
Total	100	51	100	99	100	150
Have you ever had STI						
Yes	2.5	2	4.8	6	3.9	8
No	97.5	77	95.2	118	96.1	195
Total	100	79	100	124	100	203

Source: Field survey, Gyidim 2003 (* Multiple responses)v

About 40% of those who did not do anything to avoid getting STD's believe their partners are faithful, but others (28%) said they could not use a condom because the church is against condoms. However, about 10% stated that that they did nothing because they had no knowledge of STD's/HIV/AIDS. (Fig. 4.1)



Source: Field survey, Gyidim 2003

4.3.2 HIV/AIDS Knowledge and Attitude

Awareness of HIV is generally high in Ghana. Nevertheless, it is important to ascertain whether or not people have detailed knowledge of it in terms of the mode of transmission and how to protect oneself against infection. When asked about the symptoms of AIDS, most people (80%) mentioned weight loss. Persistent diarrhoea and skin lesions were also mentioned by 26% and 30% of the respondents respectively. With regard to how HIV is transmitted, respondents mentioned indiscriminate / casual sex (85%) and sharing of blades and needles (31.5%) Surprisingly, about 9.8% mentioned travelling as a means of one becoming infected with HIV/AIDS. (Table 4.2a)

Table 4.2a: Respondents knowledge of HIV/AIDS according to their sex

HIV/AIDS	Males		Females		Total	
	(%)	Freq. (n=92)	(%)	Freq. (n=157)	(%)	Freq (n=249)
Symptoms of AIDS						
Grows lean	79.5	66	79.7	102	79.6	168
Persistent cough	16.9	14	15.6	20	16.1	34
Persistent diarrhoea	28.9	24	24.2	31	26.1	55h
Shingles/skin lesions	38.6	32	24.2	31	29.9	63
Person looks ill	3.6	3	3.9	5	3.8	8
Other	26.5	22	17.2	22	20.9	44
Total**	**	**	**	**	**	**
Modes of Transmission of HIV						
Sexual intercourse	82.8	72	86.5	128	85.1	200
Sharing of blades/needles	36.8	32	28.4	42	31.5	74
Blood transfusion	17.2	15	4.7	7	9.4	22
From traveling	13.8	12	7.4	11	9.8	23
Punishment from God	4.6	4	2.0	3	3.0	7
Devil	1.1	1	0.7	1	0.9	2
Others	2.3	2	4.7	7	3.8	9
Total**	**	**	**	**	**	**

Source: Field survey, Gyidim 2003 (** Multiple responses)

About 64% and 38% of the respondents mentioned being faithful to one's partner and abstinence as ways by which one can prevent HIV infection respectively. Majority of the respondents (about 96%) knew that there was no cure for HIV/AIDS.

Table 4.2b: Respondents knowledge on HIV/AIDS according to sex

Ways to avoid getting HIV/AIDS	Males		Females		Total	
	(%)	Freq.	(%)	Freq.	(%)	Freq
Abstinence	39.3	35	37.3	56	38.1	91
Remain faithful	62.9	56	64.7	97	64.0	153
Use condom	14.6	13	12.7	19	13.4	32
Avoid sharing blades	20.2	18	18.7	28	19.2	46
Others	19.1	17	14.7	22	16.3	39
Total**	**	**	**	**	**	**

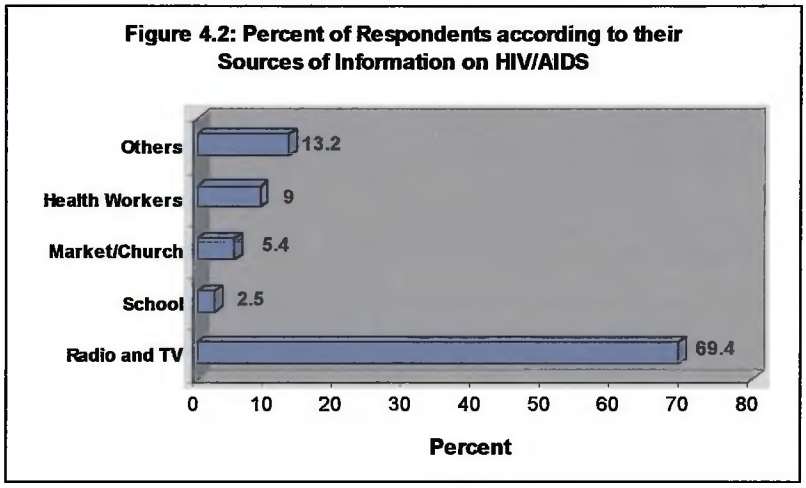
Source: Field survey, Gyidim 2003 (** Multiple responses)

Table 4.2c Respondents knowledge on cure for HIV/AIDS according to Sex

Knowledge of Cure for HIV/AIDS	Males		Females		Total	
	(%)	Freq.	(%)	Freq.	(%)	Freq
Yes	8.7	8	2.0	4	4.5	12
No	91.3	84	98.0	153	95.5	237
Total	100	92	100	157	100	249

Source: Field survey, Gyidim 2003

As regards source of HIV/AIDS information, (fig.4.2), the majority mentioned Radio/TV (69.4%). Close to one in ten mentioned health workers and a few mentioned market or church (5.4%) or school (2.5%)



4.3.3 Perception on HIV/AIDS

To a very large extent, people's perceptions influence their behaviour, so the study sought to assess the risk perceptions of respondents to HIV/AIDS. Most respondents did not see themselves at risk of HIV/AIDS. Among those aware of HIV/AIDS, 50% males and 60% females said they were not at risk of HIV infection. About 26% males and 24% females considered themselves at little risk (Table 4.3a).

Table 4.3a: Sex Distribution of Respondents and Risk Perception to HIV/AIDS

Risk Perception of infection	Male (%)	Freq. (n=92)	Female (%)	Freq. (n=157)	Total (%)	Freq. (n=249)
Small	26.4	24	23.9	38	24.8	62
Moderate	6.6	6	4.5	7	5.3	13
Great	13.2	12	7.7	12	9.8	24
No Risk at all	50.5	47	60.0	94	56.5	141
HIV positive already	0.0	0	0.0	0	0.0	0
Don't know	3.3	3	3.9	6	3.7	9
Total	100	92	100	157	100	249

Source: Field survey, Gyidim 2003

When asked further who they consider to be at risk of HIV, about 66% of males and 73% of females mentioned women who were promiscuous or who practiced prostitution. About a few (14.4%) however stated that everyone is at risk of infection (Table 4.3b)

Table 4.3b: Sex distribution of respondents according to their perception of vulnerability to HIV/AIDS

Vulnerability to HIV	Male (%)	Freq.	Females (%)	Freq.	Total (%)	Freq
Every body	14.4	14	14.4	23	14.4	37
Promiscuous women	65.6	59	72.5	112	70.0	171
Women/men	8.9	8	8.5	14	8.6	22
Secular /not religious	1.1	1	3.3	6	2.5	7
Others	10.0	10	1.3	2	4.5	12
Total	100	92	100	157	100	249

Source: Field survey, Gyidim 2003

Corroborating this finding are responses given by participants of the focus groups discussions. The majority of the participants repeatedly said that they were not at any risk of HIV. The main reasons most of them gave were that they were" well-behaved" or they did not indulge in illicit sexual behaviour. Responses given by some discussants on the issue of whom they consider most vulnerable are given as follows:

"Some do not have any work apart from prostitution and this shows that by all means they have AIDS," said a 24 young married female.

"Having sex with many partners can cause that," said a 45 year old married man.

" It is boys and girls who do not attend Saviour church who can have the AIDS, because if you are a member you separate yourself from casual sex and blood transfusion." response by a 35 young married man.

"It is casual sex that brought about AIDS, especially through those who slept with beast, I mean men who slept with beast. If a man slept with a beast and have sex with a lady it means he has transmitted it to the lady." said a 32 young married man.

Another 18 young unmarried woman in the group added his views;

"...and because of this AIDS is spreading, so far I thank God who has allowed that AIDS should come as punishment. .I am quite sure God brought AIDS for us to repent from casual sex."

Although it was clear that the study participants had internalised the message that avoiding casual sex and sticking to one partner can help protect one from

infection of HIV/AIDS, on the issue of strategies to prevent HIV spread, focus group participants provided these responses:

> "*The beauty contest should stop; the Government should use the money to help those who are virgins…"* an old 50 years married man.
>
> *"….if the Government can stop importing condoms into the country, prostitution will be reduced"* an old 45years married woman
>
> *"I also suggest that if through fornication and one gets AIDS, the Government should paste their pictures in the papers for everybody to see them and so get rid of them".* Said a 30years young married man

To further ascertain people's perception about HIV, respondents who participated in the quantitative study were asked whether they would willingly undergo Voluntary Counseling and Testing (VCT). Forty-three percent (43%) of the respondents said they would willingly go for the VCT, whilst 57% would rather not go for the test for various reasons. For instance, 57% said that they did not think they had been infected with HIV. The rest, 14.5%, 12.1% and 2.4% explained that they had been faithful, had had a good life style or had no symptoms of HIV/AIDS respectively. During the Focus Group Discussion, participants on the same issue of VCT replied as follows:

> *"I have not been infected so I would not go for it…"* Said one young unmarried man (32 years)
>
> *"We know that our wives are faithful and we also are faithful, so we will go for the test"* An older married man (48years)
>
> *"I will not go because I did not have premarital sex and my husband too did not have premarital sex till we married."* A young married woman (21years)

During the one to one interview, respondents were asked whether they will need more information on HIV/AIDS, About 75% of sample responded in the affirmative, whilst 25% did not find it necessary for reasons that HIV/AIDS information was not important or that they perceived themselves at no risk of HIV/AIDS (Table 4.3b).

4.4 IMPACT OF HIV STATUS ON REPRODUCTIVE DECISION – MAKING

4.4.1 Impact on Sexual Behaviour and Condom use

The efforts at creating awareness and increasing knowledge of HIV are expected to have an impact on the decisions on sexual behaviour. When asked how their knowledge of HIV has influenced their decisions and behaviour, 47.3% male and 58.9% female respondents mentioned that they remained faithful to their partners to avoid the risk of HIV/AIDS infection. 32% males and 17% females also mentioned abstinence as their response to avoiding risk. Others (11%) expressed the view that their knowledge of HIV/AIDS did not influence their decisions on their sexual behaviour. Only 6.6% males and 4% females said they had decided to use condoms with their sexual partners as an important way out. A few, (12.1% males and 10.6% females) who had decided to begin condom use, stressed the need for their sexual partners to be advised to accept to protect themselves. (Table 4.4a)
Group discussions also show that pre-marital sex and HIV test prior to marriage were other considered options.
During the FGDs these were their responses:

"I will avoid casual sex and will not receive blood from the hospital" a 22 year young man

"I have to abstain from sex until I have built my house, before I will marry a woman and before I marry her I will see her parents and perform the marriage rights and also we will go for blood test." A 25 year unmarried young man

Decision to use condom to protect oneself was influenced greatly by perceptions and negative attitudes of most of the people towards its use... Whilst some of the young men were against condom use, almost all the elderly discussants did not consider its use as ideal. Some in-depth understandings of the reasons for non-use are given as follows;

"I learnt in school from my friends that when you use the condom for sex, it is not enjoyable" a 25 year young man

"For me I know that it is a rubber and can tear so it does not help." Said a 45 year old married man

'Condom use is comparable to abortion, because you throw away the sperm that is going to form the human being and it is against the laws of God' a 32 year old married woman

"God doesn't like it!" a 20 year unmarried young woman.

Table 4.4a: Sex Distribution of Respondent with Knowledge of HIV/AIDS and impact on Sexual Behaviour & condom use

Sexual Behaviour	Male (%)	Freq (n=92)	Female (%)	Freq (n=157)	Total (n=249)	Freq
Abstain	31.9	29	16.6	25	22.3	54
Faithful to partner	47.3	43	58.9	89	54.5	132
Use condom	6.6	6	4.0	6	5.0	12
Advise	12.1	11	10.6	16	11.2	27
Become religious	1.1	1	1.3	2	1.2	2
No influence	13.2	12	9.9	15	11.2	27
Others	1.1	1	0.7	1	0.8	2
Total**	**	**	**	**	**	**

Source: Field survey, Gyidim 2003 (**Multiple Responses)

4.4.2 Impact on child bearing/number of children and marital status

➢ *Child bearing and number of children*

HIV /AIDS is expected to have a pronounced effect on reproductive decision-making if one is known to be HIV-positive. With some few exceptions, married women and men in the study advocated against childbearing when one knows he/she is HIV positive. Although child bearing is an important aspect of their religious belief, 70% male and 68.4% females stressed that knowledge of HIV/AIDS status would influence their decision to have children.

Table 4.4b: Sex Distribution of Respondents who tests positive for HIV/AIDS and influence to decision on child bearing

Influence decision for children	Male (%)	Freq	Female (%)	Freq	Total (%)	Freq
Yes	70.0	63	68.4	104	69.0	167
No	30.0	27	31.3	46	30.2	73
No idea	0.0	0	1.3	2	0.8	2
Total	100	90	100	152	100	242

Source: Field survey, Gyidim 2003

Reasons given was that if one is HIV positive, one will have children who are HIV positive and this may not be the best for the children. Furthermore, they considered that giving birth to children to suffer and die is not the best thing to do as a parent. Some wrong perceptions were brought to the fore as almost all focus group discussants tried to justify why an HIV positive woman should not consider child bearing. They expressed their belief that if a woman was infected with HIV, then the unborn child certainly would become infected also and die:

> *"I will not continue to have children, I will let her know that if we continue having children and we are not there they will suffer" said a 40 year old* married man
>
> *"I will prevent having children. I can't stand my child getting infected and suffering" a 30-year old* married woman

However, 30% males and 30% females (Table 4.4b) said they will still continue to have more children. They gave the reason that since children are a gift from God, one has no power to stop the work of God. Most of them said that God will take care of the children born whether HIV positive or not, and God will cause childbearing to stop when it pleases him. Only a few knew that not all babies to HIV-positive parents would be infected by the virus.

- *Influence on marital status*

When study participants were asked about what their marital relationship with their spouses would be if they tested positive, 68.9% males and 75.3% females, mentioned that they would leave or divorce their spouses. Others said they may stay and take care of their spouse or avoid sex with them altogether. Only a few, about 17%, mentioned that they would use condoms with the partner.

Table 4.4c: Percentage Distribution of Respondents who test positive for HIV/AIDS and its influence on their relationship with partner

Influence on relationship with partner	Male (%)	Freq (n= 92)	Female (%)	Freq (n= 157)	Total (%)	Freq (n= 249)
No sex	21.1	19	14.0	21	16.7	40
Divorce him/separate	68.9	62	75.3	113	72.9	175
Stay and take care of him	13.3	12	12.7	19	12.9	31
Have sex and use condoms	15.6	14	17.3	26	16.7	40
Others	3.3	3	2.0	3	2.5	6
Total**	**	**	**	**	**	**

Source: Field survey, Gyidim 2003 (**Multiple responses)

Participants during the FGD gave the following responses:

"If my wife is tested and she is HIV positive, bible allows divorce so I will call for that. I will divorce her," a married 45 year old man

"If my husband follows other women and he got it, I will have to leave him so I don't contract it." Old married woman

"So far as we have been living for some time, and if he is infected then am sure that I will also be infected so I will not divorce him so that we can take care of the children." Young Married woman

4.5 ATTITUDE TOWARDS PEOPLE LIVING WITH HIV/AIDS (PLWA)

Partipants' attitude towards a person living with HIV/AIDS (PLWHA) was assessed. To begin with, they were requested to mention whether or not they knew or had an encounter with a HIV positive person or an AIDS patient. Almost half of the respondents (56%) interviewed said they had either seen or met someone who was HIV positive or had AIDS. (Table 4.5)

Table 4.5:-Sex distribution of knowledge of people who have died/living with HIV/AIDS

	Male (%)	Freq	Female (%)	Freq	Total (%)	Freq
Knowledge of people who have died of HIV/AIDS						
yes	56.6	51	56.4	88	56.3	139
no	56.4	41	43.6	69	43.7	110
Total	100	92	100	157	100	249
Knowledge of family member who have died of HIV/AIDS						
Yes	10.0	9	11.2	21	10.7	30
No	90	83	88.9	136	89.3	219
Total	100	92	100	157	100	249

Source: Field survey, Gyidim 2003

Most of the participants of the focus group discussions repeatedly narrated their encounter with some one infected with HIV. Some further recounted the state of some HIV/AIDS patients before and after they died.

" What I know is that a woman sells food at the lorry station and at first she was fat and have a nice complexion, but now she has reduced and her stain colour has changed and she looks bony" a 17years old girl

I told you that my master and his wife died of AIDS so I have seen it myself. He even advised us all when he contracted the disease." a 28 year old married man.

One of the indicators used in measuring attitudes was to ascertain respondents' thoughts of what they considered should be done to and for HIV infected persons. About 68% respondents who were interviewed stated the need to care and support for people living with AIDS in the community and the need to avoid discrimination and stigmatisation. Others, (24%) on the contrary disagreed, saying that they deserve to be isolated and banished from the society since they had sinned by being promiscuous.

Table 4.6a: What the community should do for people living with HIV/AIDS

	%	Freq.
• Help and support them	68.8	163
• Isolate the person/expel them	20.7	49
• Pray for them	0.4	1
• Do nothing	10.1	24
• Total	100	237

Source: Field survey, Gyidim 2003

4.6 COMMUNITY BASED STRATEGIES/INITIATIVES

With regard to the community's initiatives in preventing the spread of HIV, most views given by respondents during the FGDs were that the church's doctrines were such that any member of the church is automatically prevented from the

menace. Focus group participants provided better insights into the perceptions held as follows:

> *"As far as we are in this church, if you are not married and we hear that you have fornicated, we will drive you away. Due to our laws, we don't expect such a thing to happen in the church"* Middle-aged married man (42years)
>
> *"In our community it is not allowed to talk to a girl for more than one hour. If you have not married her and this has helped us a lot. Also we have been advised against receiving or donating blood."* Young unmarried man (25 years)

On the community's role in fighting the menace, many (62.3%) expressed the need for community education and constant reminder to the youth on premarital sexual activities. About 17.6% respondents interviewed expressed the view that the church or the community should request that people undergo HIV test before marriage. However, as was expected, other views (2.9%) included that blood transfusion should be stopped and an alternative be found.

Table 4.6b: Role of the community in the fight against HIV/AIDS

	%	freq.
• Create awareness/education to members	62.3%	147
• Ensure people avoid casual sex behaviours	17.6	18
• Ensure people test for HIV before marriage	17.6	18
• People should be careful	17.6	18
• Need to pray	14.7	15
• Preach about it	5.9	5
• Others	2.9	3
• Total**	**	**

Source: Field survey, Gyidim 2003 (**Multiple responses)

One of the young male focus group participant suggested that compensation be given to those who abstain from sex. Others, particularly the female discussants commented that opportunities are created for the youth through the provision of information and income generating activities to empower them to avoid being lured by men into sex.

"I think the church leaders should advise the youth to abstain from casual sex till they get married." 20-year young married woman

The doctrine that forbids male circumcision should continue to be enforced, as it is likely for one to be infected through that means. "A 45 year old man
"If more jobs would be created for people in the community to do, it will reduce the spread of HIV/AIDS." 18-year young unmarried lady

CHAPTER FIVE

5.0 DISCUSSIONS

The overall objective of the study was to gain understanding of the impact of knowledge, attitude, beliefs and perceptions on HIV/AIDS on reproductive decision-making for programme strategizing and policy decisions. The aim of this study is to identify the perceptions of risk among women and men in a community setting but within a prevailing environment of HIV/AIDS and how their knowledge and risk perceptions impact on their reproductive decisions such as sexual behaviour, marital status, childbearing and condom use.

The study shows that the reproductive decision-making behaviour of the people in the Gyidim community is controlled largely by their religious doctrines, which are expected to have tremendous influence on their values and their life styles.

Decisions on desirable family sizes are rarely taken as the decisions to have children, or on the number of children or even have sex, are influenced by the strong belief that marriage is instituted by God, and thus prevention of child bearing, or denying one partner sex is against the laws of God.

This situation is not altogether surprising against the backdrop that most of the community members have only basic level of education. Education has been found in many studies (Takyi; 2003; Ware, 1981) to have the most pervasive influence on reproductive decision-making. Thus education has overridden religious influence on reproductive decision -making in most circumstances. Studies also show that education can have a profound impact on the position of women, giving them greater exposure to the modern world, which may influence their decisions (Kritz and Gurak, 1989).

Very small percentage of the study community could be found in high occupations. The study revealed that the main occupation of the men was peasant farming and

this may be an added reason to their demand for large family sizes to help in the farm. Most women were either small traders or not working and thus this makes them dependent on the men and thus this may also influence their inability to make any reproductive decisions (NACP, 2001).
Most female respondents as the study show, married at early ages when they had little or no information to make informed reproductive decisions (Sakyi et.al., 1995; Ankrah, 1991).

The study also shows that most respondents had not been involved in premarital sexual relations, as most respondents mentioned having had their first sexual intercourse with their married partners. Thus most respondents did not perceive themselves at risk to the consequences of any past sexual behaviour. However, those who had had earlier sexual partners did not consider themselves at risk of HIV/AIDS either.

In addition those who were in polygynous marriages did not also consider themselves at risk because they trusted their partners to be faithful as they are all members of the Saviour church. However in a society where married women are in polygynous marriages, spousal emotional links are often weak. The women may not concern themselves with their husbands' sexual relations, especially when they trust their husbands to be faithful as in this study. Nevertheless other studies show that majority of female AIDS victims have been infected by their husbands (Caldwell et.al, 1993).

The study also shows that the level of STD/HIV/AIDS awareness among the Gyidim community seems to be high, which may be due to the HIV/AIDS education going on in the mass media, schools, the church and the hospital as stated in the study. The majority of respondents in the Gyidim community as elsewhere in the country were knowledgeable of the mode of transmission and prevention of HIV/AIDS (NACP, 2002; CENCOSAD, 2003).

Irrespective of this, the community members do not perceive themselves at risk of infection. This perception held corroborates the report by other studies that although awareness of HIV/AIDS is high in Ghana [97% of women and 99% of men have heard about AIDS], majority of Ghanaians still believe that they are not personally at risk of contracting the HIV virus and thus behaviour is not influenced (GDHS, 1998; PPAG 2003). In this community, the high awareness level does not translate into behaviour change and polygamous relationships continue to be encouraged with unprotected sex in respective of the risks of STD/HIV/AIDS.

Findings also show that majority of respondents said they had never had an STD, which is quite surprising and it may be due to the fact that they associated STD to illicit sexual behaviours, which is not a characteristic of this Faith Based community. More over other studies states that women who get infected with an STD are less likely to experience symptoms and less likely to seek treatment (Ulin, 1992), although a history of STD is related to the risk of HIV infection. (Germain et. al.. Grosskurth et.al. 1995).

Another aspect of the community is the fact that the members of the church do not practice circumcision, which came up during the survey. Studies show that STD's such as Gonorrhoea and Syphilis are more prevalent among uncircumcised men than circumcised men and they appear to be at consistently elevated risk of HIV infection (Moses et.al., 1994).Thus, if the members of the Gyidim community can perceive themselves at risk of contracting HIV/AIDS, they are likely to change their reproductive behaviour [HIV/AIDS in Ghana, Dec., 2001].
But they still believe they are 'inoculated' against HIV infection. This belief stems from their strong doctrines of their faith against fornication and premarital sex as well as against blood transfusion.

Evidence on the ground nevertheless, shows that this belief does not fully provide protection of all their members from the risks of infection. Clearly, despite the strong religious rules, some never married youth respondents were already

sexually active. For instance, the data show that although most of them had their first sexual encounter when married (77.6%), the rest, quite a sizeable proportion did not.

In a similar vein, the church is against condom use and consequently most of the community members were not in favour of its use. As expected the findings show that most respondents had little knowledge on condom use as a result of their misconception that condom is not good and against the laws of God. Despite the fatalism and belief that AIDS is a punishment from God for promiscuity it is likely that some people may want to use it. This is based upon studies that the fact that although religion may have a significant effect on the use of condom for protection against pregnancy, the use of condoms for protection against HIV/AIDS may be the individual's decision (Takyi, 2003).

Indeed, a few of the youth respondents expressed the fact that economic pressures usually influence their decisions to engage in premarital sex and expressed the desire to use the condom if they had more information on how to use it. It is also to be noted that in areas where women are not economically vulnerable and have greater ability to negotiate safer sex practices, they are able to insist on condom use (Veliminc, 1987).

It is worth noting that reproductive decisions in the case of marriage would be influenced by one's knowledge of his/her HIV/AIDS status, that is, the issue of divorce or separation when one partner is discovered to be seropositive. Most respondents in this study would rather be separated from the spouse than still be married because of the understanding that HIV/AIDS is contracted through immoral sexual activities and so it is most likely that the partner had been involved in sex outside the marriage. This agrees with other studies that the relationship of partners almost always ended when one found that the other was seropositive (Peltzer et al., 1989). Since the belief that condom use is against the laws of God is greatly upheld by most of the respondents and as a result although they may

consider sex among HIV-positive couples as risky to the health of the individual and to child bearing, they would rather divorce than to use a protective method, or negotiate for secondary abstinence.

Such changes in reproductive behaviour have not been found in other studies conducted among populations who were informed of their HIV status. That research found that knowledge of one's own HIV status influenced later childbirth and marital status but not subsequent contraceptive use (Mays and Cochran, 1988).

It is importantly upheld in this study and as in other studies that the reason for marriage is for reproduction (Assmeng, 1988). However, one major finding is the fact that most participants in the study were prepared to stop child bearing if they were HIV positive. When we asked women and men to consider a hypothetical case where a woman knew she was HIV-positive, the majority view was that pregnancy should be avoided and divorce and not condom use would be the best method. It is note worthy that although child bearing forms a very important aspect of their religion, men and women's assumed knowledge of their HIV status would influence their childbearing decisions, because of their concerns about how pregnancy would affect the health of the child. This implies that majority of them understood the implications of being HIV positive and being pregnant. They would rather not have any child any more than to have children who will end up suffering, as they put it. This is contrary to study by Ankrah (1991)) that many Kampala women were keen to give birth in the belief that the production of healthy children would establish that they were seronegative. One thing, which was not clear therefore, was the fact about how they were going to prevent pregnancy from occurring without using a contraceptive method.

Sexual abstinence was often chosen when condom use was not viewed as a viable option, in relations where a spouse objects (Kline et al., 1991).

However the study shows that abstinence in marriage is also considered as against the religious belief that marriage is for procreation and that one is supposed to replenish the earth. The issue of abstinence is therefore only important during premarital life and not in marriage, neither is any other contraceptive method acceptable Abstinence would have been an important alternative, but how could one refuse the husband sex when they are married? This was a question they could not answer. On the contrary, other findings have also shown that knowledge of HIV status did not have any impact on a woman's choice to avoid pregnancy or abstain and the desire to have a baby overruled all other considerations (Johnson et.al., 1990 and Barbacci et. al., 1989).

Study findings show that some respondents had seen or had had an encounter with an HIV infected person. A few had also known someone who had died of AIDS and could describe the physical and psychological ordeal the people went through. Nevertheless, because they associated the HIV victims with promiscuous behaviours or with travelling, they still did not consider themselves at risk of contracting HIV. Although it is believed that an acquaintance with a HIV positive person could influence ones risk perception and reproductive choices, this study did not confirm that. One way to explain these seemingly contradictory attitudes and practices is that the study population due to their strong adherence to religious beliefs does not perceive themselves at risk of HIV/AIDS.

In the light of the above, the implication of the study as discussed, promise directions for further research on religion and AIDS protective and risk behaviours, and the design and development of culturally sensitive programs to help in the on going AIDS prevention efforts in the region are proposed.

CHAPTER SIX

6.0 CONCLUSION AND RECOMMENDATIONS

6.1 Conclusion

In conclusion, it is worth noting that the findings on this community show the strong influence of religious beliefs on their reproductive decisions such as marital status, childbearing, condom use, and sexual behaviour. The community, although polygynous, do not attach this behaviour to their risks of HIV/AIDS. They believe that premarital sex, fornication or sex outside marriage, and contraceptive use including condom use to prevent pregnancy or HIV infection is against the law of God.

Though the study findings indicates that their knowledge and attitude level to HIV/AIDS is high, and though the majority of the study population are aware that the main mode of HIV transmission is through heterosexual intercourse, they do not perceive themselves at risk of HIV and as such lack knowledge and skills on the use of the condom as a means of protection against STD/HIV/AIDS and unwanted pregnancy.

Women in this study community either due to their low educational status and low occupational levels do not make reproductive decisions on their own without the influence of their husbands/men and the religious doctrines. Thus some women might deny themselves the decision to prevent pregnancy or infection from HIV/AIDS for fear of their husbands/churches disapproval.

Furthermore, the study findings show that the infection of women by HIV is likely to play a significant role in couples' childbearing decisions. Many men and women

indicated their unprepared ness to give birth when they discover that the woman is HIV positive. The majority view was that pregnancy and thus childbearing should be avoided where a woman knew she was HIV-positive, yet many continued to disapprove of contraceptive use. They would rather divorce when one partner is HIV positive than to live together as married couple. The general opinion was that the marriage union would continue when both partners are HIV positive but sex would be avoided. This stance is largely influenced by the undue suffering and pain the baby is likely to go through and the cost of taking care of a child who would die anyway soon after birth. This notwithstanding, other research findings showed that knowledge of one's own HIV status sometimes did not influence fertility.

In spite of the opposition to contraceptive use by the adult community, it is important to note that young people of the study community are willing to use condoms to protect themselves against HIV infection and unwanted pregnancies.

6.2 Recommendations

As shown in this study, reproductive decision-making in this Faith-based community is strongly influenced by its religious beliefs and practices. *HIV/AIDS intervention programmes should therefore target leaders of these religious groups who have great influence on the knowledge levels and decisions making of their followers.*

As a result of the church's doctrine against premarital sex and condom use, most of the youth have limited access to accurate information and services on STD/HIV/AIDS as well as condom use although some of them are sexually active. *It is important that youth friendly services are made accessible in a strictly confidential manner to protect the sexually active youth who are more vulnerable to the risk of STD/HIV infection.*

The fight to reduce the spread of HIV infection is likely to be successful if they are implemented within the general framework of reducing individuals' vulnerability to infection. *The Gyidim community's stand against premarital sex should be considered in HIV/AIDS intervention programmes.*

The perception of HIV/AIDS among the study population is very negative with many holding the view that the infection is a punishment from God for fornication or adultery. *It is important to widely disseminate communication messages and use personal testimonies of infected people who are decent and got infected through no fault of theirs.* This is likely to generate further discussions and positively influence attitudes towards HIV infected people.

Programmes on HIV/AIDS prevention should focus on abstinence strategies. It was clear that some young people who want to abstain are unable to do so due to the advances by some adults. *It will be necessary to empower such young people with life skills as well as information to enable them avoid unwanted sex.*

Respondents' positive status of HIV is likely to influence their decisions in terms of stopping childbirth, avoiding sex where both partners are positive and seeking divorce when only one partner is infected. *The introduction of VCT services coupled with the campaign against stigmatization is likely to influence perceptions.*

Although the respondents did not believe that HIV could ever infect them, some of them have ever had STD. *It is strongly recommended that education on the relation between HIV and STDs should be provided for the people of the Gyidim community.*

6.3 Implications for Policy and Research

Results of the study have implications for policy and research and the design of HIV/AIDS intervention programmes.

Experiences from the survey suggest that *a number of approaches will have to be adopted to obtain information on individuals, especially from people who only consider other people who do not share their faith at risk of HIV/AIDS and not themselves.*

Stein comments that the success of current HIV prevention strategies among heterosexual couples depends not so much on efficacy as on the strategies acceptable to the male partner. For the foreseeable future, *preventing AIDS will continue to depend on the cooperation of both partners (Bandura 1991)*

It is worth noting that such researches on HIV/AIDS touches on intimate issues in people's sexual life, which in the Ghanaian society is considered a taboo and held in secrecy. Thus, it is necessary *to involve participants in the study in a way that will not play down on their secrecy.*

For such religious communities like the one used for this study, messages on HIV/IADS should emphasize on abstinence strategies. However, *messages on condom use and keeping to one partner should be tactfully introduced and explained, particularly where the community is polygamous. Again, risks involved in polygamous relationships could be a useful strategy for intervention programmes.*

Focus group discussions proved an important method of soliciting information from this community, particularly among the youth who otherwise did not share their concerns about sexual issues with the adults because of their religiosity. *Group*

discussions could be used as a way of providing information to empower young people to make informed choices against HIV infection.

As men travel out from rural communities to urban centres in search of employment, their sexual contacts may multiply; many may acquire the HIV virus and carry it back to infect wives at home. (Ulin 1992)
The question to be answered is, "what strategies if any will women in the Gyidim community use to influence male sexual behaviour, including condom use and multiple partners"?

Finally, with a high level of knowledge in HIV/AIDS, *educational programmes should highlight risk perceptions and decision-making towards behaviour change.*

BIBLIOGRAPHY

- African Development Forum 2000 AIDS: the Greatest Leadership Challenge 3-7 December 2000, Addis Ababa, Ethiopia *"HIV/AIDS in Africa: The impact on the world of work.*
- Agathe Latre-Gato Lawson, Women and AIDS in Africa: sociocultural dimensions of the HIV/AIDS epidemic, *International Social science Journal,* 1999:391
- Agyarko-Poku T., (2002). Asanteman AIDS Control Project
- Alcala M. J, Commitments to sexual and reproductive health and rights for all". New York, *Family Care International publications*, 1995.
- Ali Abdel Megeid, Sawsan El Sheilk, et al. Knowledge and attitudes about Reproductive health and HIV/AIDS among family planning clients, *Studies in Family Planning* 1996; 2(3): 459-469,
- Anarfi, J.K., 1993 Sexuality, Migration and AIDS in Ghana. In Caldwell et al. (eds). Sexual Networking and HIV/AIDS in West Africa. (*Supplement to Health Transition Review vol. 3)*
- Ankrah ME, AIDS and the social side of health, *Social Science and Medicine,* 1991, 32(9): 967-980
- Ann K. Blanc, The effect of power in Sexual relationships on Sexual and Reproductive Health: An examination of the evidence. *Studies in Family Planning,* 2001; 32(3): 189-213
- Assimeng, M., Social structure of Ghana: A study in persistence and change. Tema, Ghana, *Ghana Publishing Corporation,* 1998
- Awusabo-Asare K, Anarfi J.K, Social Dimensions of HIV/AIDS infection in Ghana, Feb, 1995
- Awusabo-Asare., and D.K.Agyeman., 1993. Social Science Research and the challenge of AIDS Epidemic: *Ghana Data. Proceedings of the 22nd conference of the IUSSP*, Vol. 4:357-368
- Bandura A., A social cognitive approach to the exercise of control over AIDS infection. *In Adolescents and AIDS. A generation in Jeopardy* (edited by Di Clemente R.) 1991

- Bannerman A.M, The role of interspousal communication in contraceptive use: *A study of Bawku District in the Upper East Region of Ghana,* Inst.of Pop. Stud. Univ. of Exeter, U.K, July 1999
- Blanc Ann K, Steve Gray *"Greater than expected fertility decline in Ghana: an examination of the evidence"* Micro. Int. Inc. Calverton, Maryland, U.S.A.
- Bledsoe, C.1990, Transformations in sub-Saharan African marriage, *Annals, AAPSS*, 510(July) 15-125
- Bleek. W., Family and family planning in southern Ghana, Sex role, population and development in West Africa, *Pop. Develop. Rev.* 13,138-153, 1987.
- Bongaarts J, Bruce J.: The question of access response. *Studies in family planning,* 1995, 26(4): 243-4.
- Bulatao RA: Key indicators for family planning projects. Washington, DC, World Bank, 1994 (*World Bank technical paper*, No. 297).
- Caldwell J.C., Caldwell P. and Quggin P, The social context of AIDS in sub-Saharan Africa; *Population Development Review.* 15, 185-234, 1989
- Caldwell J.C.,et. al., African families and AIDS: context reactions and potential interventions, *Health Trans. Review*, 1993, 3(suppl.) 1-16
- Daniel Tarantola, Reducing HIV/AIDS Risk, Impact, and Vulnerability, *WHO Bulletin*, Geneva, ILO, 2001
- Danielle L.Baron, Opia Mensah Kumah et al: Qualitative Research for Family Planning Programs in Africa. *JHU/CCP, Occasional paper series,* 1993(2)
- Dudley Kirk and Bernard Pillet , Fertility levels, trends, and differentials in Sub-Saharan Africa in the 1980 and 1990s, *Studies in Family Planning* 1998; 29, 1:1-22
- El Mouelhy M., et al., Women understanding of pregnancy-related morbidity in rural Egypt,. *Reproductive health matters*, 1994, 4:27-34.
- Family Health International. Dialogue: Expanding the response to HIV/AIDS, *a resource guide.* AIDSCAP Project, 1997
- Fariyal F.Fikree, Amanullah Khan, Muhammad Masood Kadir et.al. "What influences contraceptive use among young women in urban squatter settlements of Karachi, Pakistan?" *International Family Planning Perspectives* 2001, 27(3): 130-136
- Gage Anastasia. et.al, 1995, Women's socio-economic position and contraceptive behaviour in Togo" Studies in Family planning 26(5): 264-277

- Gage Anastasia: Sexual activity and Contraceptive use: The components of decision-making process. Studies in Family Planning 1998; 29, 2:154-166
- Geeta Rao G, "How Men's Power over Women Fuels the HIV Epidemic," *British Medical journal* 324, no.7331 (2002): 183-84
- Germain et. Al., eds "Reproductive Tract Infections, Global impact and priorities for women's' reproductive health, 1992
- Ghana Demographic and Health survey 1998, Accra, Ghana
- Ghana Situation Analysis. USAID Global Health: HIV/AIDS in Ghana.
- Ghana Statistical Service (GSS) and Macro International inc., (MI) 1994)
- Ghana Youth Reproductive Health Survey Report, GSMF, PPAG, JHU/POP COM, Focus on Youth Project, USAID; December, 2000
- Green Street 1987. "The Ghanaian woman Development through education and Family planning." Legon, Accra. U.G Population Impact Project
- Grosskurth H. et al., Impact of improved treatment of sexually transmitted Disease on HIV infection in rural Tanzania: randomized trial, Lancet, 1995,346(8974):530-536
- HIV/AIDS in Africa: The impact on the World of Work, ADF 2000, Addis Ababa, Ethiopia, 3-7 Dec. 2000, ILO,Geneva
- http://www.usaid.gov/pop_health/aids/countries/africa/ghana.html
- International Planned Parenthood Federation, Western Hemisphere Region: Glossary http:// www.ippfwhr.org/glossary.html
- Jain A, Bruce J, A reproductive health approach to the objectives and assessment of family planning programmes. New York, Population Council Publication, 1994.
- Jain A. Implementing the ICPD's messages. *Studies in family planning*, 1995, 26(5):296-301.
- Joint United Nations Programme on HIV and AIDS (UNAIDS) and World Programme (WHO), *Report on Global HIV/AIDS Epidemic,* Geneva, Switzerland: UNAIDS, 1998
- Kamenga M. et al., "Evidence of marked sexual behaviour change associated with low HIV-Sero conversion in 149 married couples with discordant HIV-1 Serostatus: experience at an HIV counselling center in Zaire, AIDS, 1991 5(1) 61-67

- Kathleen Henry Shears, Many uses for qualitative research, Network 2002, 22(2):5-11
- Kathleen Henry Shears, Changing attitudes present opportunities: Except from Qualitative Research, *Network, Family Health International* vol 22 (2) 2002
- Keogh P et al, and King R et al., A family planning intervention to reduce vertical transmission of HIV in Rwanda, AIDS, 1995,9(Suppl.1): S45-S51 *Social Science and Medicine*, 1994,38(8): 1047-1053
- Kim Best 'When partners talk, behaviour may change" in *Network* 2002, 21(4).
- Kline A., Husband S., and Strickler J., "Determinants of condom use among women in drug treatment. VII International Conference on AIDS, Florence, Italy, 1991
- Kline Anna, et. Al., "minority women and sexual choice in the age of AIDS.
- Kritz, M.M and D.T. Gurak, 1989 "women's position, education and Family formation in sub Saharan Africa". *Cornell University Population and Development program, working paper series106*
- Lamptey P, Merywen W, Carr, Collymore Y.: Facing the HIV/AIDS Pandemic, *Population Bulletin*, Sept. 2002,vol.57, (3)
- Margarita Diaz, Ruth Simmons, Juan Diaz et al "Expanding contraceptive choice: Findings from Brazil" *Studies in Family Planning* 30(1): 1-6
- Maun J., HIV/AIDS prevention and care in the 1990s, Report to the Ford Foundation, Cairo, 1991.
- Mays V.M and Cochran S.D. "Issues in the perception of AIDS risk and risk reduction activities by Black and Hispanic/Latin women. American Psychology, 43, 949, 1988.
- Miller K, Miller R, Askew I, et al., eds. *Clinic –Based Family Planning and Reproductive Health Services in Africa: Findings from Situation Analysis. (New York: Population Council,* 1998)29
- Ministry of Finance and Economic Planning report 1992
- National AIDS/STI Control Programme (NACP): HIV/AIDS in Ghana, Background, Projections, Impacts, Interventions, and Policy, December 2001
- Oheneba-Sakyi Y, Awusabo-Asare K, Gbortsu E, and Aryee A.F "Female Autonomy, Decision Making, and Demographic Behavior among couples in Ghana", RIPS, UG/SUNY, NY, 1995

- Orubuloye, I.O., J.C. Caldwell and P.Caldwell, 1993 "The role of Religious leaders in changing sexual behaviour in southwest Nigeria in the era of AIDS. In Caldwell et al (eds), Sexual Networking and HIV/AIDS in West Africa. *Supplement to Health Transition Review*, .3:93-104
- Peltzer, Karl and Rosemary Lijkwa 1992 "Psychosocial aspect of unwed adolescent pregnancy in Lusaka, Zambia," *Internal Journal of mental health 21,4:50-58*
- PPAG, October 2002, A Baseline Study Report: "HIV/AIDS Prevention through Sexual Abstinence".
- Reproductive health and reproductive choice: The WHO perspective, Progress in human reproductive research, 1994, 30:2-5.
- Rutenberg N, Biddlecom A.E., Kaona F.A.D: Reproductive Decision-Making in the context of HIV and AIDS: A Qualitative Study in Ndola, Zambia, *International Family Planning Perspectives,* Sept.2000, vol.26 (3) page124-129
- Ryder RW et.al., Fertility rates in 238 HIV-1 sero positive women in Zaire followed by 3years post partum women, *AIDS*, 1991, 5(1`2): 1521-1527
- Sangeetha Madhavan, Alayne Adams and Dominique Simon" Women's Networks and Social world of fertility Behaviour" *International Family Planning Perspectives* 2003, 29(2): 58-68
- Saroj Pachauri and K.G Santhya ,"Reproductive choices for Asian Adolescents: A focus on contraceptive Behaviour" *International Family Planning Perspectives,* 28(4): 186-195
- Setal P, "The effects of HIV/AIDS on fertility in East and central Africa", *Health Transition Review*, 1995, 5(Suppl.): 179-189; and Pop. Council et al, draft report, Washington, DC: Pop. Council, July 1999
- Smith. Emily J., Life circumstances influence decisions: Except from Sexual Health, *Network,* Family Health International, Vol.21 (4) 2002
- Takyi, B.K., 1993 "The status of women and fertility behaviour in sub-Saharan Africa: The effects of female labour force participants and gender preferences on fertility in Ghana.
- Ulin, Priscilla R. 1992." African women and AIDS: Negotiating behavioural change." *Social science and Medicine* 34(1): 63-73
- UNAIDS and WHO, AIDS Epidemic Update: December 1998, Geneva, Switzerland: UNAIDS, 1998

- Varga, C.A.1997."Sexual decision-making and negotiation in the midst of AIDS: Youth in KwaZulu-Natal, South Africa. "*Health Transition Review* (Supplement 3):45-67
- Ware H Women, Demography, Development. The Australian National University, Canberra, 1981
- Wendy D. Manning, Monica A. Longmore and Peggy C. Giordano "The Relationship context of contraceptive use at first intercourse" *Int. Family Planning Perspectives*, 2000,32(3): 104-110
- Wolff, Brent, Ann K. Blanc, Anastasia J. Gage. 2000a "Who decides: women's status and negotiation of sex in Uganda." *Culture, Health and Sexuality* 3(1): 1-19
- Worth, D., 1989, Sexual Decision-making and AIDS: Why condoms promotion among vulnerable women is likely to fail. *Studies in Family Planning; I.20* (6): 297-307

APPENDIX: 1

TABLE 1: Showing number of households in each plot/cluster In the Gyidim community

	PLOT (CLUSTER) NUMBER	NUMBER OF HOUSEHOLDS
1	D	12
2	E	37
3	F	24
4	G	27
5	H	27
6	J	11
7	K	11
8	L	6
TOTAL		156

(Source: House to house survey by CBS, 2003)

APPENDIX 2:

Focus Group Discussion Guide

Introduction:

You have all been invited to participate in a focus group discussion today as members of the Gyidim community. We are grateful you have come, and have made time for this exercise. Our job is to ask you a few questions, listen and learn from your experiences and thoughts about the issue of HIV. Please be assured that your presence is very important to us. In this discussion there are no rights or wrong answers. All comments both negative and positive are welcome. We believe that the in-depth information you provide would help in the development of a policies and strategies for the promotion of reproductive rights and provision of services aimed at HIV/AIDS prevention and management within this community and other parts of Ghana.

Thank you.

a. *Introduction of Moderator and Discussants.*

b. *Explain rationale.*

c. *Purpose of recorder.*

d. *Rules for the discussion.*

e. *Role of Moderator and Assist Moderator.*

Make sure all the discussants are well seated. Check the recorder to make sure it is working. The recorder should be placed such that it can pick all the voices of participants. However be sure that participants give their consent to the use of the recorder before it is used.

Issues for Discussions

1. What do you know about HIV/AIDS? (Probe for knowledge)
2. Is HIV/AIDS real? Probe for reasons
3. What are your perceptions about HIV/AIDS?
4. What strategies/activities have you initiated to prevent the spread of HIV/AIDS and what has been the effect of such interventions?
5. What do you think are the challenges/potential challenges that HIV/AIDS will have on your community?
6. Whom do you consider to be the most vulnerable to HIV/AIDS infection and why?
7. What can be done to reduce vulnerability of each category of people?
8. Has anyone been associated with a person infected by HIV?
9. Would you be prepared to undertake voluntary counselling and testing for VCT?
10. If you knew or suspected that your husband/ wife was infected with AIDS what would you do to prevent yourself from being infected?
11. Assuming you test positive, would that influence the number of children you decide to have? How about your sexual life, would it influence it?
12. How do people feel about using condoms to prevent HIV/AIDS?
13. What can be done to prevent discrimination against PLWHA in this area?
14. An outcome of this study would be the development of programme interventions for the community and the district. What suggestions do you have to ensure that the programmes are beneficial to the community?

APPENDIX 3:

STRUCTURED QUESTIONNAIRE

QUANTITATIVE STUDY ON REPRODUCTIVE DECISION MAKING IN THE CONTEXT OF HIV/AIDS IN A FAITH BASED COMMUNITY

This study is being implemented in collaboration with the District Health Management Team of the Ashanti Akim North District with the view to investigating the factors that influence reproductive health decisions making among men and women in the reproductive age group. The aim is to generate information that would help in the development of a policy framework for the integration of HIV/AIDS prevention and management strategies within this faith based community.

Please support this intervention by responding to this questionnaire. **The questions include some highly sensitive personal questions about your sexual behaviour and practices.** The information you will provide will be kept confidential and be used only for planning purposes. You are free to respond to decide not to respond to some of the questions. You can decide to continue with the interview if you so wish but remember that the information is crucial in developing programmes that would go a long way to improve the reproductive health and general health of the community. I would first ask you these questions after which you are free to ask any question you would wish to have answers to. The interview is likely to take some time.

Do you accept to fill this questionnaire?

YES ☐ Proceed to answer questions.

NO ☐ Do not answer any questions

Please fill the questionnaire below by circling the appropriate response codes

INTERVIWERS NAME _____

DATE OF INTERVIEW: _____

CLUSTER: _____

HOUSEHOLD STRUCTURE (single/compound): _____

SECTION 1: DEMOGRAPHIC SECTION

101.	Sex of respondent	a. Male b. Female
102.	Age of respondent	Years old ___ ___
103.	What is your marital status now?	a. Married b. Cohabiting c. Single never married d. Divorced/separated e. Widowed
103i.	How many wives?	
104.	What is the highest level of formal education you achieved?	a. None b. Primary c. Middle/JSS d. Vocational/Tech e. Secondary/SSS f. Tertiary g. Other, specify _____
106.	What is your Religious affiliation?	a. Christian (specify---------- b. Moslem c. Traditionalism d. No religion e. Other religions (Specify.....)
107	How many children have you?	___ ___
108	What is your occupation?	a. Farmer b. Trader c. Artisan d. Civil servant e. Driver/mate f. Apprentice g. None h. Other, specify

SECTION 2: SEXUAL PRACTICES

109. Have you ever had sexual intercourse before? a = yes b = no **(go to Q123)**

110. How old were you when you had your first sexual intercourse? Years old ___ ___

111. With whom did you have your first sexual intercourse?
a. Wife b. Husband c. Friend d. someone e. can't remember f.dont know

112. Did you decide to have sex before you did / did you plan for it? 1=. Yes 2. =No

113. How many sexual partners have you had since then? Number...

114. Do you have a regular partner? (Not applicable to married)
1 = Yes, 2 = no

115. Did you use a condom with your sexual partner(s)? 1=Yes **(go to Q117)** 2= no

116. What is the main reason you did not use the condom with your sexual partner?
1=did not know what to do
2=condoms not available
3= religion says no to condom use
4= embarrassed (purchase)
5= partner was a virgin
6= partner will suspect me
8=partner refused
9=partner is faithful
10=don't enjoy sex with condom
11=allergic to the rubber
12=fear of losing partner
13=fear being denied gifts/money/sex
15=want pregnancy
16=other (*specify* .....)

117. Do you consider your **regular partner**(s) to be faithful?
1= yes 2= no 3= not sure

118. Do you have more than one spouse (married)? 1= Yes 2=no

119. Have you been pregnant before? 1= Yes 2=No

120. What do you do to prevent yourself from being pregnant? 1. = Use a condom 2. = Use other modern contraceptives 3=. Use herbal preparations 4. = Abstain 5. = Pray 6. = Nothing

121. How many children do you want/wish to have?
1= less than three 2= 3to 5 3. =More than 6 4. Maximum of 10 5. = None 6. = Don't know 7= as many as God gives

122. Who decides the number of children you should have? 1=the man 2=the woman 3= the in-laws 4= the church 5= God 6= both man and woman 7= no one

SECTION 3: STDs & HIV/AIDS

123. Have you ever heard of any disease that one can get through sexual intercourse? 1 =yes 2 = no **(go to Q131)**

124. Indicate the names of any diseases you know that one can get through sexual intercourse
1.

2.

3.

125. State two main physical problems or symptoms **(apart from AIDS)** a person might have that suggest that he or she has a sexually transmitted disease.

1.

126. Have you ever had any sexually transmitted infection (STIs)? 1 = yes 2 = no **(go to Q128)**

127. If yes, where did you go for treatment?

1=did not go for treatment 4=clinic/hospital
2=treated myself 5=licensed traditional healer
3=drug store 6= other
(specify.....)

128. The last time you had sex; did you do anything to avoid getting an STD/HIV/AIDS?
1 = yes 2 = no **(go to Q131)**

129. If yes, what did you do?

1.

2.

130. If no, what was the **main** reason you did not do anything?

1.

131. State two main sources of information from whom you have heard about AIDS?

1.

2.

132. Do you need information on HIV/AIDS? 1= yes 2= no

133. If no. why? ----------

134. What other avenues will be good or suitable for obtaining information on HIV/AIDS?

1.

2.

3.

135. State three **main** ways by which you believe AIDS is transmitted in Ghana?

1.

2.

3.

136. How can people protect themselves from getting HIV/AIDS?

1.

2.

3.

4.

137. State three physical problems or symptoms a person might have that suggest that he or she has AIDS.

1.

2.

3.

138. Is there any cure for HIV/AIDS presently? 1 = yes 2= no **(go to 140)**

139. If yes, how?

---

140. How has your knowledge of AIDS influenced or changed your sexual behaviour?

1.

2.

3.

141. Whom do you consider to be the **most** vulnerable to HIV/AIDS infection?

1.

142. Do you think your chances of getting HIV/AIDS are small, moderate, great or that you have no risk at all?

1= small
2= moderate
3= great
4= no risk at all
5= is HIV positive already
6= don't know

143. What is the **main** reason for your response?

1.

144. What are you doing to prevent/ reduce your risk of infection?

1. =Abstaining 2. =Keeping to one partner 3. Using condoms 4. =Prayer 5. = Nothing

145. Have you ever done a voluntary counselling and testing for HIV/AIDS? 1 = yes **(go to Q148)** 2 = no

146. Would you willingly undergo voluntary counselling and testing for HIV/AIDS? 1= yes **(go to Q148)** 2 = no

147. If no, give reasons

_____

148. If you were to test positive for HIV/AIDS, would you tell your partner? 1= yes **(go to Q150)** 2= no

149. If no, give reasons

_____

150. If you had to seek treatment for HIV/AIDS, would you use health services at the hospital if these were available?

1= yes **(go to Q152)** 2 = no

151. If no, why?

_____

152. Where will you go for help?

_____

153. If you were to test positive for HIV/AIDS, would it influence your decision to have children?

1= yes **(go to Q155)** 2= no

154. If no, why?

_____

155. If your partner were to test positive for HIV/AIDS, how would it affect your relationship with him/her?

1._____

2._____

3._____

156. Do you personally know someone who has AIDS or died of it? 1= yes 2= no

157. Do any of your family members have AIDS or have died of AIDS? 1= yes 2= no **(go to 159)**

158.How did the family treat such a person (s)?

---

159. What do you suggest is the **most** important thing your community should do for a member who has HIV/AIDS?

1.

160. List two main roles that you expect your community members (who are at risk of HIV) play in the fight against the spread of HIV/AIDS?

1.

2.