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**A STUDY OF THE THREAT OF HIV/AIDS TO
ADOLESCENTS IN HOHOE DISTRICT
OF THE VOLTA REGION**

BY

ANTHONY AMOBIRE ALEKA

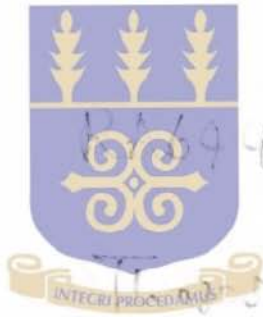


SUBMITTED TO:

**SCHOOL OF PUBLIC HEALTH UNIVERSITY OF GHANA,
LEGON IN PARTIAL FULFILMENT OF THE REQUIREMENTS
FOR THE AWARD OF THE MASTER OF PUBLIC HEALTH
DEGREE**

SEPTEMBER, 2001

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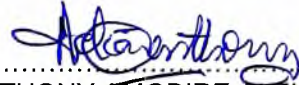


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DECLARATION

I hereby declare that this dissertation is produced by me from a study personally undertaken in the Hohoe District of The Volta Region under supervision in partial fulfilment of the programme for the award of Master of Public Health (MPH) Degree

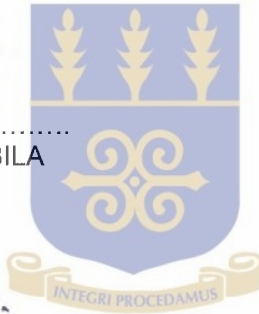


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ACKNOWLEDGEMENT

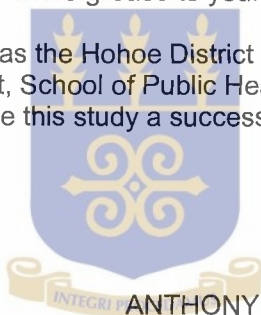
I wish to express my sincere gratitude to Dr Margaret Kweku District Director of Health Services Hohoe, (my Field Supervisor) for her patience and continual guidance during the period of my stay in her district, which enabled me, undertake this study

I wish to also acknowledge Mr S. Thompson Nursing Officer (PH) at the Hohoe DHMT for the unflinching efforts he made in taking me around most areas of the district for the collection of my data.

I also wish to thank the rest of the DHMT members especially Miss Edith G. Bio statistician for their support and co-operation during my stay in Hohoe district without which it would not have been possible to carry through this project.

To my academic supervisors Prof. John S. Nabila and Dr. Phyllis Antwi as well as the rest of my lecturers I cannot sufficiently thank you for all that you have done for me. All I can say is "more grease to your elbows"

Finally, to the other sectors as the Hohoe District Assembly, Hohoe GES, the SDHT of Akpafu Sub-district, School of Public Health staff and all those who in diverse ways helped to make this study a success, I say a big thank you.



ANTHONY AMOBIRE ALEKA
MPH RESIDENT 2000-2001

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ABSTRACT

Though the threat of HIV/AIDS is universal, there appears to be a real threat of the disease to the young people of Hohoe District in the Volta Region. The district was selected in 1999 from the national level for HIV/AIDS control activities following progressively increasing results from Sentinel Surveillance Surveys conducted on antenatal clinic attendants at the Hohoe District Hospital (a sentinel site) where only 50% of pregnant women attend.

The HIV prevalence in the district is 4% as against the national average of 5%. Besides, records in the district show a persistently high level of teenage pregnancies (above 10% of all antenatal attendants). This presupposes that the young people in the district are not protecting themselves and as such could be at a real threat of contracting HIV/AIDS. This study, which is a cross-sectional one, was conducted during the MPH field residency period, on both in-school (ISA) and out-of-school (OSA) adolescents aged 15-19 years and is aimed at validating this threat

Information was sought on the Socio-demographic characteristics, sexual behaviour, knowledge of causes and prevention of HIV, ability to identify infected persons, susceptibility and whether the condition is amenable to treatment. The findings of the study revealed incidence of premarital sex with little or no protection (low condom use) and other misconceptions on the status and modes of transmission of the disease. Recommendations have therefore been made for prevention and control programmes.

The field supervisor was Dr. Margaret Kweku, the District Director of Health Services (DDHS) of the district whilst the academic supervisors were Prof. J.S. Nabila and Dr. P. Antwi both of University of Ghana.

The findings of the study will serve as a database for the planning and implementation of programmes for the prevention and control of STDs/HIV/AIDS in the district.

CHAPTER 1

1.0 INTRODUCTION

1.1 Statement of the Problem

The threat of HIV/AIDS is universal, affecting the sexually active members of society who incidentally are the young people. Of all the new cases that occur daily worldwide, half are believed to be in Sub-Saharan Africa. Recent reports suggest that, of all the people living with HIV/AIDS (PLWA) in the world, 8 in 10 women and 6 in 10 men are in the sub-Saharan African countries. [1] Control of the pandemic appears therefore, to be the most serious challenge to the world especially to Africa, south of the Sahara.

Globally, effective lifestyle and behavioural changes resulting in the promotion and practice of safe sex has been seen to be the fundamental component of the strategy for the prevention and control of the spread of heterosexual transmission of HIV/AIDS. So as part of efforts to address this issue in Africa, a Regional Project on HIV and development was established in Dakar, Senegal in June 1992 with a two-fold objective of **Advocacy and National Capacity Building** [2]

An evaluation of this Project in 1994 highlighted a number of weaknesses. These included: **working with/strengthening existing institutions already active in responding to the epidemic** and **effective collaboration with agency partners**. In response to this and a realisation of the multi-dimensional nature of the HIV epidemic and its implications for all aspects of human life and development, an agreement was reached for a period of **Bridging Programme** in the form of:

- ◆ Continued advocacy and support for innovative works

- ◆ Building capacity to effectively respond to socio-economic dimensions of the epidemic
- ◆ Promoting innovative community-based responses to the epidemic
- ◆ Engendering all programme responses

Similarly the participants of the International Conference on Population and Development (ICPD) held in Cairo that same year identified and drew a programme of action indicating the need for adolescents to have access to appropriate direction and guidance in areas of sexual and reproductive health consistent with their evolving maturity. The conference therefore enjoined governments to act with the support of the international community, to protect and promote the rights of adolescents to reproductive information and care as well as strive to reduce STDs including HIV/AIDS and teenage pregnancy. [3]

In 1996 UNAIDS, (a joint and co-sponsored UN programme on HIV/AIDS, comprising of UNDP, UNESCO, UNFPA, UNICEF WHO and the World Bank) officially began working to promote and support more effective and complimentary co-operation within the UN system in response to the epidemic, with emphasis on supporting effective and sustainable multi-dimensional country level responses.[2]

At the five year review of the ICPD in 1999 governments established the goal of providing at least 90% of the young people aged between 15 – 24 with access to preventive methods by the year 2005 in order to reduce vulnerability to HIV infection. [4] As a result every nation and every sector of the Health Services is giving greater attention these days to the need for HIV/AIDS/STDs education, prevention and control

In Ghana HIV/AIDS transmission has been found to be largely through heterosexual contact (80%) with mother-to-child transmission and blood transfusion accounting for only 20%. [11, 12, 32] Control measures instituted to control and prevent the spread of HIV/AIDS on the mass media as well as in seminars and symposia include:

1. Interventions to control spread of HIV/AIDS through heterosexual transmissions by:
 - Promoting Safe Sex in the form of abstinence or faithfulness
 - Reducing overall number of sexual partners
 - Delaying the onset of sexual activity among adolescents
 - Promoting use and availability of male and female condoms
 - Controlling other Sexually Transmitted Diseases
 - Encouraging voluntary Counselling and testing.
2. Interventions to reduce mother to child transmission by:
 - Providing Voluntary Counselling, test and Family Planning
 - Reducing transmission through breastfeeding and
 - Use of Anti-viral Therapy.
3. Interventions to reduce transmission through Blood Transfusion and other sharps
 - Ensuring safe blood for transfusion
 - One patient one syringe at a time
 - Discouraging sharing of sharps such as razors etc.

In spite of these IE & C messages HIV/AIDS appear to be on the increase in the country [6] as it is estimated that about 200 people get infected with the virus each day.

The Adolescent Reproductive Health Policy for Ghana was drafted in 1996.[7] and all sectors of the health services have to actively participate in developing programmes on Adolescent Reproductive Health (ARH) specifically directed at controlling the spread of HIV/AIDS. In lieu of this, there is the need for baseline data on the knowledge, attitude and practices of the adolescents or young people to service as a starting point for take off in every district.

1.2 BACKGROUND OF STUDY

The last century saw the world besieged by a new crop of diseases caused by unhealthy lifestyles or risky behaviours of societal members. The most serious of these is HIV/AIDS. This is because the disease has developmental implications but no cure and is therefore threatening to destroy the very fibre of society. Since the discovery of HIV/AIDS about two decades ago, it is estimated that about 21.8 million people have died from it. At its inception, society did not feel that much threatened because, the disease was deemed to be a disease of male homosexuals who practised anal sex. As a result, women were not considered susceptible to it. About a decade later, the tables seemed to have turned upside down drastically putting women at the centre of concern as heterosexual transmission become a major route of transmission of the disease.

Today, the youth and especially the young adolescents have become the main locus of concern. This followed the realisation that many adolescents become sexually active at an earlier age than usual.[8] For instance the WHO Regional Report for Africa (1998) indicated that adolescent boys and girls in most African countries become sexually active between the ages of 12-13 years. So that by age 15 years about 56% of them would have been having

regular unprotected and premarital sex resulting in unwanted pregnancies unsafe abortions, STDs including HIV/AIDS and other social consequences such as school dropouts. In Ghana, a study also revealed that by age 19 years, 99% of adolescents had experienced sex.[9] Another study even reported sexual activity in adolescent girls as young as 10 years old.[10, 11]

This realisation coupled with the general vulnerability of adolescents resulted in the declaration of the Rights of adolescents to reproductive health, in its programme of Action at the International Conference on Population and Development held in Cairo in 1994. This declaration enjoined all countries to institute policies to protect and promote the right of adolescents to Reproductive Health services and strive to reduce STDs and teenage pregnancy amongst other things. As a result of this Ghana drafted a policy on Adolescent Reproductive Health in 1996, which requires all sectors of the health system to initiate programmes accordingly.[7]

In Ghana and for that matter Africa, young adolescents especially girls, are drawn into early premarital sex for a number of reasons among which are social, biological, and economic. Invariably the most important of these are “economic reasons” though, some adolescents have been found to regard sex as an unavoidable biological and pleasurable necessity. The high poverty levels of parents in this part of the world compel most adolescents to resort to early sexual activity usually with elderly people (Sugar Daddies and Sugar Mummies) for financial support [9]

The biological vulnerability of the young adolescent girl, which makes her more susceptible to STDs including HIV/AIDS than her male counterpart cannot be over-emphasised. Her larger genital mucosal surface area exposure, immature cervix and relatively low vaginal mucus production present less of a barrier to infections than older pre-menopausal women (WHO 1993). Hence the need for specially designed risk reduction programmes for the group since the early initiation of sexual activity marks the beginning of the period of high risk to STDs/HIV/AIDS especially unprotected sex.[12]

The simplest solution as imagined by most people is simply either the adoption of abstinence from sex or the use of condoms. This is on the assumption that mere self-awareness of risk behaviour and knowledge of the dangers, mode of transmission and methods of prevention of HIV/AIDS would suffice to make people adopt safe sex to avoid the infection. Unfortunately, studies have shown that this is not as simple as it appears since risk behaviours are influenced by personal and societal factors that determine vulnerability to infection.

For instance, ethnicity, which determine to a large extent the attitudes, beliefs and values of individual societies, have been shown to play a very important part in the knowledge, attitude and practice of safe sex. [13, 14, 15, 10]

1.3 The Study Area

The study was carried out in the Akpafu sub-district and Hohoe urban areas in the Hohoe District with a total population of about 47,835. Akpafu sub-district is one of the 6 sub-districts of the Hohoe district of the Volta Region. The sub-district is a mountainous one and is basically divided into two parts by a range of mountains (Akpafu range) which is an

outgrowth of the Akwapim-Togo range. Geographically the sub-district is bounded to the south by Alavanyo sub-district, and to North, East and west by the Jasikan District. It has 16 communities and four (4) traditional areas or ethnic groups namely the Akpafus, Santrokofis, Lolobis and the Likpes. Like the rest of the district, Akpafu sub-district has semi-deciduous forest vegetation in nature and covers an area of 65 square kilometres. Its population is approximately 20,737. In terms of Health facilities, the sub-district has 4 Health Centres with one located in each traditional area. In terms of educational facilities, it has 2 Day Care centres, 11 Kindergartens, 16 Primary Schools, 12 Junior Secondary Schools and 3 Senior Secondary Schools. The main religious practices in the district are Christianity, Islam and traditional worship. Industrial activities undertaken in the sub-district include farming, livestock rearing and trading. There is a network of roads linking all parts of the sub-district.[16, 17]

Hohoe Urban on the other hand, is part of the Alavanyo sub-district located to the south of Akpafu sub-district. It is the capital town of the Hohoe District and comprises of a total of 26 communities with a population of about 27,098 people. In terms of educational facilities, it has 2 Day Care Centres, 22 Kindergartens, 16 Primary Schools, 11 Junior Secondary Schools, 2 Senior Secondary Schools, 5 other Schools (Training Colleges 2, Technical 3 and Vocational 2).[16, 17]

1.4 Rational for the Study

Hohoe district has numerous second cycle institutions (80), hotels and tourist attractions. It is also strategically located on a main high way thereby serving as a transit point for long distant travellers. The district has being active in its AIDS control programmes. The DHMT has been organising health education talks on adolescent sexuality,

STDs/HIV/AIDS and teenage pregnancy in schools, churches, communities and social gatherings. Institutional in-charges, nurses and other staff are trained to make their facilities youth friendly and to provide services without discrimination and judgmental attitudes. [18]

In spite of these programmes, the district's record of teenage pregnancy has remained progressively high (that is, above 10% of antenatal registrants each year) over the past four years ranging from 11.5% in 1997 to 14.9% in 1999 reducing slightly in 2000 to 12.8%. (Refer to table 1). This literally implies that a meaningful proportion of the adolescents may not practising safe sex, or for that matter do not protect themselves against pregnancy, STDs and of course HIV/AIDS. This concern was raised in the form of a news item, which appeared on page 13 of the 21st of January 2001, edition of the 'Daily Graphic', which read: ***"Hohoe area records more teenage pregnancies."***

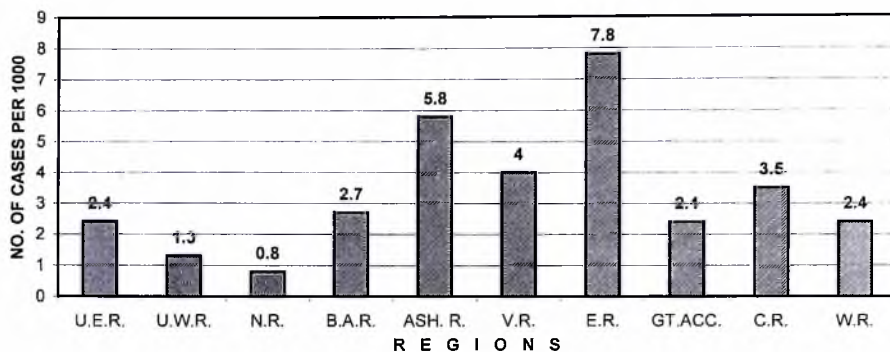
TABLE 1. Incidence of Teenage Pregnancies from 1997 – 2000 in Hohoe District

YEAR	1997	1998	1999	2000
TEENAGE PREGNANCIES	11.5%	12.5%	14.9%	12.8%

Source: 2000 ANNUAL REPORT, HOHOE DHMT

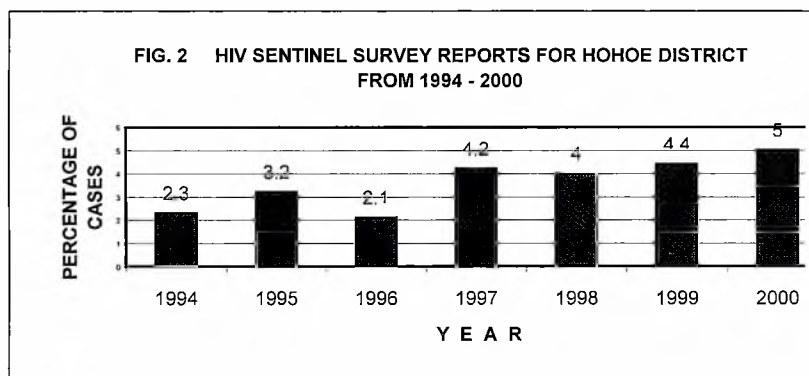
Besides these facts, no institutional data on HIV/AIDS exist in the district. However, health statistics indicate that the Volta Region has the third highest number of HIV/AIDS cases in the country as at September 2000. (Refer Figure 1)

FIG. 1 NO. OF CASES OF HIV/AIDS BY REGIONS as AT SEPT. 2000



Source: DCU, MOH,

Sentinel surveillance surveys carried out among pregnant Antenatal Clinic attendants over a period of time at the Hohoe District Hospital where only about 50% of pregnant women attend also revealed rising levels of HIV prevalence rate from 2.3% in 1994 to 5% in 2000. [11] Refer to Figure 2



SOURCE: DCU/MOH GHANA

The DHMT therefore views this a serious Public Health Concern and a possible threat of HIV/AIDS to the young people; hence the need for this study. [18] The study will

therefore serve as a source of baseline data for planning more acceptable and relevant programmes for the prevention and control the spread of disease in the district.

Though a number of similar studies have been carried out on adolescent sexuality in other parts of the country [10, 11, 19 20, 21, 22, 23], no such study has ever been carried out in the district. The study therefore serves both as a body of knowledge and as a source of baseline data for the district.

1.5 Objectives Of The Study

1.5.1 Main Objective

To determine and describe the local knowledge, risk perception, attitudes and practice of sexual behaviour of the young people of Hohoe District that may predispose them to getting HIV/AIDS infection.

1.5.2 Specific Objectives

1. To determine the socio-demographic characteristics of the adolescents of the Hohoe District.
2. To determine the local knowledge and attitudes of the adolescents relating to sexual practices.
3. To determine the local knowledge and attitudes of the adolescents towards HIV/AIDS infection.
4. To determine whether level of education has any significant influence on the perception or type of protective sexual behaviour (safer sex) the individual adopts.

Chapter 2

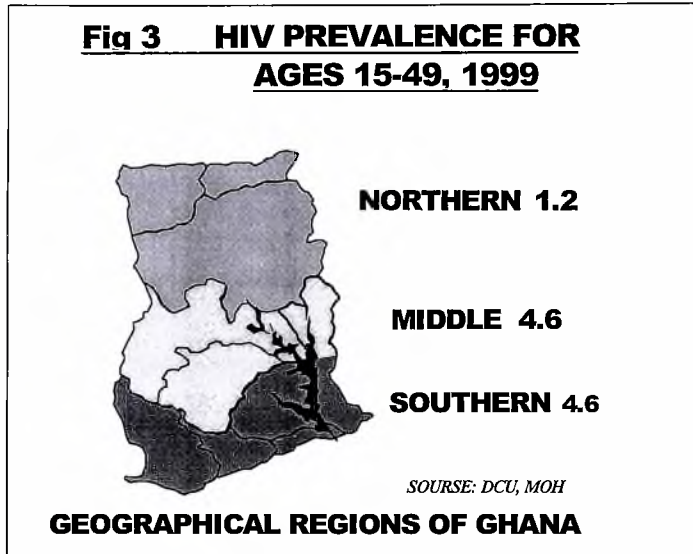
2.0 LITERATURE REVIEW

HIV/AIDS is said to be a lifestyle disease of worldwide concern and a developmental issue with no known biomedical solution but is only amenable to appropriate behavioural change. [8, 24]

WHO estimates that about one-half (50%) of all reported cases and 60% of all new cases of HIV/AIDS the world over fall between the ages of 15-24 year olds. Similarly, UNFPA (1998) estimated that about 50% of HIV infected people acquired the infection between the ages of 15-24 years. Sexually Transmitted Diseases, which are said to correlate highly with HIV/AIDS, is said to infect 1 in 20 adolescents world-wide every year. [25] Similarly, the U.S. (CDC) estimates that 1 in 4 sexually active teen will get a STD by age 20 years.

In Ghana, statistics indicate that HIV/AIDS is increasing rapidly at an exponential rate infecting about 200 people each day, affecting the southern parts of the country most. The first HIV/AIDS case appeared in Ghana in 1986 and this rose to 29,550 cases in 1998 and currently 41,229 infected cases were reported as at September 2000 (which is estimated to be only 30% of actual cases).[5] The estimated prevalence rate is 4.6 and regional variation fall between 1.2 – 4.6% as shown in Figure 3

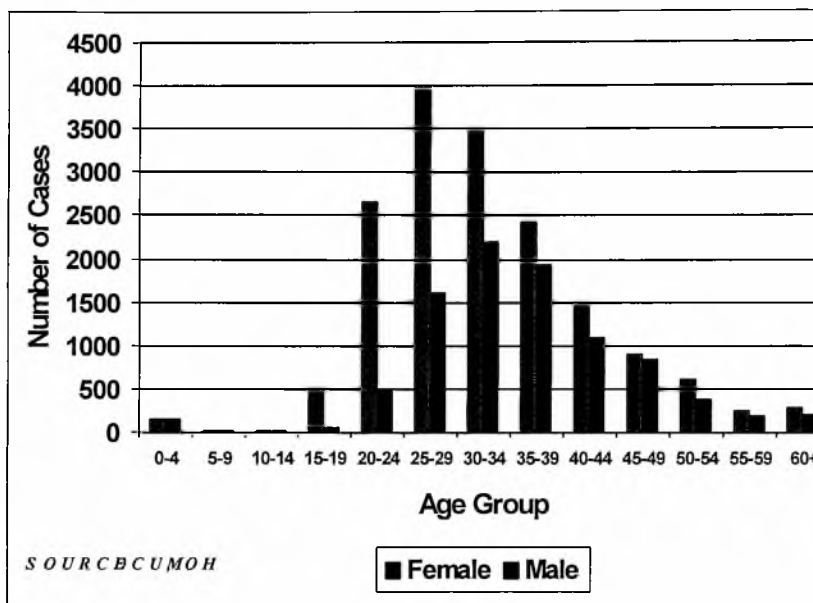
Fig. 3 MAP OF GHANA SHOWING THE DISTRIBUTION OF HIV/AIDS AMONG THE THREE ECOLOGICAL ZONES OF THE COUNTRY



Two-thirds of reported cases are believed to be females with the highest prevalence occurring among the 25 – 29 year-old group with adolescent girls aged between 15-19 accounting for 1.2% of cases (in spite of our poor records keeping system).[5]

(Refer Figure 4)

Fig. 4. DISTRIBUTION OF AIDS CASES BY AGE AND SEX IN GHANA AS AT SEPT. 2000



Source: DCU, MOH

Notwithstanding, a number of studies in the country have shown that nearly every one has heard of HIV/AIDS (80%) but in reality only a very few people seem to really understand the disease and its implications. [10, 26]

Studies into areas of adolescent sexuality identified several factors as been accountable for the utmost vulnerability of the adolescents to HIV/AIDS. These include: biological vulnerability to infection, the age of initiation of sexual activity, number of sexual partners (promiscuity), type of sexual activity (e.g. heterosexual or anal), degree of Condom use, and history of previous or repeated infection with other STDs.[21]

Ethnicity has also been identified as a major factor that influences the knowledge, attitude and practise of risk behaviour of individual. [27,28]. Knowledge, attitudes, beliefs and values are therefore important factors that must be considered in issues of adolescent sexuality, since they can give rise to a lot of conceptions and misconceptions, which will affect the type of protective behaviour that will be practised by the individual [29]. In 1989, the U.S. National Students survey revealed that many adolescents had no knowledge or had misconceptions about how to avoid STDs/HIV/AIDS infection. Where as 12% of the respondents thought, “birth control pills provided protection against STDs including HIV/AIDS”, 23% believed “it was possible to tell by looking at a potential partner whether he/she had HIV/AIDS.” Similarly, the 1988 U.S. CDC report indicated that, even though more than 50% of teenagers aged 15-19 admitted in a study to having sex in the previous three months, only 25% of them reported using condom.

Similar findings have been found in other studies carried out in Ghana. Nabila & Fayorsey (1995) in their study among 10-20 year olds reported the erroneous believe by many adolescents that, unprotected sex at first time or only occasionally cannot result in pregnancy. In 1996, Nabila & Fayorsey again reported high sexual activity among unmarried teens with low contraceptive use. In another study, condom use was associated with casual sex and therefore tended to be ignored in either more stable relationships or with sexual partners regarded as “healthy.”[30] Some respondents also associated HIV/AIDS with people who had travelled outside the country and therefore felt it was safe to indulge in sexual intercourse (without any protection) with those who do not have such a history. Others also associated the risk of HIV/AIDS infection with sexual promiscuity and mere social contact.

McCombie & Anarfi (1991), reported that many young people believed that there was a cure for AIDS and that they did not have to worry about the disease. These and many other misconceptions may be the reasons for the exponential growth of the disease in Ghana and for that matter Africa as a whole in spite of sustained campaigns to prevent and control the spread of the disease.

Chapter 3

3.0 INSTRUMENTS AND METHODS

3.1 Type of Study

This is a cross-sectional study of In-school and Out-of-school Adolescents

3.2 Variables

Demographic/personal background characteristics

Reproductive health behaviour (sexual practices)

Protective behaviour

Knowledge and perception of HIV/AIDS/STDs

3.2.1 Definition of Variable

Adolescent in this study is the period between 15 – 19 years of age

Personal background Information – Demographic Characteristics

Reproductive Health Behaviour – Sexuality or sexual intercourse practices and relations

Protective Behaviour – Condom use or Safe sex practices

Knowledge and perception of HIV/AIDS and other STDs – What respondents know and feel about HIV/AIDS/STDs

3.3 Data Collection Techniques and Tools

Person to person interviews was conducted to collect information from respondents. Structured questionnaires with both opened and close-ended questions were the tools for the data collection.

3.4 Training of Research Assistants and Pre-test

Research Assistants fluent in the local dialect were selected and given training as follows:

Self-introduction and creation of rapport

Translation of questions into the local dialect and back to English

Administration of questionnaire

Importance of providing privacy and reassurance of confidentiality and anonymity of respondents' views and identity.

Pre-test of the questionnaire was carried out on different subjects in communities other than those in the inclusion criteria. This was to ensure that the Research Assistants understood the procedure well and also served as a means of validating the instrument.(questionnaire)

3.5 Sampling

The Inclusion Criteria was males and females aged between 15 – 19 years. A multi-stage sampling procedure was used to select subjects for the study. The study was conducted in one urban and one rural community in the district because of logistics and financial constraints. Hohoe Township being the only urban community in the district, stood unopposed. The lottery method of random sampling was then used and the Akpafu sub-district was selected as the rural community to be used in addition to Hohoe urban for the study. There were a total of 38 communities, twenty-two (22) JSS and four (4) SSS in the

study area. Simple random sampling technique using the lottery method was used to select 15 communities and 10 schools for the study. For each of the schools a list of the names of students who satisfy the inclusion criteria was collected and systematic sampling used to select 15 students from each school as the “in-school” respondents.

In the selected communities systematic sampling technique was used to select 10 compounds from each community where one respondent per compound was interviewed (as the “out of School” respondents). There was an average of 30 compounds in each of the communities studied. Research Assistants (RA) were required to go to the centre of the community or market place. They then chose a direction in a random way by spinning a pen and choosing the direction the nip of the pen pointed to. They then randomly selected a compound among the first three compounds using the lottery method as a starting point. The R.A. then walked in the chosen direction and selected every other third compound until the ten have been obtained. If the R.A. reached the edge of the community and was still unable to obtain the ten compounds, he/she went back to where he/she began and walked in the opposite direction and continued to select the sample until the ten were obtained. If a chosen compound had nobody in the inclusion criteria, the next nearest compound to that one was taken. If the R.A. was still unable to get the required number of respondents, the he/she was to go back to the centre again and this time toss a coin to choose which of the remaining two directions to go first.

3.6 Sample Size

The formula for simple proportion was used to calculate the sample size. A sample size of 256 was obtained and this was rounded up to 300. (150 in-school and 150 out-of-school)

3.7 Data Handling

Raw data checks, validation, sorting, processing and storage was carried out in the office of the District Health Administration. Data entry was done using computer software and analysis was done using Epi Info 2000 Statistical package.

3.8 Quality Control of Data

The questionnaires were numbered and given different identification marks for each of the two categories of respondents. The Principal Investigator did the numbering and coding before the questionnaires were sent to the field. Completed questionnaires were edited in the field immediately after collection to ensure that all the information required had been collected and properly recorded to ensure completeness and internal consistency.

3.9 Ethical Considerations

Clearance to undertake the study was sought through the District Health Administration, to the District Assembly, the District Education Office, the Headmasters of the various schools and the traditional leaders of the selected communities.

During the administration of the questionnaire, culturally permissible terms were identified and used to avoid pornographic undertones. Informed consent and strict privacy was adhered to while respondents were assured that their views and identity will remain strictly confidential and their names were not required.

3.10 LIMITATIONS OF THE STUDY

As indicated by a number of researchers, surveys of sexual behaviour are always subject to a number of biases including presentation bias since respondents are inclined to

give socially acceptable or desirable responses rather than truthful ones. [28] However with the method used for the data collection, the frequency of untruthful answers will be minimal if not completely eliminated. There were few instances especially in the schools when chosen subjects had to be replaced with opportunistic samples because they were absent on the day of administration of the questionnaire.

Notwithstanding, the findings can be considered a fair representation of the local knowledge, risk perception, attitudes and practices of sexual of sexual behaviour of the adolescents of Hohoe District that may predispose them to HIV/AIDS infection. The findings of the study can therefore be generalised to the entire population of adolescents or young people in the district and as such used for planning HIV prevention and control programmes for them.

Chapter 4

4.0 RESULTS

4.1 Background characteristic of respondents

4.1.1 Age

The minimum age was 15 and the maximum 19 years with a mean age of the in-school respondents being 16.3 years and a modal age of 15 while that of the out-of-school respondents was 17.3 years and 19 years respectively. Below is a summary table of the percentage distribution of the various age groups for both the in-school (ISA) and out of school adolescents (OSA) interviewed. Refer Table 2

4.1.1 Sex

Out of the 300 respondents, 147 (49%) were males and 153 (51%) females. The in-school respondents were made up of 74 (49.3%) males and 76 (50.7%) whilst the out-of-school were made up of 73 (48.7%) and 77 (51.3%). The reason for the disparity was that there were less males in the study area who satisfied the inclusion criteria. See Table 2

Table 2 SUMMARIES OF BACKGROUND CHARACTERISTICS OF RESPONDENTS

Characteristic	IN-SCHOOL	OUT-OF SCHOOL
	N = 150	N = 150
Age	%	%
15	36	18
16	26.7	13.3
17	19.3	17.3
18	12	20.7
19	6	30.7
Sex		
M	49.3	48.7
F	50.7	51.3
Education		
Never	0	2
Primary	2.6	10
JSS	69.3	74.7
SSS	28	13.3
Religion		
Christian	94.7	94
Muslim	4.6	6
Marital Status		
Married	0.6	4
Single	99.3	96

4.1.3 Educational Characteristics

Only 3 (1%) of the total number of respondents (out-of-school) had never had any formal education. 19 (6.3%) had primary school education, 216 (72%) had JSS, 60 (20%) SSS and 2 others had tertiary education. Refer table 2 for breakdown of in-school and out-of-school respondents.

4.1.4 Marital Characteristics

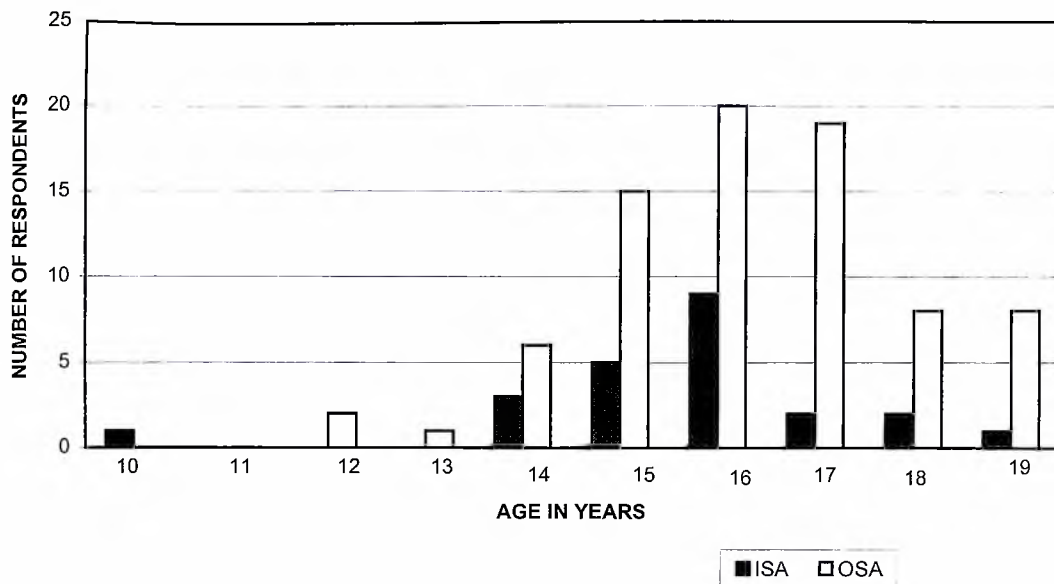
Only 7 (2.3%) of respondents were married made up of 1 (0.3%) in-school and 6 (2%) out of school. The remaining were all single and had never being married before.

4.1.5 Religious Characteristics

Majority of respondents 283 (94.3%) were Christians with only one respondent being a Buddhist. The remaining 16 (5.3%) were all Muslims. Refer Table 2 for breakdown of in-school and out-of-school respondents.

4.2 Reproductive health or Sexual Behaviours

A total of 107 (35.7%) of respondents comprising of 26 (8.6%) in-school and 81 (27%) out-of school, were sexually active or had had sexual intercourse before. Out of this number only 93 (86.9%) made up of 17 (15.9%) in-school and 66 (61.8%) out-of-school respondents had regular partners. Age at first sexual intercourse ranged between a minimum of 5 years to a maximum of 19 years. However the actual minimum age for consent to sex was 10 years. The 5 (4.7%) comprising of 2 (7.7%) in-school and 3 (3.7%) out of school respondents were said to have been raped. See Fig. 5

FIG. 5 AGE AT FIRST CONSENTUAL SEX

As to the keeping of multiple sexual partners, of the 83 (19 ISA and 64 OSA) who were sexually active, 59% had changed more than two sexual partners

4.2.1 Attitude and perception of Sex

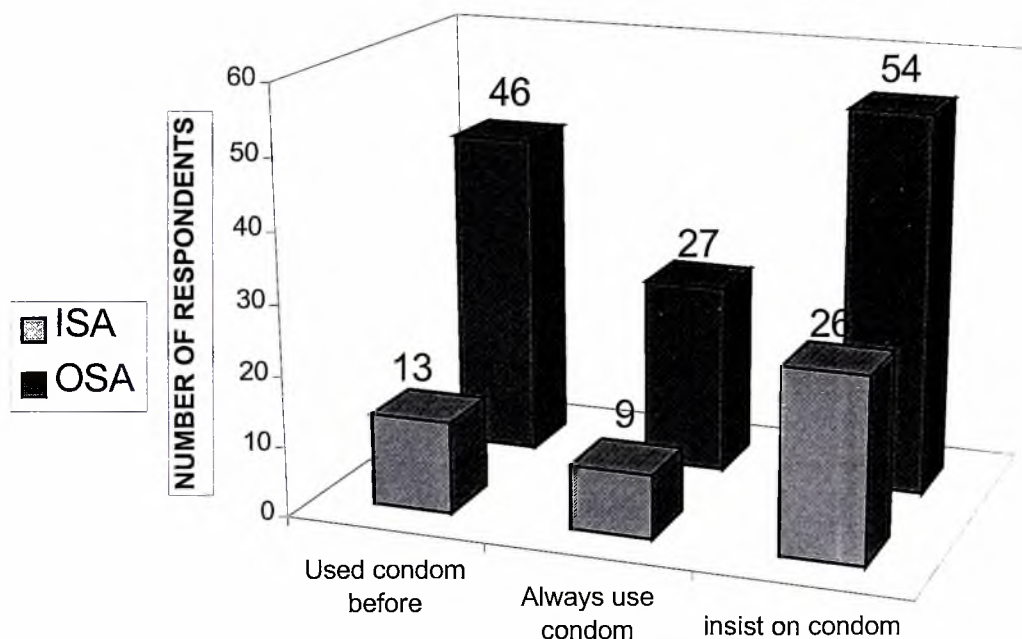
Eight (5.3%) of in-school and 12 (8%) out-of-school respondents erroneously believe that something adverse could happen to an adolescent who was not sexually active such as frequent sickness, anxiety, foolishness or stupidity; whilst 16(10.7%) in-school and 17 (11.3%) out-of-school respondents, however did not know if anything could happen to such a person or not. The remaining were however confident that nothing could happen to such a person.

In answer to another question 13 (11.3%) in-school and 9 (6%) out-of-school respondents agreed with the misconception that any adolescent boy/girl who was not sexually active could become foolish or stupid.

4.2 Protective Behaviour (Condom use)

Majority of respondents 142 (94.7%) in-school and 144 (96%) out-of-school, had either heard of or seen a condom before but only 13 (8.6%) in-school and 46 (30.7%) out of school, had ever used one. Refer fig 6

FIG. 6 DEGREE OF CONDOM USE



4.4 Knowledge and Perception of HIV/AIDS/STDs

4.4.1 Knowledge of HIV/AIDS

One hundred and forty-seven (98%) in-school and 149 (99.3%) out-of-school respondents, had heard of HIV with only 3 (2%) in-school and 1 (0.6%) out-of-school saying they had never heard of it before. Of this number, 82 (55.8%) in-school and 99 (66.4%) heard

of HIV/AIDS from the Mass media (TV, Radio), 31 (10.5%) from health workers, 49 (16.5%) from teachers, 12 (4%) from friends/colleagues, 7 (2.4%) from parents, 3 (1%) from churches/mosques and 13 (4.4%) from other source such as NGOs (eg Pro-link)

4.4.2 Perception of HIV/AIDS

One hundred and twenty-one (82%) in-school and 137 (91.9%) out-of-school respondents indicated that HIV/AIDS can be avoided while 23 (7.8%) indicated otherwise. The remaining 16 (5.4%) did not know whether it can be avoided or not. Of the 23 who indicated otherwise, 18 were In-School respondents whilst the remaining 5 were Out-of-School respondents.

About a quarter of the respondents 76 (25.7%) made up of 35.4% in-school and 16.1% out of school, were of the view that a healthy looking person cannot have HIV/AIDS while 22 (7.4%) did not know whether a healthy looking person could have HIV/AIDS. The remaining 198 (66.7%) however were positive that a healthy looking person could have the condition. Here too the in-school respondents represented 52 (68.4%) of the 76 who expressed the negative view.

Another third of respondents 85 (29.7%) claim they could identify any person having HIV/AIDS of which the in-school respondents were the majority (ie 57 - 67%). 210 (70.9%) indicated otherwise with only one person claiming ignorance.

As to the risk of getting infected with HIV/AIDS (perceived risk), about half of the entire respondents 152 (51.3%) made up of 85 (57.8%) in-school and 67 (45%) out-of-school, thought they were not at any risk of infection for various reasons. However, 30.6% in-school

and 52% out-of-school respondents believed they were at risk of infection with the virus while the remaining 4.6% and 2.7% respectively did not know whether they were at risk or not.

Nineteen (12.9% in-school and 5 (3.4%) out-of-school respondents believed HIV/AIDS can be cure while 13 (8.8%) and 13 (8.7%) respectively had no idea as to whether the disease can be cured or not. The remaining 78% in-school and 87.0% out-of-school, however were positive that the disease has no cure

4.4.3 Knowledge of Modes of Transmission

Nineteen (12.7%) in-school and 17 (11.4%) out-of-school respondents believed that HIV/AIDS can be contracted from eating with an infected person, 75 (50%) in-school and 84 (56.4%) out-of-school, from staying with an infected relative, 87 (29.4%) from mosquito bites, 14 (4.7%) from shaking hands with an infected person, and 281 (94.9%) from sharing razors/toothbrushes. As many as a third of respondents 98 (33.1%) did not think that HIV/AIDS could be contracted through kissing an infected person while 10 (3.4%) did not believe that the disease can be got through sharing razors/toothbrushes. (See table 4)

TABLE 3 SUMMARY OF KNOWLEDGE OF RESPONDENTS ON MODES OF TRANSMISSION OF HIV/AIDS

MODE OF TRANSMISSION	IN-SCHOOL (ISA) N = 150			OUT-OF-SCHOOL (OSA) N = 150		
	YES	NO	D. K.	YES	NO	D. K.
Eating with infected person	% 12.7	80	7.3	11.3	80	8.7
Kissing an infected person	% 50	35.3	14.7	56	30	14
Staying with an infected relative	% 20	73.3	6.7	21.3	71.3	7.3
Mosquito bite	% 28.7	67.3	4	29.3	62	8.7
Shaking hands with infected	% 5.3	90.7	4	4	92.7	3.3
Sharing razors/toothbrushes	% 95.3	2.7	2	92	4	4

* D.K = Don't know

As to who gets infected with HIV/AIDS, 53 (35.3%) ISA and 91 (60.7%) OSA thought anybody. 41 (27.3) ISA and 16 (10.7%) ISA thought only those who have unprotected sex while 8 (5.3%) ISA and 2 (1.3%) OSA thought females only, and 2 (1.3%) ISA with no OSA thought males only. Of the remaining, 18 (12%) ISA and 11 (7.3%) OSA thought only prostitutes could get infected while 25 (16.7%) ISA and 29 (19.3%) OSA gave other categories such as those who keep changing partners. It was however generally agreed by most participants, 142 (94.7%) ISA and 146 (97.3%) OSA that, a person with many sexual partners and a person whose partner has many other sexual partners 137 (91.3%) ISA and 146 (97.3%) were at risk of getting infected with the disease. The remaining had a contrary view or did not know whether the said persons were at risk or not.

4.4.4 Previous infection with others STDs

Eighty-four (56%) ISA and 101 (67.3%) OSA knew of other STDs besides HIV/AIDS while as many as 66 (44%) ISA and 49 (32.7%) OSA did not know. A total of 6 (2%) respondents had ever had a STD infection (gonorrhoea) and were treated. These comprised of 2 (1.3%) ISA and 4 (2.7%) OSA respondents.

CHAPTER 5

5.0 DISCUSSIONS

5.1 Background characteristics

There was a predominance of respondents aged 15 years in the in-school group while that of the out-of school group was the 19-year-old group. In each of the groups however, the female domination was universal. Literacy level was very high (99%) with most of the respondents being Christians. As expected most respondents were not married with only 2.3% being married. This is low compared to other similar studies, which recorded 6.5 % or more of married adolescents aged 15-19 years. [11].

5.2. Reproductive Health Behaviour (Sexuality) or practise of sexual intercourse

Increasingly young adolescents, especially the females as found in this study, begin sex at an earlier stage of life whether coercive (sexual abuse) or consensual i.e. below 10 years of age. [43] At such a tender age, the girl child is not biologically matured to withstand the sex ordeal. This is because, their immature cervix and their relatively low vaginal mucus production is unable to withstand the frictional force of the sex act. This therefore results in tears or lacerations exposing the cervix to direct blood-semen contact and subsequent infection.

This early initiation of sex is said to occur as a result of decline in the age at menarche. The early physical maturity is therefore believed to be associated with early sexual feelings, which leads to early sexual activity and an increased risk to HIV infection. . [42] Though this biological explanation is tenable, some early initiation is often as a result of

coercive sex (sexual abuse) or a breakdown in parental control as a result of collapse of the social order resulting in the girl seeking to fend for herself.

Pre-marital sex was therefore seen to exist amongst the two groups in this study though it was higher among the out-of-school respondents than the in-school group. This finding agrees with other similar studies in adolescent sexuality. It was however not as high as the findings of other similar studies which found levels as high as 50% [19], 59% [11,32]. The reasons for sexual intercourse were peer pressure, curiosity and coercion by sexual partners and the main benefits were, a source of pleasure (enjoyment) and at times for economic reasons. As expected the out-of school respondents (53.3%) were about three times more sexually active than the in-school respondents (17.3%). However the mean age of first intercourse is lower for the in-school respondents (14.6) than the out-of-school (16.0) years is lower than the findings of other studies. [11,32]

The low age at first sex (5 years) in this study appears to be the lowest so far from the review of literature though it agrees with the findings of Ahedor (1999) [23]. The lowest age in other similar studies was reported to be 8 years [19, 31] and 10 years. [10] It is therefore not surprising that the reason for such early age of intercourse was given as rape.

5.3 Protective behaviour

Protective behaviour entails sexual abstinence, consistent condom use, keeping of only one sexual partner and faithfulness to sexual partner. Low condom or contraceptive use is a major characteristic of adolescents and has been reported in most studies on adolescent sexuality. So many reasons have been assign to the phenomenon such as lack of knowledge, lack of access or refusal to use contraceptives because of misconceptions about their actions and effects. Other reasons reported include the wrong believe or feeling by most teenagers

that they are either too young to become pregnant or that infrequent sex cannot cause pregnancy. There have also been reported cases of males refusing to use condoms because they believe that it is the duty of the female to protect herself from unwanted pregnancy. [44] However, it is clear that in the developing world, young women have little or no control at all over how, when and where sex takes place. Therefore, even when they are aware of measures to protect themselves from HIV, they are unable to enforce them.

To assess whether high level of knowledge was accompanied by the practice of appropriate behaviour, a number of questions were asked on condom use. As in other studies, though level of knowledge of condoms was high, usage was low. [8, 11, 12, 32, 35] The issue of multiple partners was also found in the study, which agrees with the findings of other studies. [36] Though the number of sexual partners was not as high as have been reported in other studies, it was significant because, though only 10.2% of the sexually active had two or more partners whilst another 10.3% had no regular partners and yet were having sexual intercourse. This finding was not surprising for; early initiation of sexual activity often results in the taking of multiple partners. The reason being that, an early initiation of sex means the individual has a longer pre-marital exposure period to sexual activity before she goes into marriage hence more sexual partners. The situation therefore exposes the young adolescent to unwanted pregnancies and infections such as STDs/HIV

It is also surprising that in a small study such as this there were as many as five (5) rape victims. This presupposes that sexual abuse may be a common feature of the study area and needs serious consideration. A number of studies have also revealed this unfortunate and disturbing occurrence. In one such study, physical and sexual abuse were "disturbingly

common" throughout life among women at high risk for HIV infection. Childhood sexual abuse (42%) and physical abuse (42%) was also common. [47]

5.4 Knowledge and perception of HIV/AIDS

Knowledge about HIV/AIDS and its mode of transmission was high and universal as found in other similar studies. [10,11] However, the findings show that the out-of-school respondents appear to have more knowledge than their in-school counterparts. The source of most information on HIV/AIDS was the mass media (TV, Radio), which is similar to the findings of other studies.[11]. There are however a lot of misconceptions such as the feeling of not being at risk, being able to identify infected persons, the presence of a cure for the disease and the believe that a healthy person cannot have HIV. Perceived susceptibility was also low in the two groups and especially so in the in-school group. These misconceptions probably prevent respondents or make them complacent about taking adequate preventive measures to protect themselves.

5.5 Knowledge of modes of transmission.

Though the knowledge of respondents on the modes of transmission is high, there were a number of serious misconceptions. Similar misconceptions have been found in other studies [33, 38,20]

As to who gets infected with HIV/AIDS, 144 (48.6%) thought anybody, 57 (19.3%) thought only those who have unprotected sex, 10 (3.4%) thought females only, 2 (0.7%) thought males only, 29 (9.8%) thought prostitutes only while 54 (18.2%) thought only those who keep changing partners. It was however generally agreed that a person with many sexual partners 289 (97.6%) and a person whose partner has many other sexual partners 283 (95.6%) was at risk of getting infected with the disease, with 5 (1.7%) and 9 (3%) respectively having

a contrary view. The remaining 2(0.7%) and 4 (1.4%) respectively did not know whether the said persons were at risk or not.

However, as found in this study, most adolescents feel they are not at risk of contracting HIV/AIDS usually for certain frivolous reasons. That feeling of insusceptibility makes them complacent and they, in effect, do not bother taking any measures to protect themselves.

The findings also show a small percentage of respondents reporting of having had a STD, which is a significant finding. This is because most people even if they have ever had an STD, will never admit having had it. STDs are also known to be precursors of HIV/AIDS infection and should therefore never be taken lightly.

CHAPTER 6

6.0 CONCLUSIONS

Young people including adolescents are especially vulnerable to HIV and other sexually transmitted diseases (STDs). This is because they often have multiple short-term sexual relations and do not consistently use condom. Besides they also lack the self-confidence necessary to protect themselves. Sexual abuse or exploitation, lack of sex education, lack of access to reproductive Health services as well as lack of access to contraception and their inability to negotiate with their sexual partners about sexual decisions, makes the adolescent girl particularly at greater risk. The study has confirmed some of the risk factors of vulnerability to HIV/AIDS/STDs, found by other researchers.

In sum, though the knowledge of HIV/AIDS is high among the adolescents in the study area, they were still victims of some of the risk factors that can expose them to infection with the disease. Their perception and practices are therefore not commensurate with their knowledge posing serious issues of concern such as:

- Disparity between awareness or knowledge of HIV as well as its mode of transmission and actual precautionary practices such as sexual abstinence, condom use and keeping of multiple partners.
- Misconceptions as to who can get infected, modes of transmission and personal perception of risk.
- Sexual abuse and
- Perceived susceptibility

In the light of the above HIV/AIDS can be seen as a threat to the adolescents or young people of the study area (Hohoe District. Meeting adolescents needs for sexual and reproductive

health information and services is therefore vital for the future of the not only the district, but the region and the country as a whole.

CHAPTER 7

7.0 RECOMMENDATIONS

- 1 The presence of misconceptions suggests the need for intensification of HIV/AIDS prevention education. In order for any service to reach adolescents however, it must be simple, ensure privacy, and be accessible, cheap and free from demoralising. [39] the main fact that health workers as a source of information was not unanimous indicates a need for more vigorous health prevention activities from the DHMT

- 2 It is commonly believed that educating young people about sex will make them practice it. As a result, many teachers, youth workers and parents refuse talking about sexual matters to adolescents. Alternatively, that situation may rather encourage an over-emphasis on the negative aspects of sex such as unwanted pregnancy and sexually transmitted diseases/HIV/AIDS, rather than the positive aspects. So contrary to this popular belief, research looking at the effects of sex education on young people's sexual behaviour offers little evidence that it hastens the onset of sexual experience, or increases sexual risk among those who are already sexually active. Rather, several studies from different countries show that good quality sex education can actually decrease the likelihood that young people will have sex, and increases condom use among those who are already sexually active.[47]

- 3 The DHMT should involve communities and educational institutions in the designing and implementation of HIV/AIDS prevention programmes to provide prevention messages to adolescents through community-based organisations (CBOs), school-

- based programs, and public information and education programs. For an optimum effect, community involvement should be at all levels
- 4 For adolescents or young people especially the females to protect themselves from HIV infection, they must not only rely on their own skills, attitudes, and behaviours regarding condom use, but also on their ability to convince their partner to use a condom. Gender, culture and power may be barriers to maintaining safer sex practices with a primary partner. HIV prevention strategies must therefore target both women and men especially where gender norms in sexual decision-making need to be made.
 - 5 The DHMT and the District Assembly should organise training for religious ministers, parents and peer workers to improve their communication and counselling services in mission houses, work places and at home with emphasis on providing more reproductive health services to young people. There should be a systematic plan of action for educating all people on reproductive health with encouragement of inter-generation communication (parent -child) on issues of sexuality and reproductive health. Also most adolescents or young people belong to one religious denomination or the other and are often very active members of church societies. Religious leaders, pastors etc can be made to play a greater role in STD/HIV prevention programmes for combating the spread of HIV/AIDS.
 - 6 Parents also have a very great role to play. They need to be realistic about the possibility that their children will engage in sexual activities which can lead them to unwanted pregnancies, infection with STD/HIV/AIDS or even death from abortion, Being a primary source of socialisation, they can significantly play an active role of

providing good quality sex education which can drastically decrease the likelihood of young people engaging in unprotected sex.

- 7 A number of NGOs mentioned by respondents such as Pro-link should be liased with by the DHMT to facilitate commonality in messages and programmes
- 8 Programmes that aim to reduce specific sexual risk-taking behaviours as well as reinforce group norms against unprotected sex and discuss social pressures to have unprotected sexual activity have been shown to be particularly successful. School curricula with these qualities have been shown significantly to reduce the likelihood that students who have not had sex prior to their exposure to the curriculum will have had unprotected sexual intercourse eighteen months later.[47]
- 9 Sexual abuse and coercive sex places many adolescents at risk of HIV/AIDS/STDs It has been found out that women who have been abused are more likely to have multiple sex partners.[47] There is therefore the need to raise public awareness about sexual abuse and coercion and help women and men develop the skills needed to prevent it. Laws on sexual abuse, coercive sex and the rights of children should be enforced.
- 10 The government on its part need to provide the necessary political and put certain measures in place such as the passing of legislation and programmes targeting young people by:
 - Integrating the necessary information into school curricula:
 - ◆ Providing good role modules for the young people to imitate.
 - ◆ Reaching out to the out-of-school young people
 - ◆ Providing sex education amidst positive attitudes of parents

- ◆ **Improving recreational facilities for the young people**
- ◆ **Providing easy free and accessible channel of information for young people**
- ◆ **Providing employment avenues and social welfare packages for young people**

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APPENDICES

Appendix A

TABLE 2 SUMMARY OF SELECTED COMMUNITIES AND SCHOOLS

No	Name of Sub-district	Communities selected	Sample Size	Schools selected	Sample size
1	Alavanyo	Zongo East	10	St Francis Jss	15
2		Torkoni Newtown	10	Newtown JSS	15
3		Ahado East	10	HEPSS	15
4		Segbedeme I	10	St Agartha SSS	15
5		Tse vi	10	Mosama JSS	15
6		Bla Dziehe	10		
7		Bla Anyiehe	10		
8		Segbedene II	10		
9		Zongo West	10		
10		Low Cost	10		
11		Kpeme Anyiehe	10		
12	Akpafu	S. Bume	10	Ashiambi JSS	15
13		S. Gbedome	10	St Mary SSS	15
14		S. Benua	10	Gbodome JSS	15
15		A. Odomi	10	Mempeasem JSS	15
				Bume JSS	15
TOTAL		15	150	10	150

Appendix B

CALCULATION OF SAMPLE SIZE

That is $\tilde{N} = P(1 - P)/e^2$. An assumed proportion of awareness of HIV/AIDS among adolescents was taken to be 80% and a confidence level of 95%, the calculated sample size was then found to be 256. So a sample size of 300 was used for the study. Where \tilde{N} is Sample size

P is estimated proportion of awareness of HIV/AIDS

(1 - P) is the level of acceptance

e is the degree of confidence

12. Occupation of mother
- 1). Government Employee
 - 2) Farmer
 - 3) Self-employed
 - 4) Unemployed
 - 5) Other (Specify).....

REPRODUCTIVE HEALTH BEHAVIOUR

13. Do you have a lover? (1) Yes (2) No

14. How many lovers do you have?.....

15. Have you ever had any sexual intercourse before? (1) Yes (2) No

IF NO, GO TO QUESTION 22

16. At what age did you have your first sex?.....

17. Under what circumstances did you have your first sex?

- 1). My friends convinced me
- 2) It was out of curiosity
- 3) I was Raped
- 4) Other (Specify).....

18. What benefits do you get from having sex?.....

19. Since you started having lovers how many lovers have you changed so far?...

20. When was the last time you had sexual intercourse? 1).Days ago
2).....Weeks ago
3)....Months ago

21. What type of lovers (sexual partners) do you prefer?

- 1) lovers (Girls/boys) of the same age with you
- 2) lovers (Women/men) older than you
- 3) Lovers younger than you
- 4) Both

22. Do you think something can happen to a girl/boy if she/he does not have sex?

- 1) Yes 2) No 3) Don't Know

23. If yes what can happen

24. Do you think a girl/boy can become foolish or stupid if she remains a virgin (doesn't have sex)? 1) Yes 2) No 3) Don't Know

PROTECTIVE BEHAVIOUR

25. Have you ever heard of or seen a condom? 1) Yes 2) No

26. Have you ever used a condom before? 1) Yes 2) No

(IF NO GO TO Q. 29)

27. Does your lover (if a girl) /do you (if a male): -

- 1) Always use a condom during sex with you
- 2) Or sometimes use a condom during sex with you.
- 3) Or never used a condom during sex with you.
- 4) Don't know

28. Do you always insist on your lover using condom anytime he wants to have sex with you?

- 1) Yes 2) No

KNOWLEDGE AND PERCEPTION OF STDs/HIV/AIDS

29. Have you ever heard of HIV/AIDS? 1) Yes 2) No

(If No go to Question 52)

30. From where did you hear of HIV/AIDS? 1). Mass Media (Radio, TV, etc)

- 2) Health workers
3) Schoolteachers
4) Friends/colleagues
5) Parents/relatives
6) Church/Mosque
7) Other (Specify).....

31. What is HIV/AIDS?.....

32. What causes HIV/AIDS?.....

33. How can some one get HIV/AIDS?.....
.....

34. Can anybody avoid getting HIV/AIDS?

- 1) Yes
2) No
3) Don't know

35. What can a person do to avoid getting HIV/AIDS?

36. Is it possible for a healthy looking person to have HIV/AIDS? 1)

- Yes 2) No 3) Don't know

37. Can you identify a person with HIV/AIDS?

- 1) Yes 2) No

38. If yes how?.....

39. Can anybody get AIDS by eating with somebody having HIV/AIDS?

- 1) Yes 2) No 3) Don't know

40. Can anybody get HIV/AIDS through kissing an infected person?

- 1) Yes 2) No 3) Don't know

41. Which people can get HIV/AIDS? 1). Anybody

- 2) People who have unprotected sex
3) Only women/girls
4) Only men/boys
5) Only Commercial Sex Workers (Prostitutes)
6) Other (Specify).....

42. Do you think HIV/AIDS can be cured?

- 1) Yes 2) No 3) Don't know

43. If yes by whom? (Specify).....

44. Do you think you are at risk of getting HIV/AIDS?

- 1) Yes 2) No 3) Don't know

45. If yes or no why?.....

46. Can anybody get HIV/AIDS by staying with a relative who has AIDS?

- 1) Yes 2) No 3) Don't Know

47. Can HIV/AIDS be transmitted through mosquito bite?

- 1) Yes 2) No 3) Don't Know

48. Can anybody get HIV/AIDS from shaking hands with a person having AIDS?

- 1) Yes 2) No 3) Don't Know

49. Can anybody get HIV/AIDS from sharing razor blades or toothbrushes with an AIDS person? 1) Yes 2) No 3) Don't know

50. Do you think a girl/boy with many lovers is at risk of getting HIV/AIDS?

- 1) Yes 2) No 3) Don't know

51. Do you think any girl/boy whose lover has many other lovers is at risk of getting HIV/AIDS? 1) Yes 2) No 3) Don't know

52. If a number of people are having HIV/AIDS, how many of them will die of the disease?

- 1) A Few of them will die
2) All of them will die
3) None of them will die
4) Don't know

53. Do you know of some other diseases that somebody can get through sex?

- 1) Yes 2) No 3) Don't know

54. If yes, name those diseases you know.....

.....
.....

55. Have you ever had Gonorrhoea/Syphilis? 1) Yes 2) No

(IF NO, END HERE)

56. If yes what did you do when you discovered you had the disease?

- 1). Went to hospital for treatment
2) Didn't do anything
3) Went for traditional treatment
4) Other (specify).....

- 57 What else did you do after that?.....
- 58 Did you inform your partner (Love) to go for treatment?
1) Yes 2) No
- 59 If no why didn't you inform him/her?.....