

The Youth, Safer Sex Behaviour And HIV/AIDS Prevention: A Case Study Of Agogo

By



**This research is in partial fulfillment of a Master of Public Health Degree at
the School of Public Health, University of Ghana, Legon.**

***Academic Supervisor – Dr. K. Senah, Dr. Margaret Gyapong
Field Supervisor – Dr. Conelius Doodo***

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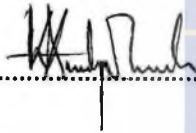


DECLARATION

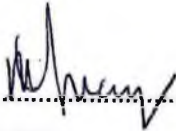
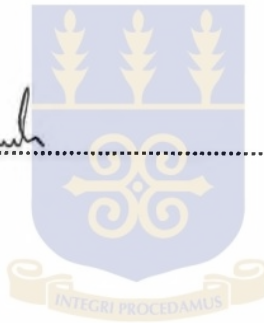
I Declare that this dissertation has been as a result of my own research except where specific references have been made and that it has not been towards any other degree or has it been submitted concurrently in candidature for another degree.



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Silas Quaye

ACADEMIC SUPERVISORS

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Dr. K Senah



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Dr. Margaret Gyapong

DEDICATION

I dedicate this work to my Ernestina and Naa Lamily Quaye

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Academic Supervisors are: Dr. K. Senah, Department of Sociology, University of Ghana and Dr. Margaret Gyapong, Health Research Unit, Ministry of Health Accra.

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Abstract

The HIV/AIDS pandemic continue to spread in Sub Saharan Africa and Ghana is no exception. 2001 estimates of prevalence from sentinel centres across the country suggest between 3 to 4 percent . This study was conducted in Agogo, in the Ashanti Akim North District of Ghana. It is a qualitative descriptive study that set out to describe the youth and the environment they live in, document what safer sex and HIV/AIDS prevention information the youth have, describe what safer sex and HIV/AIDS information the youth need, and identify the factors that promote the practising of safer sex and HIV/AIDS prevention among the youth. (youth defined as aged between 15 and 24) The study collected data using Participatory Rural Appraisal Methods - focus group discussions, matrix ranking, daily activity chart and in-depth interviews. 91 discussants/respondents were involved (8 discussion groups and 20 in-depth interviews) Respondents include chemical shop attendants, opinion leaders, students, artisan, farmers and health professionals. Data analysis involved transcribing tape recording, comparing tape recording with notes, coding transcripts and analysis according to the objectives and themes.

The findings indicate that demand for condoms among the youth has increased but condoms are not always used. Reason for the demand in condoms relate to knowledge that HIV/AIDS is real and has no cure and a condom can prevent its transmission. Reasons for not always using condom always relate mainly to sexual in-discipline, low self-esteem and wrong perception about who can possibly be infected with HIV. Women are at a higher risk of having unplanned sex and unprotected sex due to perceived gender domination of the male, low self-esteem and lack of parental support. The study also shows that whilst radio and television programs have played a significant role in shaping Safer Sex and HIV/AIDS prevention behaviour among the youth consistent educational is lacking. Over 40 clarification questions were asked indicating the need for feed back in education programs. Increase in face-to-face fora for the youth will clear most of the misconceptions the youth have about the HIV/AIDS. Factors that promote safer sex behaviour among the youth are: co-operation and understanding between sexual partners on the importance of using condom, accessibility of condoms to the youth, correct information on HIV/AIDS, a culture of sexual discipline among the youth, assertiveness and self confidence. HIV/AIDS prevention programs must be participatory, involve the youth and linked to promoting livelihood and positive self esteem among the youth.

List of Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
CBO	Community Based Organisation
CVA	Cardio Vascular Accidents
CRF	Chronic Renal Failure
GAC	Ghana AIDS Commission
GarFund	Ghana AIDS Response Fund
GDHS	Ghana Demographic and Health Survey
GSMF	Ghana Social Marketing Foundation
HIV	Human Immunodeficiency Virus
IEC	Information Education Communication
MTCT	Mother To Child Transmission
NGO	Non Governmental Organisation
NTCA	National Technical Committee on AIDS
NACP	National AIDS Control Program
NACA	National Advisory Council on AIDS
STIs	Sexually Transmitted Infections
STDs	Sexually Transmitted Diseases
POW	Plan Of Work
PLA	Participatory Learning and Action
PLWA	People Living with AIDS
UNAIDS	Joint United Nation Program on HIV/AIDS
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

DEFINITION OF KEY WORDS AND CONCEPTS

In this dissertation, **Safer Sex Behaviour** means :

- Sexual activity that prevents the exchange of bodily fluids, blood and semen
- HIV/AIDS High Risk Behaviour

In this Dissertation **HIV/AIDS Prevention** means:

- Avoiding HIV/AIDS high-risk behaviour. HIV/AIDS High Risk behaviour involves
 - Having sex with multiple partners
 - Having sex with someone with multiple partners
 - Not using condom
 - Use of unsterilized needles during intravenous drug use
- Use of safe blood products
- Educating others on the dangers of HIV/AIDS
- Being faithful to one partner
- Use of Condom
- Use of sterilized needles, blades

In this Dissertation **the Youth** means:

Between the ages of 15 and 25

CHAPTER 1

1.0 INTRODUCTION

The problem of Acquired Immune Deficiency Syndrome (AIDS) has affected all countries. As greater numbers of people continue to be infected with the disease, the provision of information and education has become a major weapon against the disease and a way of encouraging appropriate reactions to it.

1.2 The Youth and Sexual Behaviour

Young people engage in behaviours including early sexual activity partly because of general societal influences, but more specifically because of peer pressure. They often perceive themselves at risk not because of their own behaviour, but because of the past or current, perceived or real behaviour of their sexual partner (Best 2000). Neither young people nor those in decision-making positions talk openly about sensitive issues such as adolescent sexual activity. As a result, few services are specifically designed for young people, and this has contributed to the incidence of HIV/STIs, and unplanned pregnancies among young people. For young people who are just starting out on their sex life, the fear of losing the trust of the partner and wrecking the relationship is generally stronger than the fear of AIDS or the feeling of responsibility vis-à-vis the other person (Dowsett, 1998).

In most cases, their first objective is to make a success of this new experience, for which they are all too often ill prepared. Faced with the fear of failure, suggesting the use of a condom may be perceived as a mark of distrust and look like a way of complicating the situation further. By their nature, getting access to condom may also be a problem to the youth, and they may lack support from others to discuss their reproductive health concerns and problems.

Young people today however are at high risk of unintended pregnancies and sexually transmitted infections (STI's) including HIV/AIDS, because they are sexually active at younger ages than previous generations. As a critical grouping in the growth and development of almost every country's population the potential of HIV AIDS transmission among the youth is of great concern. The need to bridge this gap between knowledge and practice of the youth cannot be over emphasised.

1.3 Epidemiology of HIV/AIDS

Human Immunodeficiency Virus (HIV) is a retrovirus that exists in two forms: HIV1 and HIV 2. When infected with this virus, an individual becomes a carrier and shows no symptoms of the disease but can infect others through sex, blood and foetus. A person can be in the carrier state for 2-10 years or more. Eventually however he or she suffers from Acquired Immune Deficiency Syndrome (AIDS), which makes him or her susceptible to opportunistic infections and malignancies as a result of the HIV virus infecting and destroying his or her immune system (Hubley 1995). There is still no cure for this condition. Once a person develops AIDS, the average survival time is between one to three years (Hubley 1995). The World Health organisation (WHO) has produced a clinical case definition, which is divided into major symptoms and minor signs.

The Major symptoms are:

A loss of ten percent of body weight within a short period

Chronic diarrhoea persisting for more than a month

Chronic fever for more than a month

The Minor signs are:

Persistent cough for more than a month

Generalised itchy skin lesions (dermatitis)

Recurrent Herpes zoster (shingles)

Oral candidiasis (thrush)

Chronic Herpes simplex

Generalised enlargement of lymph nodes

According to the WHO case definition, AIDS in an adult is defined by the existence of at least two major signs and one minor sign in the absence of immunosuppression (Hubley 1995).

The global burden of HIV/AIDS as presented in table 1 stands at 36.1 million people as at the end of 2000.

Table 1

Global Distribution of Adults and Children Living With HIV/AIDS - 2000 (UNAIDS 2000)

Region	Adults & Children living with HIV/AIDS	** Adult Prevalence Rate (%)	% Of HIV Positive adults who are women	Main Rout(s) of transmission for Adults Living with HIV/AIDS
Sub Saharan Africa	25.3 Million	8.8%	55%	Heterosexual
North Africa & Middle East	400,000	0.2%	40%	Heterosexual & Intravenous Drug Use
South and South East Asia	5.8 Million	0.56%	35%	Heterosexual & Intravenous Drug Use
East Asia & Pacific	640,000	0.07%	13%	Heterosexual & Intravenous Drug Use Homosexual

Region	Adults & Children living with HIV/AIDS	** Adult Prevalence Rate (%)	% Of HIV Positive adults who are women	Main Rout(s) of transmission for Adults Living with HIV/AIDS
Latin America	1.4 Million	0.5%	25%	Heterosexual, Homosexual & Intravenous Drug Use
Caribbean	390,000	2.3%	35%	Heterosexual, Homosexual
North America	920,000	0.6%	20%	Heterosexual, Homosexual & Intravenous Drug Use
Eastern Europe & Central Asia	700,000	0.35%	25%	Homosexual & Intravenous Drug Use
Western Europe	540,000	0.24%	25%	Homosexual & Intravenous Drug Use
Australia & New Zealand	15,000	0.13%	10%	Homosexual
Total	36.1 million	1.1%	47%	
** Adult prevalence is the proportion of adults (15-49 years using 2000 population figures)				

The table shows that sub Saharan Africa has the highest adult prevalence of 8.8% and the highest number of HIV/AIDS cases (25.3 million). in the Americas, Europe and the pacific countries, homosexuality plays a key role in the transmission of the disease. In the same vein, intravenous drug use has a major impact in South and South East Asia, Americas and Europe.

1.4 HIV/AIDS in sub-Saharan Africa

According to Piot (1998), out of the 36.1 million people living with AIDS (PLWA) worldwide, 95 percent live in the developing world. By far sub-Saharan Africa is the hardest hit, with over 25.3 million people estimated to be infected with HIV or living with AIDS. Twenty nine African countries have had their life expectancy reduced by seven years due to AIDS and by the year 2010 it is estimated that 40 million children in sub Saharan Africa may have lost their mothers or both parents to HIV/AIDS (Piot, 1998). In Botswana a shocking 35.8% of adults are now infected with

HIV while in South Africa, 19.9% are infected up, from 12.9% just two years ago (UNAIDS 2000). The UNAIDS 2000 report on global HIV epidemic also indicate that in West Africa although the prevalence is relatively less, large countries like La Cote d'Ivoire and Nigeria have over 5% prevalence. East Africa, which used to have the highest prevalence (15%) in the continent have been exceeded by Southern Africa but are still above West Africa.

1.5 AIDS in Ghana

The National AIDS Control Program's report (NACP 1999) indicates that medical staff diagnosed the first case of HIV/AIDS in Ghana in 1986. Since then more than 90,000 Ghanaians have died from AIDS. In Ghana the cumulative case as at September 2000 is 400,000 with female-male ratio being 2:1. The adult HIV prevalence as at year 2000 was 4.6% (30% reporting) with the prevalence among commercial sex workers being as high as 75.8% in Accra-Tema and 82% in Kumasi. Ashanti Region has about one third of the cases with 13,023 cases representing 31.6%. Brong – Ahafo Region has 3,534 cases (8.8%) and Eastern Region 6,938 cases (17.3%). The lowest rates are found in the Northern Regions; Northern, Upper East and Upper West Regions.

In Ghana heterosexual contact is the main mode of transmission (Heterosexual contact 75-80%; vertical from mother to child 15%; direct blood contact and transfusion 5%) thus making the issue of safer sex and behaviour change central to any planned intervention. Analysis based on sentinel surveillance data shows HIV prevalence in 15-49 year olds age group rose from 2.7 percent in 1994 to 4.0 percent in 1998, representing an increase of nearly 50 percent in just four years. (NACP 2001)

The disease trend in Ghana indicates that it peaks between the ages of 30 and 34 and the youth form a vital grouping that needs special attention. Most people (97% of women and 99% of men) know about HIV/AIDS, and two thirds of women and four fifth of men believe that a healthy person can have the HIV virus. The most common source of HIV AIDS information is the radio; other sources of HIV/AIDS information include TV, newspapers, friends and churches (GDHS 1999).

Personal risk perception is low. 58% of adult males do not perceive themselves, as being at risk of infection and knowledge about condoms among adults is about 90%, (NACP 1999). However condom use during last sexual activity is very low (16% in men and 6% in women) (GDHS 1999)

If the current incidence rate of 230 new cases continues, it is projected that by 2004, 720,000 individuals will be infected (prevalence rate of 6.5%) and by 2014 the prevalence will be 9.5 and will account for 1.36 million Ghanaians. The overall trend of rising prevalence clearly indicates an epidemic that will worsen if nothing is done about it. Although HIV has spread slowly in Ghana compared to many other African Countries, Ghana must do well and learn from the south and eastern African countries where in the late 1980's trends were similar to that of Ghana but worsened rapidly.

The economic benefit of investing in HIV/AIDS prevention is manifold. The fall in new HIV infections would reduce the number of new AIDS cases. Over the next 20 years, some 6.7 million adult deaths would be averted. In economic terms, this would result in lower costs of treatment and care of HIV/AIDS patients.

HIV/AIDS has a profound impact on the social and economic development of Ghana well into the future. One serious consequence of AIDS is an increase in both maternal and paternal orphans, which has tremendous strain on social systems, especially caring for orphans in families where family bonds and structures are not strong. Mortality and morbidity is another impact in the sense that it affects life expectancy and puts pressure on the health system as a result of an increase in opportunistic infections.

1.6 Policy Framework For HIV/AIDS Control In Ghana

The Government of Ghana, donors and NGOs are committed to controlling the spread of the diseases especially among the youth. Indeed the 1999 theme for the AIDS Day celebrations in Ghana was " The Youth without AIDS, our best resources". The Five-year Plan of Work (POW) of the Ministry of Health identifies HIV/AIDS as one of the key/priority services, along with immunization, management of malaria, TB, maternal and reproductive health, and the eradication of the guinea worm. While the health sector response to the epidemic needs to be strengthened, it has made some notable advances. Training for syndromic management of sexually transmitted infections (STIs) has been carried out widely and effectively, all blood for transfusion is being screened, providers are improving infection prevention practices including use of clean needles and sterilization practices and the sentinel surveillance system is functioning well.

In response to the HIV crisis government in 1985 established the National Advisory Council on AIDS (NACA) and National Technical Committee on AIDS (NTCA). In 1987, the government established the National AIDS/STD Control Programme (NACP) and in 1997 NACP led the drafting of a Policy Document on HIV/AIDS. The purpose of the policy is to create a favourable

environment for all HIV/AIDS control and prevention programmes and to mitigate the social and personal consequences of HIV infection on those living with the virus and those who have already developed AIDS.

The draft policy seeks to:

- Reduce the impact of morbidity and mortality as a result of HIV/AIDS in the general population
- Ensure that the basic human rights of persons infected with and persons with AIDS are protected and upheld
- Ensure that HIV infected persons and persons with AIDS are provided with adequate medical and social care
- Ensure that access to social and economic opportunities remain open to HIV infected persons and persons with AIDS
- Ensure that adequate attention is paid to groups such as women who have been found to be vulnerable to HIV
- Ensure that there is a consistent programme of information and education about HIV/AIDS among the general population, especially among youth, and that this increased knowledge is translated into an increase in attitudinal and behavioural change and
- Decrease vulnerability to infection, reduce stigmatisation and discrimination and minimize the socio economic impact of the epidemic.

Given the complex nature of HIV/AIDS, the context in which it is spread, and the rapid growth of the epidemic, the response needs to be rapid, flexible, broad-based. This must include all relevant levels and sectors of government and society. Since early 1999 the Government of Ghana has

conducted a Situation Analysis of HIV/AIDS, a Response Analysis examining its achievements to date and gaps, and has developed a Strategic Framework for the next five years.

In addition, it has established a high level multi-sector commission the Ghana HIV/AIDS Commission (GAC) under the executive arm of government - The Presidency.

The objectives of the Strategic Framework for HIV/AIDS in Ghana are to:

1. Reduce new HIV infections by 30 percent by 2005;
2. Improve service delivery and mitigate the impact of HIV/AIDS on individuals and families;
3. Create an enabling environment for the implementation of the strategic framework; and,
4. Establish a multi-sector and multi-disciplinary institutional framework for the co-ordination and implementation of HIV/AIDS programs in Ghana.

The National AIDS Control Program is pursuing six main areas of intervention to limit transmission through heterosexual contact. These are: Promoting abstinence and faithfulness, reducing the number of overall sexual partners, delaying the onset of sexual activity among adolescents, promoting the use and availability of condoms, controlling other sexually transmitted diseases and encouraging voluntary counselling and testing. Other measures to control and manage the disease include controlling child-to-mother infection, home based care and blood safety. (National AIDS Control programme 1999)

In addition to mainstream Ministry of Health activities, the Government of Ghana has established the Ghana AIDS Response Fund (Garfund) with support from the World Bank through a \$ 25 million IDA credit for a period of 4 years. Garfund will be implemented within a four-year period. The objective of the Ghana AIDS Response Fund (Garfund) is to reduce the spread of HIV

infection, and reduce the impact of AIDS on those infected and their families by financing interventions outside the Ministry of Health's mandate.

The main purpose of the Ghana AIDS Response Fund (Garfund) is to support the implementation of the Government's effort to reduce the spread of the HIV/AIDS epidemic and reduce the impact on those already infected and affected as articulated in the "Strategic Framework for HIV/AIDS in Ghana." The Ghana AIDS Response Fund (Garfund) is under the authority of the Ghana AIDS Commission (GAC), which is in charge of defining broad priorities for action, the selection of eligible proposals (through a technical subcommittee), and the monitoring of the performance of the project.

The expected outputs of the project include an increase in the proportion of funds awarded to community based organisations (CBOs), increase the proportion of sub projects that develop IEC materials specifically designed for rural populations (in local dialects) and by 2005, 50% of all 1st and 2nd cycle schools will be providing HIV/AIDS education. Also by 2005, all line ministries will have trained trainers at the district level on HIV/AIDS and an increase by 50% the number of districts that provide community-based care for people living with HIV/AIDS (PLWHA)

Chapter 2

2.0 PROBLEM STATEMENT

One-third of sub-Saharan Africa's 630 million people are between the ages of 10-24. More than half of all new HIV infections in sub-Saharan Africa occur among young people aged 15-24, and every year about 1.7 million young people in Africa become infected. According to a report prepared for the Third African Population Conference in 1999, the reproductive health needs of adolescents in sub-Saharan Africa have 'largely been ignored'. The field of adolescent reproductive health is still relatively new in the sub-Saharan region, and those working to develop youth programs face many challenges that are often not a priority for policy makers or health workers.

The HIV/AIDS epidemic has become a serious health and development crisis especially in sub-Saharan Africa as it affects the whole socio-economic fabric of the population leading to serious disruption of allocation of resource and manpower.

In the absence of an effective cure or vaccine, HIV AIDS preventive measures focus on education and information to prevent and reduce risk behaviour associated with AIDS transmission. Research has, however, proven that often education alone is not sufficient to induce behavioural change among most individuals (Wong 1995)

Interventions to stem the spread of HIV throughout the world are as varied as the contexts in which they are found. This makes prevention of HIV, enormously complex involving a multiplicity of measures. The relationship between behaviour and HIV infection is extremely complex and may be

poorly understood. Many would argue that to understand the spread of the virus, we need not look at specific sexual behaviours but at the whole fabric of cultural, social and economic circumstances that prompt people to behave in one way or another.

Young people account for a fairly large proportion of the population in Ghana. An estimated 31 percent of the total population is aged between 10-24 years with a median age of 17.5 years. This large proportion of young people is of considerable demographic importance since it will account for future momentum of population growth. The youth by their very nature are adventurous, inexperienced and vulnerable when it comes to safer sex practices.

Young people, as a group tend to be uninformed or misinformed about sexual and reproductive health and are reluctant to take action to protect themselves. (Best 2000) As a distinct group, information to the youth should be fashioned to their worldview and not lumped with the adult population.

This study is relevant, as it will target the youth who constitute the future of Ghana and who are often not targeted in educational programs. This study will provide information that will give an insight into what the expectations of the youth are and how this can be integrated into an overall educational programme that has the potential to influence safer sex, attitude and behaviour change to prevent HIV infection.

There is an ongoing peer education HIV/AIDS project by the Agogo Hospital and this study will complement the work done so far and will benefit also from the experience from that project.

2.1 OBJECTIVES

2.2 General Objective

The general objectives of this research is to:

Document factors that can contribute to safer sex behaviour and HIV prevention among the youth of Agogo.

2.3 Specific Objectives

The specific objectives of this research are to:

Describe the youth and the environment they live in

Document what safer sex and HIV/AIDS prevention information the youth have

Describe what safer sex and HIV/AIDS information the youth need

Identify the factors that promote the practicing of safer sex and HIV/AIDS prevention

2.4 Research Question

What information and services will influence the youth to practice safe sex and HIV/AIDS prevention?

2.5 Hypothesis

Lack of information about HIV/AIDS contribute to high risk sexual practices among the youth

2.6 METHODS

This research is a *cross sectional descriptive study using qualitative methods*. Qualitative research has been used in a number of research projects on HIV AIDS. World Neighbours Programme in Nepal used participatory rural appraisal methods to conduct a reproductive health needs assessment in 1996 (PLA note No 37 2000). Action Aid Ghana is also in the process of implementing the stepping stone project in Ghana using participatory methods. CARE in Zambia has also used it as a tool to explore adolescent sexual and reproductive health.

Participatory Learning and Action (PLA) tools were used to collect the information for this research. PLA tools were used because as participatory tools, they create opportunities for open and frank discussions. PLA tools are activity oriented and therefore keep the discussants active and interested throughout the discussion. As a qualitative study, PLA tools also provide as output, diagrams, charts and tables that support analysis in addition to quotations that will be taken from the discussants. Key tools used are Daily activity charts based on recall of activities by the youth. Matrix Ranking, Pair Wise Ranking. Also Focus Group Discussion and In-depth interviews were conducted.

Brief description of Participatory Learning and Action tools used

Daily Activity Chart

Daily Activity Chart is a visual presentation in a form of a histogram the daily activity schedule and time expenditure. It represents the activities undertaken in a day and amount of time spent on those activities. This tool was used to delve into a typical day in the life of the youth. This tool was used to collect and discuss information on the activities that the youth go through from when they

wake up to the time they sleep and possible times of sexual activities and opportunities for possible education programmes.

Matrix Ranking

Matrix Ranking is a visual analytical tool to place issues in terms of preference, knowledge, practice or priority by scoring on a matrix. In matrix ranking different variables are matched e.g. a disease condition and possible causes while pair wise ranking matches the same variables e.g. out of a number of diseases which one is preferred to be tackled first. This tool enabled the researcher to investigate HIV/AIDS information that the youth have and which of this information is perceived as been effective for safer sex behaviour and HIV prevention.

Focus Group Discussion

The purpose of this exercise was to have an interactive discussion with respondents to gain insight into the environment in which the youth live in and how this environment affect their practice of safer safe and HIV/AIDS prevention. The focus group discussion enabled the researcher to hear from the respondents, challenges they face in practising safer sex/ HIV prevention, what HIV/AIDS information they have and what is their preferred safer sex and HIV AIDS information and programs.

The target group were the youth between the ages of 15 and 24 (male and female were separated). They were selected from vocational and artisan apprenticeship groups, senior secondary school students, farmers groups, Churches, Moslem groups and youth clubs. Due consideration was given to making sure that the discussant included both in and out of school

youth. In addition opinion leaders, parents, community health nurse, medical assistants involved in AIDS control program at Agogo, and chemical shop attendants were interviewed.

Sampling Method

Purposive sampling was used based on identifying key youth groups and institutions in Agogo.

Sample

- Youth selected from identifiable groups in the community - 8 groups, 4 male groups and 4 female groups
- AIDS Co-ordinator, Disease Control Officer
- Chemical shop attendants
- Community health nurse
- Opinion leaders, Youth leaders, Parents,

The Sample was selected based on the following procedure

- Discussion with key stakeholders who work on a day to day basis with the people of Agogo. They include Primary Health Care Co-ordinator, Environmental Health officer, Disease Control officer, Nifa Hene of Agogo and some Youth leaders.
- Based on the discussions and the researcher's own observation, six groupings were identified as constituting the bulk of the youth of Agogo. These are the artisan groups, the school group, the religious group (Moslem and Christian) and the farmers group.
- Large groups like the artisan group was broken down into specific trades

- The leaders of the groups were contacted and informed about the research and were asked to select 8 members from their group.
- The leaders of the various grouping were then identified and interviewed as youth leaders
- For the Chemical shops, the town was divided into four and one shop was picked from each section.
- Opinion leaders respondents were selected from these four categories: traditional leader, religious group leader (Christian and Moslem) and assemblyman.
- Parents were selected if they had children who were aged between 15 and 24 years.

2.7 Data Collection Process and Problems

The data collection started with enquiry into the knowledge the youth have about HIV/AIDS, problems the youth face in practising safer sex and HIV/AIDS prevention and then questions or issues on which they want further clarification. Daily activity chart and pair wise ranking followed this. The discussions took between 45 minutes and one hour fifteen minutes. All discussions were tape recorded in addition to hand written notes. Four persons were involved in the data collection process; each of them had a specific role. The researcher conducted all the discussions.

The other three had the following responsibilities

1. Operating the tape recorder
2. Taking Notes
3. Venue is ready and discussant dully notified

There were daily reviews of activities. The data collection took twelve days.

The tape recording was transcribed and then compared to the notes; a final copy of proceedings was then generated from both records. The transcripts were coded according to the objectives and analysed. A similar process was used by Rutenberg et. al (1997) (coded transcripts and summary matrices) when eight focus groups and 23 in-depth interviews were conducted among women and men in Zambia

The focus group discussions were at two sites: the chief's palace and Agogo State Senior Secondary School. The Chief's palace was chosen because it was at a central location and had enough space and chairs. Agogo State secondary School was used for the student discussants. In-depth interviews were done at respondents' shops, residence and offices.

Some problems were encountered at the initial stage of the data collection. Some of the selected youth thought they will be tested for HIV/AIDS and therefore did not show up at the appointed time. When this was found out, the researcher held a meeting with the various groups and clarified the purpose, objectives of the study, what data and activities will be undertaken. It was difficult getting the Moslem girls because they live far away from the venue being used for the interviews. This problem was however solved when transportation was provided to bring them.

2.8 Data collection Methods

Data Collection Method/ Technique	Data Collection Tool	Target Population	Outline of information
In-depth interview	Semi structured questionnaire	Disease control officer AIDS control Co-ordinator – Agogo Hospital Chemical sellers Community Health Nurses Selected opinion leaders, Parents Youth Leaders	Details of ongoing programs to prevent HIV infection and safer sex among the youth Views on challenges facing the youth on safer sex and HIV prevention Condom availability and accessibility to the youth
Participatory Rural Appraisal	Daily Activity Chart Matrix and Pair wise Ranking	Youth – Male and Females	A typical day in the life of a youth and possible periods of safe or unsafe sex (through recall by the youth) Pair wise ranking of HIV/AIDS preventive behaviour
Focus Group Discussion	Topic/question guide	Age specific groups	The environment the youth live in Challenges in practising safer sex/ HIV prevention Preferred safer sex and HIV AIDS information and programs that are likely to influence their behaviour

2.9 Data collection Format

Discussant	Number	Methods/ Tools
Girls Moslem Group	5	Problem tree/ Diagramming/
Girls Seamstress Group	10	Daily Activity Chart/
Girls Senior Secondary School Group	8	Matrix and Pair wise Ranking/
Girls Active Church Goers group	9	Focus Group Discussion/
Boys Tailors Group	8	Problem tree/ Diagramming/
Boys Farmers Group	11	Daily Activity Chart
Boys Mixed Religious Group	10	Matrix and Pair wise Ranking/
Boys Senior Secondary School Group	10	Focus Group Discussion/
Other stakeholders-		In-depth interview /
Chemical shops in Agogo,	4	
Medical assistants	2	
AIDS Co-ordinator Agogo Hospital	1	
Opinion Leaders	5	
Selected Youth Leaders	4	
Parents	4	
Total	91	

CHAPTER 3

3.0 Social Structure of Agogo

Agogo is one of the sub districts of the Ashanti Akim North District. It is situated in the northern part of the district and it covers more than half of the district. Agogo Township is thirty kilometres from Konongo the district capital and it is the largest of the sixty-five communities in the sub district. It is designated as an urban centre administered by an urban council. Agogo is Paramouncy under the Ashanti Regional House of Chiefs. The language of the people is Twi and as an Ashanti society, inheritance is matrilineal. The population of Agogo Township is Twenty Four thousand and ten. (24,010) Ten thousand nine hundred and seventy (10,970) males and thirteen thousand and forty (13,040) females. This accounts for sixty one (61%) of the total population of the sub district. The growth rate of Agogo Township and other communities in the sub district is three percent.

3.1 Health

The Presbyterian Church has adopted the health services in the Agog Sub District. The is done through the Presbyterian Hospital and the Primary Health Care Unit. The hospital, which is reputed to be the first mission church in the Ashanti Region is a level C health facility, that provides houseman opportunities and training for newly trained doctors from Kwame Nkrumah University of Science and Technology. The Hospital is one of the most important institutions in the sub district employing three hundred and thirteen people. As the Paramount chief of Agogo puts it "Agogo is the hospital and the hospital is Agogo". Common disease and cases of mortality are malaria, severe dehydration, severe anaemia associated with malaria, Cardio Vascular Accidents (C.V.A). and Meningitis. Disease for which medical treatment is sought malaria, Diarrhoea diseases, T.B.

and Buruli Ulcer. The Agogo Presbyterian Hospital has facilities to conduct HIV/AIDS tests and also has facilities for voluntary counselling and testing. It also has an HIV/AIDS control program supported by the Presbyterian Church, UNAIDS and Christian Health Association of Ghana (CHAG)

In the year 2000 18% of HIV/AIDS positive cases reported at the Agogo Presbyterian Hospital came from Agogo Township.

3.2 Administration, Infrastructure and Services

Administratively the Agogo Township is divided into ten units headed by assemblymen. In terms of the decentralised departments and statutory institutions, Agogo by virtue of being the capital of the sub district, play host to the following institutions: Ghana Fire Service, Ghana Police Service, Ghana Education Service, Agric, Veterinary departments and a Circuit Court. There are two banks: Ghana Commercial Bank and Ashanti Akim Rural Bank. In terms of education, In terms of educational institutions, Agogo has a Nursing Training School, Teacher Training College, two Senior Secondary School, two Junior Secondary Schools and Eight Primary Schools. There are telecommunication facilities in Agogo Township; one can therefore have access to Radio FM, telephones, fax and television.

3.3 Environmental Health

There are twelve refuse sites in Agogo Township and refuse dumping is done crudely and haphazardly. There are however four refuse containers placed at vantage points in the town. In terms of human waste management, there are four functioning KVIPs. Some household have

Ventilated improved pits, water closet and septic tanks. However there is frequent use of open space literally called “free range” in some areas of the township where no public toilets are available. Agogo Township has pipe borne water but this runs only from May to early January. There are two market centres, the central market, which opens all days from 6:30 am to 1pm, and the Akosombo market, which opens Monday to Thursday in the afternoons from 1:30 pm to 6:30pm.

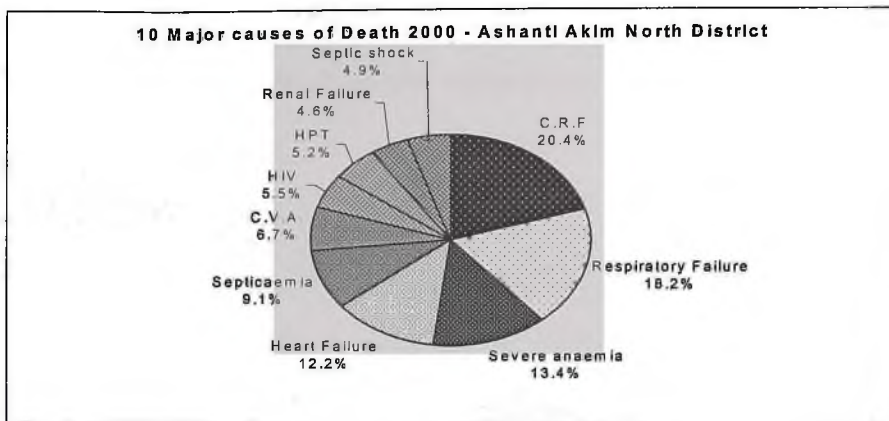
3.4 Occupation

The main occupation of the people in Agogo is farming. Maize, tomatoes, cassava, yam and plantain are the main crops produced. There are two main rainy seasons between mid March and late June and between September and October. These are said to be the best periods for farming in the area. Trades such as tailoring, dressmaking, health dressing, petty trading, photography, auto mechanic and welding are available in Agogo

3.5 AIDS in Ashanti Akim North District

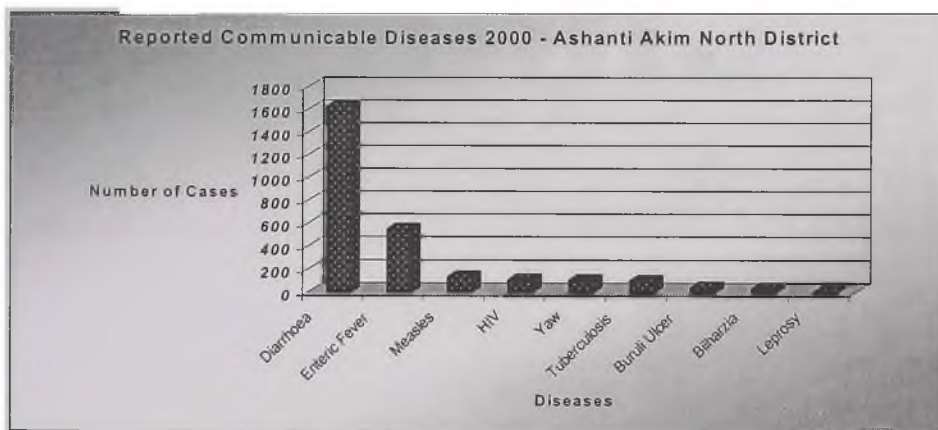
Ashanti Region has about one third of all cases in Ghana with 13,023 cases and a prevalence rate of 5.8%. Information gathered from Agogo Presbyterian Hospital indicate that out of the 1438 blood sample screened for HIV in 1999, 203 were HIV positive representing 14%. Out of this number, 166 came from Ashanti Akim North district representing 82%. In the year 2000 18% of HIV/AIDS positive cases reported at the Agogo Presbyterian Hospital came from Agogo Township. Teenage pregnancy, which is one of the indicators of unsafe sex among the youth, accounted for 16% of the total deliveries at Agogo Hospital in 1999. HIV also represent 5.5% of total deaths recorded in Ashanti Akim North District, and is ranked fourth in the top 10 reported communicable diseases in the district. (Figure 1&2)

Figure 1



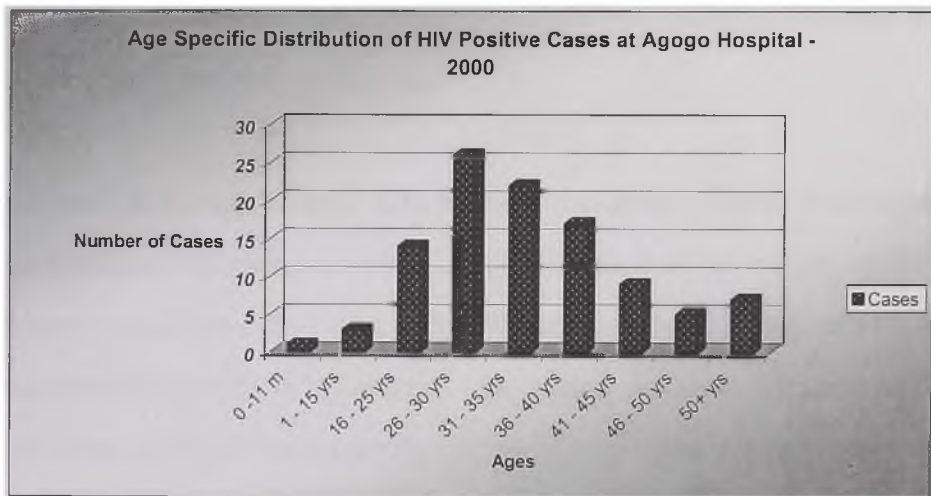
*** CRF – Chronic Renal Failure, CVA – Cardio vascular Accidents, HPT - Hypertension

Figure 2



The effect of all this on the youth is alarming. Figure 3 shows that of the total number of 104 HIV positive cases in 2000 in Ashanti Akim North District, 13% were between the ages of 16 and 24. This represents a sharp "take off" after the "window of hope" (5-14 years) which accounted for 2% of the cases.

Figure 3



Chapter 4

4.0 LITERATURE REVIEW

4.1 Information Education and Communication

Public awareness of HIV/AIDS is extremely high and it is also becoming increasingly clear that changing behaviour to slow the speed or limit the extent of transmission will remain for the foreseeable future the first and probably the most important line of defence against HIV/AIDS. Nevertheless, no single factor, be it biological or behavioural, determines the epidemiological pattern of HIV/AIDS infection. Instead a complex of interaction among several variables determines how and where HIV spreads in the population.

An analysis of the messages adopted by the information and education programs of national AIDS control programs of 38 different countries in sub-Saharan Africa, found that over 90% focused on correcting misperceptions about AIDS. About 80% provided information about personal risk assessment (Cohen, 1992). In many countries, mass education provided the first step to national AIDS control programs. Mass education for HIV prevention has taken many forms and is often seen as a key component of a comprehensive AIDS prevention programme. Mass media, for example, are directed to the general public and aim at teaching people essential facts, promoting healthy behaviour, quieting anxiety about casual transmission and preventing discrimination (Cohen, 1992).

There is encouraging evidence from literature available on HIV/AIDS and safer sex that intervention programs to influence behaviour change can be effective. A study in Zimbabwe has shown that while self-reported behaviour change may be exaggerated, the true level of change has

nonetheless been significant and includes delayed onset of sexual relations, increased use of condom and possibly, increased monogamy (Gregson et. al 1998). Results from the Zimbabwe study suggested that effective behaviour change is facilitated by greater knowledge, experience and personal risk perception. The need for behavioural change strategies is obvious. As Gregson et al (1998) put it, there is a need for intensification of behaviour interventions, which should include peer education, which targets individuals without access to modern media.

Hillier et al (1998) in their study (which involved five hundred and twelve senior rural students) argue that the predominant emphasis in education programmes on safe sex, as condom use may be counter-productive for some young heterosexuals for two reasons. First, this strategy is male-focused and may not extrapolate well to young women who face special risks around pregnancy and rigid societal gender norms, which govern sexual behaviour. Second, health promotion strategies aimed at young heterosexuals are based on an assumption of rational decision-making in sexual encounters and obscure the non-rational nature of arousal and desire, and the unequal power relations that exist between young men and women engaging in sex. It is argued that successful sexual health promotion strategies must address the broad spectrum of concerns facing young men and women when they become sexually active and that consideration be given to the social context in which young people conduct their sexual lives (Hillier et al 1998).

Another study conducted was conducted in Zambia in selected urban areas to examine the sexual networking and activities of urban youth both in-school and out-of-school, aged between 12 and 25. The study results indicated that sexual matters are discussed with close friends of the same

sex and peer group, or with cousins who are of the same age (Kalunde 1997). It is clear that sex education programmes which simply advocate 'safer sex' practices without addressing the interpersonal skills and emotional implications of negotiating such practices, and which do not provide a positive view of sexual health, are failing to influence adolescent behaviour. Peltzer (2000), examined the opinion on AIDS prevention and education among 308 pupils (132 boys and 176 girls) ages 17 to 25 in rural secondary schools in the northern province of South Africa. Analysis of ratings given on items of a questionnaire on AIDS prevention and education indicated that 'Isolating people who are HIV positive' and 'How to protect yourself from getting HIV/AIDS' received the highest ratings. (Peltzer 2000)

4.2 Knowledge, Attitude Belief and Practice

The gap between knowledge and practice was confirmed in a study on the knowledge, risk perceptions of AIDS and reported sexual behaviour among students in secondary schools and colleges in Tanzania. Students engaging in risky behaviour were aware of the risk even though they failed to change their behaviour (Maswanya et. al 1999). Maswanya et. al (1999) categorized risk behaviour into two: risk behaviour where sexually active respondents did not always use condom (Risk behaviour 1) and risk behaviour where those with multiple partners in the previous year did not always use condom (Risk Behaviour 2). Thirty percent of the 1041 students who were sexually active did not use condom (Risk Behaviour 1) and 35% of those with multiple partners in the previous year did not always use condom (Risk Behaviour 2)

In a Reproductive Health Survey conducted in Ghana in 1998 by the Ghana Social Marketing Foundation, (n = 3,107 males, 2,533 females, 2,147 adults) it was found out that overall, there is high awareness of STDs and HIV/AIDS among the youth in Ghana. The survey also found that knowledge and awareness of STDs and HIV/AIDS was higher among those who had ever had sex, compared to those who had never had sex. Levels of perceived approval towards condoms to prevent HIV/AIDS and other STDs ranged from about 40-50%.

In Uganda, for example, a study of 4,510 young people aged between 15 and 24 found that knowledge about condoms was high, and that men and women had a positive attitude about condoms. However, while more than three-quarters of young men and women knew that condoms prevent STDs, less than 13 percent of males and virtually no females (fewer than 1 percent) said they used condoms (Barnett 1997). Despite this gap, knowledge continues to play a key role in HIV/AIDS prevention.

In Mali, a survey in 1999 confirmed that young women want to know more. In the survey one of the key questions was "If you could change the past, which information would you have wanted to have about sex?" The most common response by 41 percent of women surveyed was that they wished that as youth they had known better how to prevent pregnancy and STDs. Survey participants reported that lack of information was one obstacle to reproductive health. Other obstacles included distance to health services, lack of contraceptive methods and cost (Robinson 2000)

Even when adolescents have accurate knowledge about STDs, they often do not heed warnings to reduce risky sexual behaviours. Some adolescents at high risk, for example, do not adopt safer behaviours because they incorrectly perceive their risk as low. Familiarity with a sexual partner often leads to a perception of decreased risk. In a study from Malawi, girls perceived little risk in having sexual relations with a boy whose mother knew their family (Helitzer-Allen 1994)

Most 16- to 22-year-old participants in a focus group discussions held in South Africa as part of a commercial marketing initiative said they did not use condoms due to lack of availability. Most of the 78 participants simply did not have the courage to ask for condoms at pharmacies and clinics (Best 2000) Young adults may not seek reproductive health services, or be capable of saying "No" to unwanted sex. Similarly if young women do not believe in themselves, and they do not believe they have the capacity to insist on their reproductive rights, then they will be unable to assert their rights in [high-risk] situations. (Keller 1997) It is becoming clear that condom usage for the youth may not be a straight forward issue.

4.3 Sex and Condom Use

Less than 20% of males and females in Ghana use condom at first sex (GSMF 2000). In repeated peer group discussions in South Africa (with girls aged 14-15 and boys aged 16-19) to explore influences on safe sex behaviour, separate male and female safe sex paradigms emerged. Males are less likely to perceive themselves as 'at risk' and more likely to use condoms. Females, who had not used condoms, would have preferred to delay sexual relationships and feared pregnancy as well as HIV/AIDS.

Both sexes deemed it difficult for girls to initiate condom use, although both sexes viewed condoms favourably. Girls saw condoms as a sign of love and protection, whereas boys tended to use them with casual partners.

A lack of decision-making autonomy within relationships further constrained girls' ability to practice safer sex (Harrison et al 2001). Using theories of health behaviour, Keller (1993) conducted a study aimed to advance the understanding of risk-taking regarding human immunodeficiency virus (HIV) infection among young adults. The study described: (a) their representation (i.e., schema) about HIV infection, (b) their problems with use of condoms and comfort with safe-sex practices, and (c) situations associated with risky sexual behaviour and reported reasons for risk-taking. From the sample of 272 young adult college students whose average age was 19.3 years it was found out that for 60% of them, the stated reason for the risk-taking was that the intercourse was unplanned or spontaneous. Fifty percent reported that they "just knew" the partner was safe and not infected with HIV.

In a study, which included group discussions about sexuality, the meaning of safe sex and accessibility and use of condoms (Hillier et. al 1998) it was found out though most students identified condoms with safe sex, many were ambivalent about using them. Reasons given related to problems of negotiation, difficulties of access, and the risks which condoms gave no protection from, such as a sullied reputation.

In Ghana high AIDS related knowledge among women is yet to translate into increased condom use.

Taky (2000) suggests that the use of rational choice models in AIDS prevention programs may not be adequate to change peoples sexual behaviour especially in societies like Ghana where prevailing culture practices and norms encourage large families. As contraception use increases it is likely that the use of condoms for AIDS prevention would increase.

It can be hypothesised that observed declining trends in HIV correspond to change in sexual behaviour and condom use especially among the youth (Asiimwe-Okiror et al 1997)

In the light of this, there is the need to urgently shift the frame of reference from the hitherto naïve and simplistic representations of young people and HIV/AIDS toward this more sophisticated and directly useful framework. The starting point is a significant re-working of the concept of prioritising of young people in relation to risk-in-context, as distinct from merely as 'at-risk' by definition.

4.4 Safer Sex and HIV/AIDS Prevention Information the Youth Should Have

Petosa (1990) found out in a study that conducted an educational diagnosis for AIDS prevention among school age adolescents that many adolescents hold serious misconceptions that could lead to unintentional risk behaviour. In another study that describes the knowledge, beliefs and sexual behaviour of urban adolescents and adolescent peer educators and identifies the elements needed to design effective HIV/AIDS prevention programs, it was found out that HIV prevention interventions need to include information about specific risk behaviours such as using condoms. Specific information that will increase perception risk of HIV and the development of condom use skills were identified by adolescents and adolescent peer educators as relevant approaches to reduce HIV infections among the youth. (Villarruel et al 1998) Targeted information to the youth will

help reduce high risk behaviour. Main DS et al (1994) in an intervention study using school based HIV education programs also found out that intervention students exhibited greater knowledge about HIV and greater intent to engage in safer sexual practices than the comparison students. HIV prevention information however need to be designed for specific cultures. In a study conducted by Eriksson T, Sonesson A, and Isacsson A (1997) to compare knowledge of HIV/AIDS exposure and appreciation of given information among Swedish and Kenyan teenagers it was found out that though over knowledge was high in specific items the knowledge and awareness of different risk behaviour for contracting HIV/AIDS differed for Kenyan and Swedish teenagers.

4.5 Conceptual Framework

As HIV transmission is propelled by behavioural factors, theories about how individuals change their behaviour have provided the foundation for most HIV prevention efforts worldwide. These theories have been generally created using cognitive-attitudinal and affective-motivational constructs (Kalichman, 1998). There are several models that look at behaviour risk and HIV infection. One of such models is the psychosocial model of behavioural risk, which is categorised into three major groups (King 1998). These are:

1. Those predicting risk behaviour,
2. Those predicting behavioural change and
3. Those predicting maintenance of safe behaviour.

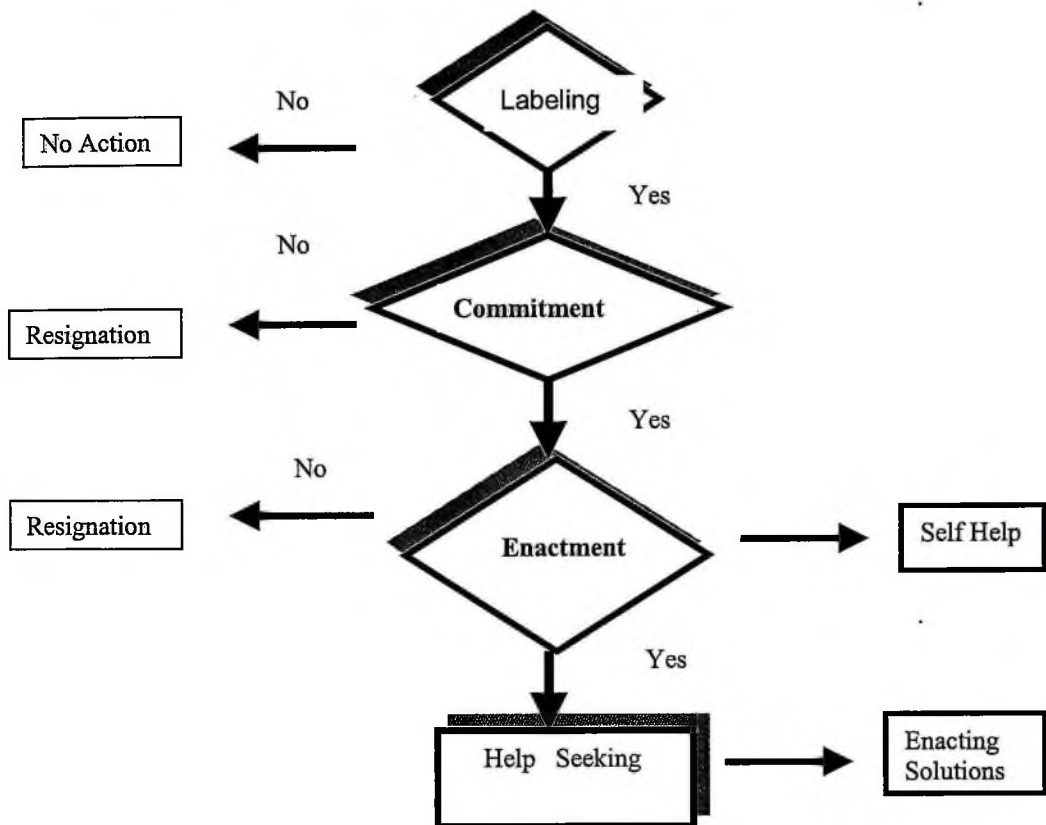
Models of behavioural change generally focus on stages that individuals pass through while trying to change behaviour. Although each theory is built on different assumptions they all state that behavioural changes occur by altering potential risk-producing situations and social relationships,

risk perceptions, attitudes, self efficacy beliefs, intentions and outcome expectations (Kalichman, 1997).

4.6 AIDS Risk Reduction Model

The AIDS risk reduction model, was developed specifically for AIDS. (Catania et al 1990) The model uses constructs from the health belief model and the social cognitive theory to describe the process individuals (or groups) pass through while changing behaviour regarding HIV risk. The model identifies three stages involved in reducing risk for HIV transmission, (Catania et al 1990). These include behaviour-labelling, commitment to change, taking action.

The framework below shows how the AIDS Risk Reduction Model works.



According to Catania et al (1990), in the first stage, there should be recognition and labelling of one's behaviour as high risk by the individual himself. Knowledge about HIV transmission, perceived HIV susceptibility, as well as aversive emotions influence how people perceive AIDS. If there is no labelling of behaviour as high risk by the individual then no action will be taken. The second stage, which is the commitment stage, is about making a commitment to reduce high-risk sexual contacts and to increase low risk activities once high risk labelling has been made.

The commitment of an individual is shaped by four factors: perceptions of enjoyment, self-efficacy, social norms and aversive emotions. If one labels high risk behaviour but there is no commitment there will be a feeling of resignation. The last stage is to take action. There should be information seeking, obtaining remedies and enacting solutions to change behaviour. Here, aversive emotions, sexual communication, help-seeking behaviour and social factors will affect people's decision-making process (Catania et al, 1990).

The AIDS Risk Reduction Model is relevant to this research. It provides the framework for assessing how the youth perceive their sexual behaviour. What kind of information is available to enable them make a commitment to alter their high-risk behaviour and what safer sex behaviour they can adapt to protect themselves e.g. condom use.

Chapter 5

5.0 FINDINGS AND DISCUSSION

5.1 Respondent Profile

A total of ninety-one (91) people were interviewed over a two-week period. This is made up of seventy one (71) in school and out of school youth aged between 16 and 24 years (interviewed in eight (8) focus group discussions) and twenty (20) in-depth interviews using semi structured questionnaire. Between six (6) to eleven (11) people participated in each of the focus group discussions. There were four (4) male groups and four (4) female groups selected from identifiable groups in Agogo, taking into consideration those in school and those out of school.

5.2 Youth Respondents

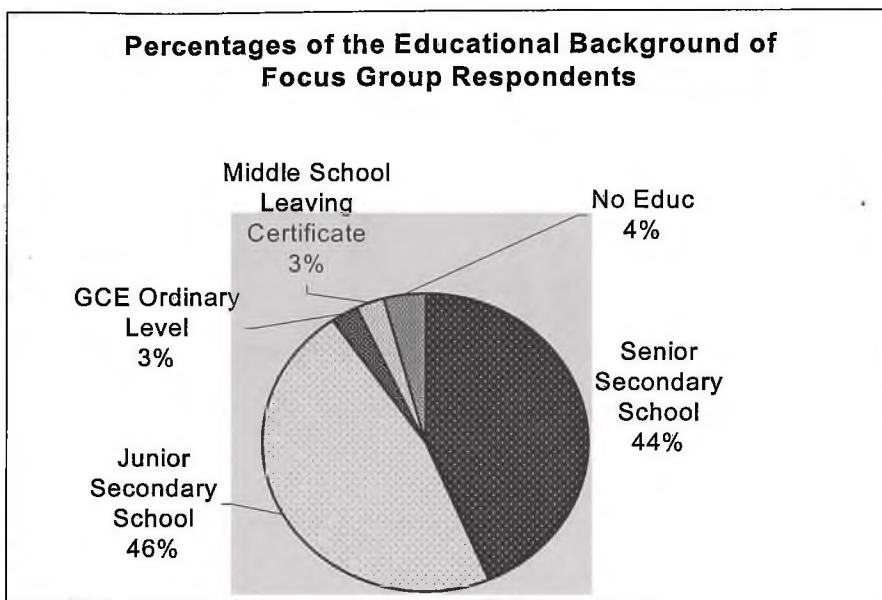
Out of the seventy one (71) youth interviewed, thirty eight were males (54%) and 33 females (46%). The educational levels of the youth respondents ranged from those who had never been to school to those who had General Certificate of Education (GCE) Ordinary Level. Forty six percent (46%) of the respondents have finished Junior Secondary School (JSS) and forty four percent (44%) Senior Secondary School (SSS). Three percent of the respondents have no education.

Table 2 and figure 4 show the educational background of the discussants

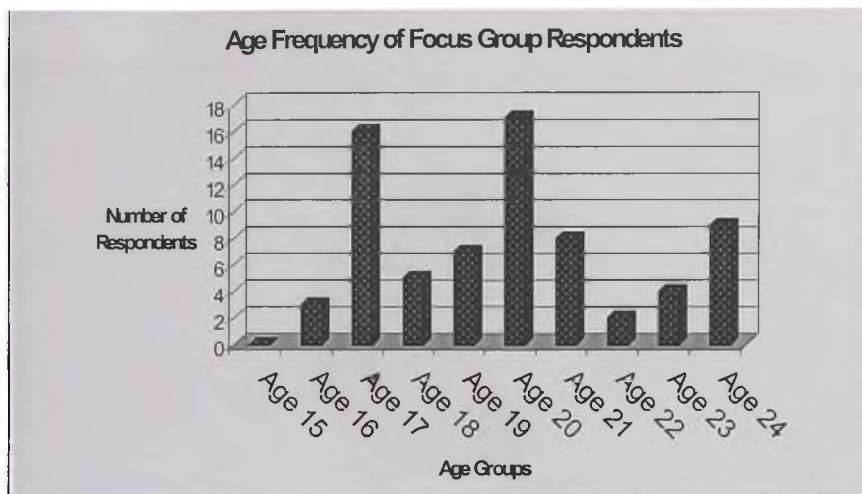
Table 2

Educational level	Male	Female	Total
Senior Secondary School	18	13	31
Junior Secondary School	15	18	33
GCE Ordinary Level	1	1	2
Middle School Leaving Certificate	2	0	2
No Education	2	1	3
Total			71

Figure 4



The modal age of the youth respondents is twenty years (20 years). The age with the least number of respondents was twenty-two years (22 years), which had two people. The age distribution had two peaks, ages seventeen (17) and twenty (20). Figure 5 shows the ages and frequency distribution of the youth respondents

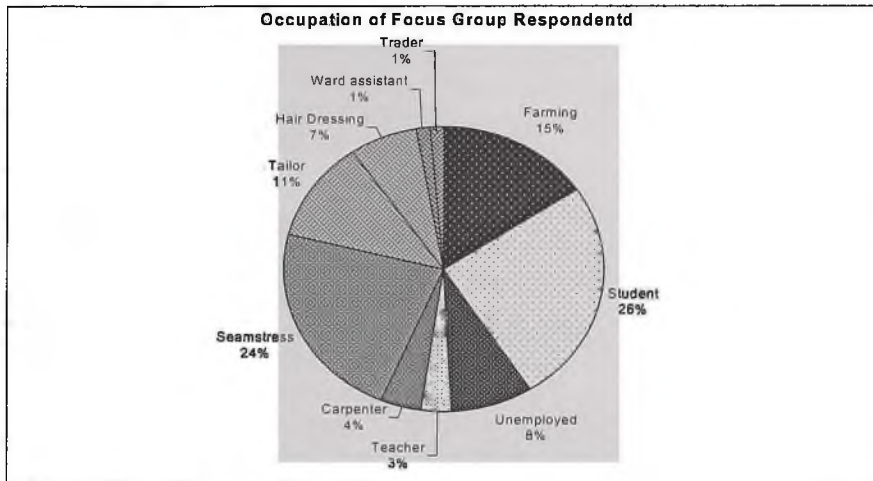
Figure 5

Ten different occupations were observed from the youth respondents. Students formed the majority of the respondents, followed by seamstress, farmers and tailors. The profession with the least number of respondents were trading and ward assistant with one (1) respondent each.

Table 4 and Figure 6 shows the frequency of the occupations and the percentages respectively.

Table 4

Occupation	Frequency
Farming	11
Student	18
Unemployed	6
Teacher	2
Carpenter	3
Seamstress	16
Tailor	8
Hair Dressing	5
Ward assistant	1
Trader	1
Total	71

Figure 6

5.4 In-depth Interview

The twenty respondents were divided into five groups and interviewed. The groupings are: Chemical shops, parents, opinion leaders, youth leaders and health professionals. These were mostly adults interviewed for their views on the Youth and HIV/AIDS. Table 5 shows the details of their occupational background

Table 5

Group	Occupation	Number
Chemical Shop	Shop Attendant	3
	Shop Owner	1
Opinion Leaders	Chief/Pensioner	1
	Assembly Man	1
	Moslem Leader/Alhaji	1
	Reverend Minister	1
	Catchiest – Catholic Church	1
Youth Leaders	Girl School Prefect	1
	Boys School Prefect	1
	Trader/Moslem	1
	Medical Assistant - AIDS Counsellor	1
Health Professionals	Medical Assistant - Secretary - Agogo Presbyterian Hospital AIDS Program	1
	Community Health Nurse - AIDS Counsellor	1
	Agogo Presbyterian Hospital AIDS Program Co-ordinator	1
	Chop Bar Operator	1
Parents	Trader	1
	Farmer	1
	Administrative Officer	1
	Total	20

5.5 Results and Discussion

5.5.1 The Youth of Agogo

The day of the youth in Agogo generally starts between 5.am and 6.am. This was accepted among all the groups. Sweeping their surrounding, fetching water and washing dishes are the first household chores undertaken. For the youth who are farmers work starts as early as 6 am when they set off for their farms. For other occupations like seamstress, hairdressers, teachers, traders and students, work starts between 7a.m. and 8.30 a.m. Between the hours of 12.30 p.m. and 2 p.m. is used for lunch, resting and visiting boy or girl friends. Work resumes from 2 p.m. till between 4.30 p.m. and 5 p.m. Vocations like tailoring and hair dressing can go on till about 7 p.m.

The journey home from work is not always a straight route; a stop over at a boy or girl friend's house is considered as normal. According to the female respondents, on their way home after work they are caught up on the way by boys who inquire about their names, places of habitation and go ahead to propose to them.

There are household chores like cooking, fetching water for females and bathing between 5.30 – 7 p.m. For males relaxation, playing games and chatting are the main activities. Between 7.00pm and 11 p.m. was accepted as free period for personal activities to take place before going to bed. During this time, visiting boy and girl friends, going to church, watching T.V/video, and selling of eggs, oranges, bread etc are undertaken.

Life in Agogo was described as interesting and full of entertainment opportunities by the youth. Opinion leaders, parents and youth leaders, however, decried the lack of employment opportunities apart from farming and vocational apprenticeship. All opinion leaders interviewed on the potential of the youth maintained that the youth were not taking advantage of the educational institutions - (Nursing and Teacher Training) in Agogo. To the youth it is possible to achieve something but if one wants to get more money one must travel either to Accra, Kumasi or abroad.

5.5.2 The Youth and Sex

The youth of Agogo are sexually active. In six out of the eight focus group discussions conducted, there was no body who was not sexually active. In the other two groups, which had nine and eleven people, two people in each group said they were not sexually active.

The respondents indicated that, sexual activities could occur between 12.30 and 2 p.m. when they take their lunch break. However, the ideal period is between 7 p.m. and 11 p.m. where many go to see their boy or girl friends. Others too indicated that sexual activity could also take place between 5 a.m. and 6 a.m. if they sleep at their boy friend's house. This was confirmed in all the female groups and two of the male groups.

Poverty is the most significant determining factor in the possibility of sexual activity among the youth. In all the interviews both focus group discussion and in-depth interviews, poverty was mentioned as the main cause of sexual activities among the youth. Discussions engaged in during the development of the daily activity schedule/chart revealed that most young females, who do not have money, find their way to their boyfriends during lunch time for food and this in most cases leads to a sexual activity. Most females who have been showered gifts by males also find it difficult to refuse a sexual encounter. As one female senior secondary student put it

"It may happen that you have been in the relationship for a long time and the boy has been providing for you, so if he comes demanding sex you can not say no". "Sometimes also some of the girls are not interested in the boys on campus and therefore befriend boys in town who can shower gifts on them. If the boy you love comes demanding sex, looking at his face and telling him "no" is difficult to say".

The issue of poverty comes in various forms. A parent respondent narrated how her seventeen year old daughter got pregnant as a result of not having any body to take care of her when she went to her home town for a while.

As Moslem one respondent puts it,

"the majority of the cases (promiscuity) can be attributed to hardship or poverty, because some of the girls don't get parental support and therefore in their times of need, they feel it is right to get it from a boy or boys. But if you are working and get what you need, then sex will be only at your discretion and pleasure, but not a way of making a living".

Focus group discussions with seamstresses and Moslem females also yielded two poverty related sources for sexual activities:

"For some of the girls it usually occurs when we drop out from school and find no work to do and this leads us to prostitution to make a living".

"Sometimes the things some girls tell their friends about what their boy friends do for them also encourage those who do not have, to force themselves to have in order to enjoy such gifts and treatments. Sometimes some friends will dress very gorgeously and come and tell you that the secret is their boy friend which will influence you also to go after boys".

As a piece of advice a parent suggested that girls should also beware of unknown men who demand sex from them in order to support them financially and materially. The irony here is that it is not only "unknown men" who can infect you with the HIV virus.

The role of economic factors in sexual activities has also been documented by Rwenge (1995) who concluded (study of 671 youth in Cameroon) that youth with few economic resources and those with less stable living environments are more likely than other youth to engage in sexual behaviours that puts them at risk of contracting HIV.

5.5.3 Safer Sex Practice and HIV/AIDS Prevention

Females are at a higher risk of consenting to unprotected sex. In all the female focus groups, it was accepted by the respondents that it is difficult for a female to struggle with a man who wants to have sex with her. Most of the female respondents also accepted that they would not refuse their regular boyfriends who do not want to use condom although they accepted that the men are generally promiscuous. Moslem women could be at a higher risk because of their religion and other practices like arranged marriage. A moslem lady was very emphatic when she made this statement.

"Excuse me to say, some of our men are illiterates and older so when they don't want to use condom you cannot complain; Our religion does not accept the use of condom".

Although the second statement about Islam's acceptance of use of condom is debatable, many of the female youth will easily succumb to that argument when their husbands or boy friends do not want to use a condom.

5.5.4 Condom Use

For the youth of Agogo buying a condom is not an easy task for two main reasons: shyness and the price. Best (2000) has also found out that the youth did not simply have the courage to ask for condoms at a pharmacy or clinic. Confidence in one's ability to obtain the condom is an important precondition for use (GSMF 2000). Although majority said the price should be reduced there were some who felt the price was affordable.

In a focus group of eleven males of mixed religious background nine of the then said that the price should be reduced to encourage more people to buy. All chemical shop respondents however indicated that customers have been complaining about the price. Shyness was however universal to the sample.

All chemical shop owners indicated that shyness was the main cause of relatively low patronage. Experiences of the chemical shop operators indicate that children are in most cases sent with a note by the youth requesting to buy a condom. In some cases the youth will wait until everybody goes before he will come forward to buy the condom. Others use coded names like "CD", "the thing" to refer to condoms. For the youth a younger chemical shop attendant makes things easier. A very understanding chemical shop attendants, makes it better. According to all the chemical shop attendants interviewed, they wrap the condom quickly and secretly so that no one sees it. This they say makes it easy for the youth to buy. The main source of the shyness is being branded a bad boy. During the focus group discussion with male tailors one of the discussants made the picture clear when he said

" The person who is the seller could be your church member and depending on what role you play in church, the person may have some wrong impressions about you"

Condoms are however readily available. All chemical shops have also recorded an increase in sales. On the average of 10 - 25 pieces of condoms are sold a day. One shop could sell one box of condoms (100 pieces) in 4 days. In all the focus groups the respondents said if they wanted condoms they could easily get them at the chemical shops.

The increase in demand for condom was confirmed by the discussants who said that males always keep condoms in their wallet:

“Some of the boys put condoms in their wallets and use it anytime they get a girl to have sex” (female senior secondary school students).

From the focus group discussion held with female students, it was also revealed that student girls wrap condoms as gifts for their boy friends.

Despite the availability and the general increase in demand of condoms, the youth continue to practice unsafe sex. Results from the Ghana Youth Reproductive Health survey (GSMF 2000) indicated that 90% of both male and female youth did not use condom every time they had sexual intercourse. In this research, various reasons were given as to why they will have sex without a condom.

This list of reasons summarizes why the youth may have unprotected sex. (Direct Quotes)

Low Sensitivity and condoms

1. Some of the boys say they enjoy “flesh against flesh” and therefore with condom on they do not enjoy sex.
2. The ladies do not like it because it does not give them maximum feelings.
3. “The feeling you get from using condoms is very low”.

Misconception about Condoms and AIDS

4. Condon is not used when the person is perceived to be healthy.
5. Some people say the condom can burst.

6. Some of the boys even say there are tiny holes in the condom where the semen can pass through. So there is no need to use it.
7. Those who do not believe in the disease have sex without condoms even if the condom is given free.
8. Some people also use it to protect unwanted pregnancies but even that they say the condom can burst so it is better to do without it.
9. "It is said that if you do not wear it properly it can burst so I prefer to go it raw like that".
10. "When we the ladies insist that they use condoms, the question they normally ask is "do you trust me?"
11. "I do not trust condoms and will not even use it in my marriage".

Self Control

12. Impatient of the youth to wear the condom because he has longed for sex so much that, he even forgets that something of that is there for protection.
13. There are instances when the foreplay overwhelms them that they even forget that they have condoms on them.
14. When one is under the influence of alcohol.
15. In time of rape.
16. "Sometimes, our parents upon seeing condoms on us "label" us as bad boys so this discourages us from buying the condom and therefore sometimes have sex without it".
17. "Emergency cases where I do not have condom".
18. "When I am convinced that the girl is innocent".
19. "I use condom regularly but sometimes when I see that a particular girl looks innocent, I do not use the condom".

20. "Sometimes we have the condoms on us but because of our impatience we end up having sex without condom".

Cost

21. The condoms are costly and if the price could be made cheaper like ₵100.00 or ₵50.00 if not free.

Keller (1993) found similar response when 60% of 272 young adult students stated that the reason for risk taking was that the intercourse was unplanned for or spontaneous, 50% reported that they "just knew" the partner was safe and not infected with HIV. GSMF (2000) also recorded misconceptions like "you can tell some one has an STD by looking at them".

5.5.5 HIV/AIDS Prevention

Respondents suggested a number of measures that can help reduce HIV/AIDS. They are:

- Abstinence
- One partner
- Seeking advice
- Peer education
- Condom use
- No pornography
- Proper dressing
- Voluntary counselling and testing.

Condom use, one partner and abstinence were mentioned in all the 4 pair wise ranking exercises conducted.

Although the pair wise ranking was conducted with four different groups (Student females, farmers, student males and active female churchgoers) abstinence came up as the measure that could best prevent HIV/AIDS. It was the first option in the female students, third option for active female churchgoers, second option for male farmers and second option for male students. Condom use can be said to be the next perceived means of preventing HIV/AIDS. It was ranked second among female students, fifth among active female churchgoers and first for male farmers and male schoolboys. GSMF (2000) also found out that the Ghanaian youth who have had sex identified condoms as safer sex followed by abstinence, avoiding multiple partners and avoiding prostitutes

Voluntary counselling and testing was also significant. It was rated as the best option for HIV/AIDS prevention by the female active churchgoers, second* by the male farmers and also second** by male schoolboys. Voluntary counselling and testing is increasingly becoming acceptable among the youth especially for females. Most of the female respondents said they would like to test for HIV/AIDS before they get married on condition that they have not had unprotected sex with their spouse to be. It was agreed by respondents however that it cannot apply to a "boy friend relationship" The issue of voluntary counselling and testing (VCT) was raised in all the focus group discussions. Respondents were asked whether they are willing to take a VCT if the service is available for free. Sixty three percent of the respondents were willing to do VCT. Significantly all the members to the female active churchgoers' group were willing to take a VCT.

* In addition to abstinence

** In addition to abstinence and one partner

The respondents had varied views as to what can be done to prevent the spread of the disease. To a Moslem opinion leader

"if the disobedient youth contract the disease through the deaf ears to the message, then they should be subjected to severe whipping as in the case of Islamic Sharia law".

Other proposed measures include confinement to a common place and stringent measures such as the death sentence by firing squad. However, there was reaction to these propositions as others contended that not all victims are promiscuous and therefore such measure will be unfair.

5.5.6 Knowledge on HIV/AIDS

The Youth of Agogo are aware of HIV/AIDS and are concerned about its impact on the youth.

Six main reasons were given for the concern about the spread of the disease.

These are:

1. The victim becomes unhappy till he/she dies,
2. Friends will no longer get closer to the AIDS victim,
3. You suffer for a long time before you die,
4. You grow lean before dying,
5. The virus can make other illnesses attack you,
6. Social stigma and disgrace associated with the disease.

All the respondents in this study had heard about the disease called HIV/AIDS. Respondents indicated that one could get HIV/AIDS from someone who is infected with the disease through sex without using condoms.

It was also mentioned very frequently during the discussions and in all the focus groups and in-depth interviews that HIV/AIDS is a dangerous disease that has no cure. It was added that when one gets AIDS, it takes a longer time for the person to discover it. Also through blood transfusion and the use of same toothbrush and sharing of sharp objects. Mother to child transmission was also mentioned.

This confirms GSMF (2000) which found out that 91% of males and 87% of females in Ghana were aware that people can contract diseases through sexual intercourse. Rwenge (1995) also found out that 97% of the young people had heard about AIDS. In that study 94% identified sexual intercourse as a way in which HIV is transmitted. The most commonly mentioned methods of preventing HIV/AIDS in that study were abstinence faithfulness, and condom

To the youth of Agogo, HIV/AIDS is real although they have heard some people say evil spirits causes it and all those who die through it are cursed to die in that manner. They believe HIV/AIDS is real because they have heard it on radio, on programmes organised by the hospital, and seen it on TV. The Agogo hospital was mentioned by most of the respondents, as their source for believing HIV/AIDS is real. When they visit Agogo hospital they often hear that HIV is on the increase. This information was however mostly from fellow patients at the hospital.

5.5.7 HIV/AIDS Information the Youth Need

There are opportunities for HIV/AIDS education to the youth in Agogo. The youth are ready and eager to learn more about the diseases. Despite that in all the focus group discussions, the respondents said they had heard about the diseases and were able to identify ways in which the

disease is transmitted and some of the symptoms, there were still a lot of information which they did not have. There are still grey areas which the youth will need some clarification on. These include issues about the nature of the virus, the role of sex in the transmission process, and the difference between HIV/AIDS and other sexually transmitted diseases. A total of forty two (42) different questions about HIV/AIDS were recorded. According to one respondent

"The virus they say can die in about five minutes of it's exposure to the open air but why is it that it is still said that when one uses a blade used by a victim several minutes after, the person can still contract the disease?"

Another also asked

"I have learnt that the transmission of AIDS is faster from male to female than the vice-versa why?" There were also questions such as *"can kissing give you the disease"*, *"why is it that even when you use condom, you still get pregnant or AIDS"* and *"Why is it that we have drugs for other STDs but not for AIDS?"*

There is readily available reference material for educational program on HIV/AIDS for the youth. The HIV/AIDS Questions and Answers Book, published by Ministry of Health with support from USAID and Johns Hopkins University/Centre for Communication Programs provided answers to some of the questions asked by the youth. (Health Education Unit 1999) Copies of the book were available at the Agogo Presbyterian Hospital AIDS Control Program and some respondents confirmed that they have seen the book before. Some Counsellors of the Agogo Presbyterian Hospital AIDS Control Program have also used the booklet at a guide for their education programs. Twenty-two of the forty-two questions got direct answers from the book.

Below is a list of questions that did not have answers in the HIV/AIDS Questions and Answers Book. (HEU/NACP 1999)

Daily Life and AIDS

1. How can the use of sharp objects serve as a mode of transmission?
2. "I have learnt that when some one uses a blade and you also use it you will get HIV why?"
3. Can you get AIDS through barbering?

The AIDS Virus

4. I do not understand how the disease came into existence.
5. Why is it that the virus can die within 5 minutes of exposure but yet they still insist that we hairdressers have to put the combs into bleach for 10 minutes before using them?
6. Why is that the virus can not die after some time?
7. The virus they say can die in about five minute of it exposure to the open air but why is it that it is still said that when one uses a blade used by a victim several minutes after the person can still contract the disease.

Blood and AIDS

8. Why is it that blood transfusion is still a source of infection?
9. Why is it that when people donate blood and they are found to be HIV/AIDS positive, doctors hide the information from the donors?
10. Does AIDS exist only in human blood or the virus can be found in animals?
11. Why is the virus in the blood?
12. Some say if your blood is stronger than your partner you can't get it

AIDS and Drugs

13. "Why is it that we have drugs for other STDs but not for AIDS?"

People Living with HIV/AIDS

14. Why is it difficult to tell people with HIV their fate and it takes a long time before referring the fellow to a counsellor to be told?

15. Is it true that good diet can prolong the life span of an AIDS victim?

16. Can a child with AIDS live longer?

17. At what age can you die after you have acquired the disease?

Sex and AIDS

18. Is it true that gonorrhoea can lead to bareness?

19. What is the difference between gonorrhoea and AIDS?

20. "I have learnt that the transmission of AIDS is faster from male to female than the vice-versa why?"

The full list of questions asked and their corresponding reference in the HIV/AIDS Questions and Answers Book can be found in appendix 3 (HEU/NACP 1999).

5.5.8 Specific HIV/AIDS Mass Communication Programs

Information and knowledge of the disease is fundamental to any behaviour change process. Radio and Television has played a very important role in providing information on HIV/AIDS to the youth, as most of the youth interviewed had not attended any HIV/AIDS program. Television, and radio advertisement were cited in all the focus group discussion and in-depth interviews as the reason why the youth believe HIV/AIDS is real.

McCombie et al. (1992) has found that there was a decrease in the number of sexual partners and greater use of condom in Ghana as a result of a campaign to promote AIDS awareness and prevention among 15-30 year olds in Ghana by using television and radio advertisement, community meetings and disseminating of promotional materials. In this study however, artisans especially the tailors and seamstress however said they did not have enough time to watch television.

Programs and information that come in the form of a story or life experience appeal most to the youth were recounted easily and are more likely to have the most effect on any safer sex behaviour. In all the discussions conducted these types of information were the first to be cited as known information about HIV/AIDS. The most frequently cited stories six out of eight focus group discussion) are:

“ I saw a documentary where a lady went to Abidjan and when she returned to Ghana, she had contracted the disease which later killed her” (Female Seamstress).

“I also saw on television a lady who was selling kenkey and a boy proposed love to her and she refused. Later a rich contractor came in with his money and the girl agreed. The man later went to bed with the girl and gave her the virus” (Male student).

“Our Pastor also gave us a story of a man who travelled and got himself in extramarital affair. So when he came back, he had three children with the wife. But one day the wife was admitted at the hospital and the doctor demanded blood for her. The husband donated the blood and the doctor found out that he was HIV positive.

The whole family was tested and it was revealed that all the children including the wife had been infected." (Active female churchgoer)

A male tailor respondent also narrated a story of two girls who were involved in trading. According to him, at a point one decided to stop and went into prostitution, which, later translated into her getting HIV/AIDS. He then linked this story to the attitudes of parent who are not supportive, which make girls go into prostitution. Mmaa Nkomo (a Ghanaian social talk show targeting women) was also cited. (People living with AIDS had given testimonies on the talk show program). Other printed and promotional material like the European Union Sponsored comic booklet on AIDS, Ghana Social Marketing Foundation/Johns Hopkins University sponsored Questions and Answers Booklet and leaflets, T shirts, were cited as specific HIV/AIDS information ever seen.

HIV/AIDS Advertisements on Ghana Television

The Ghana Social Marketing Foundation/Johns Hopkins University Center for Communication Programs, sponsored "Stop AIDS Love Life" advertisement was cited in all the focus group discussions and in-depth interviews as a source of HIV/AIDS information. In a follow up to the impact these advertisement have had on the youth it was found out that the slogans "Stop AIDS Love Life" was very popular among the youth and has always reminded them of the need to protect themselves. Some of the Ghana Social Marketing Foundation/Johns Hopkins University sponsored advertisement on HIV/AIDS however had both positive and negative comments. Below is a Table 7 that shows the various advertisements on television and some of the comments made about them by the youth.

Table 7

TV Commercial & Program	Comments by the Youth
Panther Condom Advert "A pack of three"	<ul style="list-style-type: none"> ▪ it talks about condom use
Chiefs of Ghana Talking about HIV/AIDS	<ul style="list-style-type: none"> ▪ it tells us to abstain from sex. ▪ When an adult bathes water finishes, any matter that the chief or elders talks about it means the matter is finished
Douglas Sem an HIV/AIDS Positive person talking about HIV/AIDS	<ul style="list-style-type: none"> ▪ tell us to use condom or abstain from sex.
TV Drama Series – Things we do for love	<ul style="list-style-type: none"> ▪ "the advert impacts negatively on me because I have learned how to talk and chase girls. On the other hand, it shows chasing girls can lead to STDs and AIDS". ▪ "Pusher" character tells us to stick to one partner
Music Video on HIV/AIDS	<ul style="list-style-type: none"> ▪ advise us to protect themselves ▪ AIDS is a killer disease and that we should abstain from sex or use condom. ▪ Music video talks about everything, Abstain, be faithful, use a condom ▪ Tells Ghanaians that they should be careful about the disease
Red Candles representing people who are infected with HIV/AIDS	<ul style="list-style-type: none"> ▪ "it shows us how the disease spreads daily". ▪ The candles tell us that everyday 200 people are infected with the disease ▪ The idea is that people should see the disease, as real otherwise one day we will all die because of the disease.
Boys night out Three boys in a dormitory preparing to go out	<ul style="list-style-type: none"> ▪ Advises us to take condom on them and use it always. ▪ You can talk about condoms but not in front of children ▪ Stop AIDS tells us to avoid AIDS by all means
Sorry no sex - Girl tells boy we have to wait (in front of a gate)	<ul style="list-style-type: none"> ▪ tells us that the girl loves the boy but she does not want them to involve in sex before they marry. ▪ "the advert talks about abstinence and that we should wait

In a matrix ranking exercise to assess which advert impacts on which HIV/AIDS prevention behaviour, it came out that for abstinence behaviour, the advert using the chiefs and "sorry no sex we can wait (boy and girl)" was perceived as those that sent the message well. The *chiefs advert* best sends the message of faithfulness, *boys' night out*, *panther condoms*, *candles and musical video* promote condom usage and the need for education about the disease very well.

According to one health professional working with the Agogo Hospital HIV/AIDS Control programme, the chiefs' advert has a lot of influence when it comes to warning people about the existence of the disease. To him this is significant because in the Ashanti tradition it is said that

"When a chief bathes, water finishes; this means that any matter that the chief talks about is serious and must be implemented"

Below is the result of one matrix ranking conducted with female senior secondary school students.

Matrix Ranking of HIV/AIDS Mass Communication Advertisement and How it Affects HIV/AIDS Behaviour Identified by the Youth

(Female Senior Secondary School Students) - Total Score allowed is 20

***** Each of the Mass Communication Advertisement is ranked as to its effect on the four HIV/AIDS Prevention Behaviour Identified. A total of 20 marks is distributed among the four behaviours according to the effect the advert Can have on that behaviour. A high score means a high effect of that Particular behaviour**

Mass Communication Advertisement	HIV/AIDS Prevention Behaviour Identified by the Youth			
	Abstinence	Faithfulness	Condom Use	Voluntary Counselling and testing
Music Video	7	5	8	0
Boys Night Out	2	3	15	0
Sorry no sex - Girl tells boy we have to wait (in front of a gate)	15	0	0	0
Panther Condom Advert "A pack of three"	3	5	12	0
TV Drama Series – Things we do for love	3	5	12	0
Chiefs of Ghana Talking about HIV/AIDS	10	5	3	2
Douglas Sem - an HIV/AIDS Positive person talking about HIV/AIDS	5	5	5	5

(Please find as appendix 5 two tables of the ranking conducted for tailors and mixed male religious groups).

Chapter 6

6.0 CONCLUSIONS AND RECOMMENDATIONS

The findings from this qualitative study indicate that although the youth are buying condoms they may not be using them always. The reason for the demand in condoms comes from the knowledge that HIV/AIDS is real and has no cure and that condoms can prevent HIV/AIDS, pregnancy and other sexually transmitted diseases. Condoms are not always used because of in-discipline, low self-esteem and wrong perception about who can possibly be infected with HIV. This is evident from the emphatic "No" to the question whether the youth always use condom and the type of reasons given for the non use of condoms every time. The reasons includes statement like "I use condom regularly but sometimes when I see that a particular girl looks innocent, I do not use the condom" and "Sometimes we have the condoms on us but because of our impatience we end up having sex without condom". Correct information and knowledge is very essential in this case. Keller (1997) also raises this issue of self esteem and confidence. *"If young women do not believe in themselves, and they do not believe they have the capacity to insist on their reproductive rights, then they will be unable to assert their rights in [high-risk] situations"* (Keller 1997).

Women are at a higher risk of having unplanned sex and unprotected sex due to perceived gender domination of the male, low self-esteem, lack of parental support and poverty. Of these three, poverty is the most significant when it comes to women. Poverty here ranges from the very basic level like money for lunch to unemployment. Most of the female youth consent to sex because they have been provided for or will be provided for by males who will not always use a condom.

To be assertive and say no to sex for a female youth means to be able to take care of yourself and forego "material things" that you or your family cannot provide. Education, vocational or artisan skills are therefore essential in this case

The study has shown that whilst radio and television programs has played a significant role in shaping Safer Sex and HIV/AIDS prevention behaviour among the youth consistent educational for the youth is lacking. Most of the information about HIV/AIDS was heard on radio or television. The several questions that were asked by the youth points to the fact that radio and television do not provide feedback. Increase in face-to-face fora for the youth will clear most of the misconceptions that they have about the diseases and thus promote safer sex and HIV/AIDS prevention behaviour. The way an HIV/AIDS educational program on radio and television is designed is very important. Participatory, and story like presentations that narrates how one got the diseases and how he or she is dealing with it appeals more to the youth.

From the study the factors that promote safer sex behaviour among the youth are:

1. Co-operation and understanding between sexual partners on the importance of using condom
2. Accessibility of condoms to the youth
3. Correct information on HIV/AIDS
4. A culture of sexual discipline among the youth
5. Assertiveness, self confidence and ability to insist on abstinence and
6. Economic/Parental support for the youth

To conclude it is necessary to mention that this qualitative research has produced a snap shot of the youth and HIV/AIDS: what environment they live in, what information they have, what information they need and what are the factors that can promote safer sex and HIV/AIDS prevention behaviour. The findings can be used to design and implement HIV/AIDS programs as well as the basis for further research into the youth and HIV/AIDS.

The ADIS Risk Reduction Model has a role to play in promoting Safer Sex and HIV/AIDS prevention among the youth. It is clear from the findings that the youth have not fully recognised and labelled "having sex without a condom as a high risk behaviour. Moral uprightness of the youth and the fruits of sexual discipline have not been well appreciated to generate commitment to adopt HIV/AIDS behaviour. The youth need to be supported with information made readily available and in a way that appeals and motivates change. The youth cannot afford not to take action about their sexual life but they need support. A number of issues needs further research. These include the role of behaviour change theories on the youth, since these theories provide a mixture of information, practice and services needed to make the desired safer sex behaviour. For the youth how much of these "ingredient" do you have to emphasis on to motivate the youth change to safer sex and HIV/AIDS behaviour

6.1 Recommendations

The youth have now been identified as the most important targeted group for HIV/AIDS prevention. Targeting the youth however require specifically designed programs that can bring the best out of them.

Recommendation 1

Education programs targeting the youth should be participatory and include drama and role-plays. The youth have identified strongly with stories of how people had HIV/AIDS. They also have a lot of questions, which may not be included in "most frequently asked questions" list. These questions and the list of reasons why the youth do not always use condom can be used as a base for designing HIV/AIDS prevention education programs targeting the youth. A participatory drama and role-play approach will open opportunities for clarifying these types of issues. It will also provide opportunities for several vivid and practical scenarios of the situation and motivation for the desired behaviour change.

Recommendation 2

HIV/AIDS prevention activities just as the disease go beyond the biological realm. Under the broad development cap however, certain key aspects need urgent attention to provide the enabling environment for change to occur. Two of such aspects are self-esteem and employable skills for the youth. The research has shown that economic capacity can boost abstinence especially among females and faithfulness to "boy friends". Economic capacity improves self-esteem and can lead to confidence and making of right choices. Any HIV/AIDS project that intends to implement a comprehensive program should include activities on self-esteem, and livelihood/micro enterprise. Mobilisation and support of the youth with income generation skills, skills development programs at community level by District Assemblies under their poverty reduction programs will contribute substantially to the fight against HIV/AIDS. Training programs on negotiating skills to insist on condom use should be included on part of peer education programs.

Recommendation 3

It was observed in all the focus group discussions whenever somebody who is perceived to be experienced in sexual activities speaks the rest become keen and listens attentively. The youth are more comfortable with themselves when discussing sexuality issues. Peer education programs will go a long way in strengthening the conviction of the youth that HIV/AIDS is real and there is the need to protect themselves and their future. Selection of peer educators must however be done carefully to assure the confidence of the youth. Peer educators should be youth who have had experience of the peer pressure, life set backs as a result of sexual experience and not people who are proud and like to control or dominate.

Recommendation 4

It has been observed that there are several HIV/AIDS control programs going on in the country. In Agogo where this qualitative research was conducted several HIV/AIDS education programs by different groups (churches, District Assembly, Regional Health Office, Ashantiman Council etc). There is the need for organisations and institutions involved in HIV/AIDS programs to network and collaborate with each other and form partnership alliance in order to pull resources, avoid duplication of activities and conflicting messages.

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Appendix 1 Data Collection Tools

Daily Activity Chart

This tool will be used to delve into a typical day in the life of the youth. This tool will be used to collect and discuss information on the activities that the youth go through from when they wake up to the time they sleep and possible times of sexual activities and opportunities for possible education programmes.

There will be some assumptions in using this tool:

1. There will be discussion and agreement on a range of daily activities the youth undertake within hourly time scales taking into consideration week days and week end activities. Bars will represent the activities. Time expenditure on these activities will be reflected by the height of the bar on the Y-axis. The hourly time scale will be on the X-axis.
2. Young women and Young men will have separate daily activity charts
3. All special and occasional events like festivals, Christmas, Easter and will be held constant and will not apply

Steps

1. Self introduction of interviewer and team
2. Self introduction of respondents
3. Explain purpose of activity
4. Address issues of confidentiality
5. Explain and seek permission for tape recording and note taking
6. Re arrange seating arrangement into circle
7. Start the discussion by asking what time do the youth usually wake up and sleep

8. Mark the time on the X-axis starting from the time they wake up to the time they sleep.
9. Continue the discussion by asking what the youth normally do within the next hour of waking up.
10. List the activities after there has been a discussion and agreement by the group
11. Represent the time expenditure of the activities for that particular hour by a bar on the Y-axis using a scale of 1 to 10. This should be done after it has been discussed and agreed upon by the group
12. Repeat the process for the next hour until they sleep
13. Give an overview of the daily activity chart and discuss the following issues:
 - When are possible times when sexual activities occur and what conditions makes this possible.
 - What are the possible free time for any education programme on safer sex and HIV/AIDS?
 - Any questions or comments from respondents
 - Collection of detail background data of respondents
 - Thank you and refreshment.

Matrix and Pair Wise Ranking

Through the process of problems ranking, the group will be able to decide on issues, which needs priority attention. This tool will enable the researcher to investigate HIV/AIDS information that the youth have and which of this information is perceived as been effective for safer sex behaviour and HIV prevention.

Steps

1. Self introduction of interviewer and team
2. Self introduction of respondents
3. Explain purpose of activity
4. Address issues of confidentiality
5. Explain and seek permission for tape recording and note taking
6. Re arrange seating arrangement into circle
7. Discuss the various HIV/AIDS messages the youth have heard
8. Discuss where they heard these messages
9. Discuss what are the safer sex practices and HIV/AIDS prevention behaviour that they know of
10. Draw a matrix with the HIV/AIDS prevention messages on the horizontal axis at the top and the HIV prevention messages that the youth have heard on the vertical axis. Create blank boxes which matches each behaviour to the messages and allow the group to score using stones or any appropriate material (total of 20 stones to be scored against the most appropriate information that can change a particular behaviour)
11. Discuss the outcome of the exercise and give an overview
12. Discuss the reasons behind each score given
13. Open a discussion on what can be done to improve the practising of safer sex based on the outcome of the problem tree analysis exercise.
14. Discuss and agree on five most important interventions.
15. Construct a pair wise matrix and score/compare to get a priority list of what interventions related to safer sex behaviour the youth will like to be tackled
16. Discuss the reasons for the preference of one intervention over the other

17. Discuss how these interventions can be tackled and what information or education programmes will be appropriate.

- Any questions or comments from respondents
- Collection of detail background data of respondents
- Thank you and refreshment.

Focus Group Discussion Guide

The purpose of this exercise is to have an interactive discussion with respondents to gain insight into the environment in which the youth live in and how this environment affect their practice of safer safe and HIV/AIDS prevention. The focus group discussion will enable the researcher to hear from the respondents, challenges they face in practising safer sex/ HIV prevention, what HIV/AIDS information they have and what is their preferred safer sex and HIV AIDS information and programs.

Steps

1. Self introduction of interviewer and team
2. Self introduction of respondents
3. Explain purpose of activity
4. Address issues of confidentiality
5. Explain and seek permission for tape recording and note taking
6. Re arrange seating arrangement into circle
7. The environment the youth live in

- Life in Agogo
 - a. Morning, afternoon, evening
 - b. Entertainment/hang outs (what goes on there)
 - c. Social life and education programs
 - d. Morality, values and discipline
 - e. How does all these affect sex life of the youth
- 8. Knowledge of HIV/AIDS
 - What do the youth know about HIV/AIDS (from whom, when, where, how)
 - How useful is the information
 - What is unclear/feared about HIV/AIDS
- 9. HIV/AIDS information needs of the youth
 - What do the youth wish to know about HIV/AIDS
 - Where should the information be given
 - When should it be given
 - From whom should the information come from
 - What form should the information take
 - How will this information help prevent HIV/AIDS
- 10. Practising safer sex
 - Is safer sex difficult or easy to practice
 - Under what circumstances is it easy or difficult (time, personality, place)
 - What skill is necessary to make practising safer sex easier
 - What skills do the youth have
 - What skill do the youth need

- Is condom accessible (where, when)
- What is the process of acquiring condoms
- What are the enabling or disabling environment for condom acquisition

11. Summary

- What can be done/need to be done to improve safer sex practices and HIV/AIDS prevention (by who, when, how, where)
- Any questions or comments from respondents
- Collection of detail background data of respondents
- Thank you and refreshment.

Interview with AIDS Co-ordinator of Agogo Hospital, Community Health Nurses and District Disease Control Officer

1. Objectives of the AIDS control program of the district or hospital
2. Target group
3. Activities and implementation strategy
4. Messages being given
5. Response to the program by the target group
6. Lessons learnt
7. Challenges and difficulties of organising such a program
8. What institutional arrangement is used to implement the program
9. From experience what are the Obstacles to safer sex among the youth
10. Suggestions to promote safer sex behaviour and HIV/AIDS prevention
11. Impact of the program

Interview of opinion leaders (parents, traditional leaders and youth leaders)

1. The youth and their potential
2. How the youth are handling their sex life
3. Challenges the youth face in practising safer sex and HIV/AIDS prevention
4. Awareness of programs on safer sex and HIV/AIDS prevention?
5. If yes what are these programs and how appropriate are they in promoting safer sex and HIV/AIDS prevention
6. Role in promoting safer sex and HIV/AIDS prevention
7. Opinion on accessibility of condoms to the youth.

Interview of Chemical sellers

1. Demand for condom
2. Awareness of programs to promote condom use among the youth
3. Do the youth have difficulty in buying condoms
4. Have there been any attempt to make the purchase of condom easier for the youth
5. Interactions during the purchase of condom

Appendix 2

Focus Group Discussion Guide For Assessing Availability of HIV/AIDS Material and The Effect of Educational Programs on Radio and Television.

Steps

1. Discuss what specific HIV/AIDS information/programs the respondents have heard of, received, or participated in.
2. What are the sources of HIV/AIDS information i.e. organizations, groups etc
3. Initiate a discussion on the most interesting HIV/AIDS education program/material respondents have participated in or encountered
4. Discuss what made the program interesting and what key messages were taken "home". Find out if any HIV/AIDS materials were used.
5. Briefly discuss the various HIV/AIDS communication programs and find out which of these are they familiar with and how they feel about it.
6. Discuss when did they have access, under what circumstance did they have access, how were the materials/programs utilized and who was involved
7. Discuss response to peer pressure, emphasizing on coping strategies.

8. Discuss the reaction to people living with HIV/AIDS
9. Recap desired safer sex behaviour (from earlier discussions)
10. Draw a matrix with desired safer sex behaviour on the horizontal axis and HIV/AIDS TV/Radio programs and materials (based on what they are familiar with) on the vertical axis

HIV/AIDS Materials/Programs	Desired Safer Sex Behaviour		
	A	B	C
1			
2			
3			
4			

11. Allow participants to discuss and score which material/program best promotes a particular desired safer sex behaviour. (using a total of 10 points)
12. Discuss the result, emphasizing on strengths of the various materials and programs

3.1 Guiding Principles/Analysis Plan

1. A description of what the materials/programs have achieved compared to what it was intended to do
2. Some analysis on changes that might have occurred as a result of exposure to the materials/programs
3. How has HIV/AIDS materials produced by MOH/JHU been used and the benefit thereof

4. Recommend some actions based on the answers and response from the respondents.

4.1 Check List of Programs and Materials

1. Road show
2. Posters and Stickers
3. Information services Van initiative
4. Leaflets
5. Booklets
6. T Shirt and Cap
7. Music Video
8. TV Drama Series – Things we do for love
9. TV Commercials
 - ◆ Candles
 - ◆ Paa Kwesi
 - ◆ Douglas
 - ◆ Boys night out
 - ◆ Sorry no sex
 - ◆ In the dark
 - ◆ Panther
 - ◆ Chiefs
10. Radio Commercials
11. Slogans and logo
12. Compassion campaign

Appendix 3

List Of Questions And Information The Youth Need About HIV/AIDS

HIV/AIDS Questions by the Youth	Corresponding Answers Numbers in Questions and Answers Book (HEU 1999)
1. If a boy and a girl both uses condom can they get AIDS	41
2. Can kissing give you the disease	23
3. Why is it that even when you use condom, you still get pregnant or AIDS	41
4. If you travel and a friend with AIDS offers you a towel and sponge can you get the disease through that	33
5. "I do not also understand why we can not detect that this person has AIDS"	7
6. Why is it that the doctors can not give HIV test result before 6 months and why can not they make the test affordable?	53
7. Why is it that they isolate HIV/AIDS patients away from the family and rather propose that they should be shown love?	55
8. "Why does it take along time before you can discover that this person has AIDS?"	8
9. "Will sharing of brush make you get AIDS?"	32, 27
10. How to protect oneself from the disease?	6
11. Why do you live with a victim without getting the disease?	32, 33
12. Can HIV/AIDS be acquired through the male sperms or vaginal fluid?	13
13. Can mosquito transmit since it is a blood disease?	36
14. Why does HIV result take six months to come out?	53
15. How can you detect the disease from a health looking victim?	7
16. Why is it that some people are still not convinced that AIDS is real? It is because they feel AIDS is caused by evil spirit and not sex?	39
17. "I have also learnt that deep kissing can cause AIDS. Is it the saliva you swallow or what causes it?"	23
18. "Why do you share meals with an HIV/AIDS patients without getting the disease?"	32
19. Can you get AIDS from toilet seats?	34
20. Sometimes a pregnant woman goes to the hospital and her blood sample shows positive but after birth she tests negative, can that be possible	53
21. Can someone sleep (not sex) with HIV/AIDS person without contracting AIDS?	33
22. I do not also understand how people carry the virus and transmit to another	13, 26

HIV/AIDS Questions by the Youth	Corresponding Answers Numbers in Questions and Answers Book (HEU 1999)
person.	
23. I do not understand how the disease came into existence.	
24. How can the use of sharp objects serve as mode of transmission?	
25. "I have learnt that the transmission of AIDS is faster from male to female than the vice-versa why?"	
26. "I have learnt that when some one uses a blade and you also use it you will get it why?"	
27. "Why is it that we have drugs for other STDs but not for AIDS?"	
28. The virus they say can die in about five minute of it exposure to the open air but why is it that it is still said that when one uses a blade used by a victim several minutes after the person can still contract the disease.	
29. Why is it that blood transfusion is still a source of infection?	
30. Why is it that when people donate blood and they are found to be HIV/AIDS positive, doctors hide the information from the donors?	
31. Can you get AIDS through barbering?	
32. Does AIDS exist only in human blood or the virus can be found in animals?	
33. Why is it that the virus it is said can die within 5 minutes exposure and they still insist that we hairdressers have to put the combs into bleach for 10 minutes before using them?	
34. Why is it difficult to tell people with HIV their fate until a long time before referring the fellow to a counsellor for the person to say it?	
35. Why is the virus in the blood?	
36. The blood on a used blade after some time why is that the virus can not die?	
37. Is it true that gonorrhoea can lead to bareness?	
38. What is the difference between gonorrhoea and AIDS?	
39. Is it true that good diet can prolong the life span of an AIDS victim?	
40. Can a child with AIDS live longer?	
41. At what age can you die after you have acquired the disease?	
42. Some say if your blood is stronger than your partner you can't get it	

Appendix 4

Matrix Ranking of HIV/AIDS Mass Communication Advertisement and How it Affects HIV/AIDS Behaviour Identified by the Youth (Male Tailors)

- Total Score allowed is 20

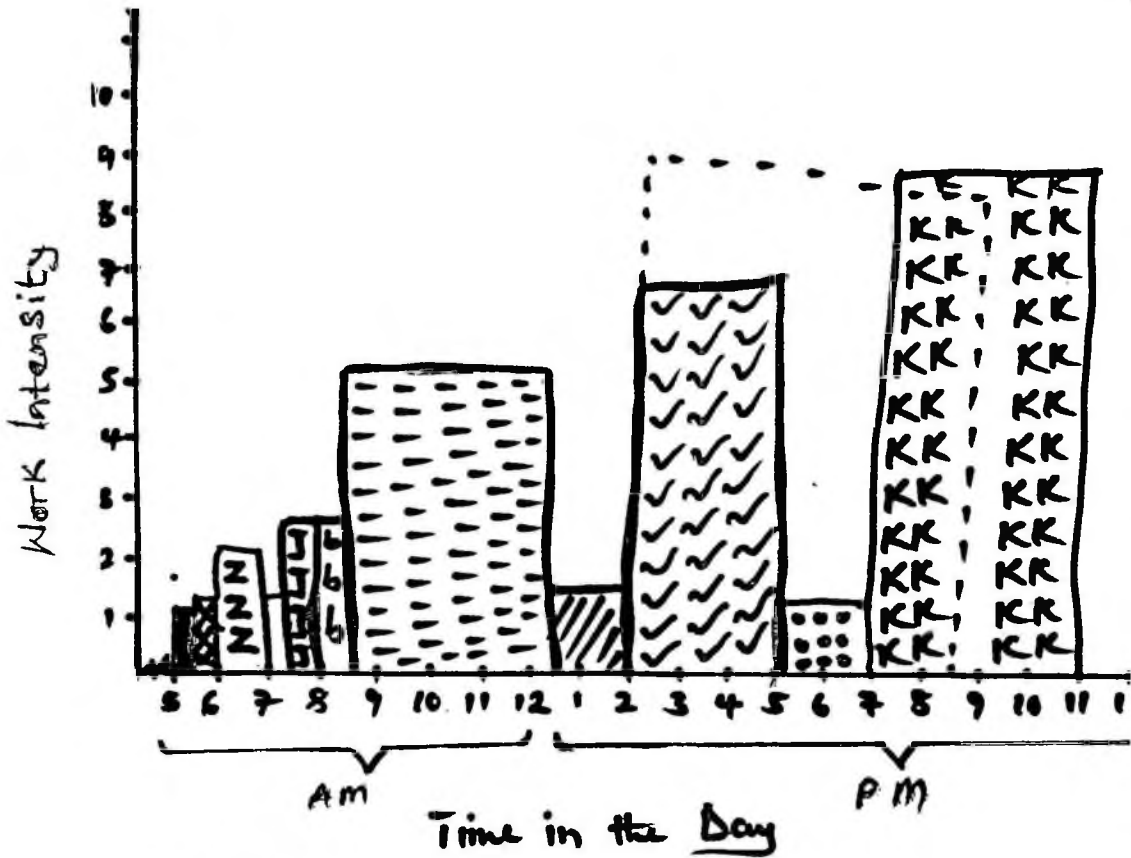
*** Each of the Mass Communication Advertisement is ranked as to its effect on the four HIV/AIDS Prevention Behaviour Identified. A total of 20 marks is distributed among the four behaviours according to the effect the advert Can have on that behaviour. A high score means a high effect of that particular behaviour

Mass Communication Advertisement	HIV/AIDS Prevention Behaviour Identified by the Youth			
	Abstinence	Faithfulness	Condom Use	Appropriate Dressing By ladies
Music Video	5	5	5	5
Boys Night Out	5	2	10	2
Sorry no sex - Girl tells boy we have to wait (in front of a gate)	10	5	3	2
Red Candles representing people who are infected with HIV/AIDS	5	3	10	1
Panther Condom Advert "A pack of three"	2	2	12	4
Chiefs of Ghana Talking about HIV/AIDS	10	4	5	1











Matrix Ranking of HIV/AIDS Mass Communication Advertisement and How it Affects HIV/AIDS Behaviour Identified by the Youth (Male Farmers) - Total Score allowed is 20


Mass Communication Advertisement	HIV/AIDS Prevention Behaviour Identified by the Youth			
	Abstinence	Faithfulness	Condom Use	Appropriate Dressing By ladies
Music Video	5	10	3	0
Boys Night Out	5	15	0	0
Chiefs of Ghana Talking about HIV/AIDS	12	6	2	0

Daily Activity Chart: Seamstress Group (Source: Directly Copied From Participants' Sketch)



KEY

-  Waking up from bed
-  Time of Sweeping
-  Fetching of Water
-  Bathing
-  Setting off to work
-  Tidying up work place
-  Sewing activities (Morning Session)
-  Break time
 - ▶ Lunch
 - ▶ Resting
 - ▶ Visiting boy/girl friends
-  Afternoon working Session
-  Going to bed after work

-  Free times for Individual Act
 - ▶ Visiting boy/girls friends
 - ▶ Going to Church
 - ▶ Watching T.V/video
 - ▶ Selling of eggs, oranges, bread tea etc.
 - ▶ Going to bed

MAP OF AGOGO SUB - DISTRICT SHOWING AVAILABLE HEALTH FACILITIES

