HIV/AIDS EDUCATION AND ATTITUDINAL CHANGE AMONG THE YOUTH IN MAMOBI, NEW TOWN AND JAMES TOWN.

BY

WILMA MAAME WOODE

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DECLARATION

I do hereby declare that work, with the exception of acknowledged quotation and ideas attributed to specified sources, is entirely my own, done under the supervision of Dr. Kodjo Senah and Dr. Yvan Yangyuoru, and it's the true record of the set goals. No part of it has ever been presented for any degree.

Supervisor .....

Dr. Kodjo Senah

Supervisor .....

Dr. Yan Yangyuoru

Student .....

Wilma Maame Woode

DEDICATION

This thesis is dedicated solely to my sister Winifred Naana Woode who sponsored my M.Phil programme.

TABLE OF CONTENT

CHAPTER FIVE

CHAPTER SIX

LIST OF TABLES

LIST OF FIGURES

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ACRONYMS

WHO- World Health Organisation

MOH- Ministry of Health

NACP- National AIDS Control Programme

UNAIDS- Joint United Nations Programme on HIV/AIDS

UNICEF- United Nations International Children Education Fund

MTCT- Mother- to- Child Transmission

PPAG- Planned Parenthood Association of Ghana

GSMF- Ghana Social Marketing Foundation

FHI- Family Health International

PLWHA- People Living with HIV/AIDS

JHU- John Hopkins University

MOC- Ministry of Communication

GSS- Ghana Statistical Services

MCT- Mother- to- Child

UNESCO- United Nation Education Scientific and Cultural Organisation

UNFAO- United Nations Food and Agricultural Organisation

NACA- National Advisory Commission on AIDS

UN- United Nations

CHAJI- Commission on Human Right and Administrative Justice

HIV- Human Immune Deficiency Virus

AIDS- Acquired Immune Deficiency Syndrome

ABSTRACT

The HIV/AIDS pandemic continues to spread all over the world and Ghana is no exception.

The prevalence rate from sentinel centres across the country in 2001 suggests between 3 to 4 percent of the spread. The study was conducted in Mamobi, New Town and James Town, all suburbs of the Greater Accra Region of Ghana. It is both a qualitative and quantitative study that sets out to describe the youths perceptions of what constitutes risk behaviours in relation to HIV/AIDS, examine the knowledge level of HIV/AIDS among the youth, examine the attitude of the youth towards HIV/AIDS, enquire about the importance the youth attach to the HIV/AIDS education, find out whether they understand the processes of controlling the spread of the disease. The youth in the study are defined as those aged between 15 and 35. these were grouped into two, those in formal training as apprentices in various forms of trade such as dressmaking, auto-mechanics and the like are termed the 'regular youth' and those who are not in any formal training, such hawkers, are termed as 'irregular youth'. The researcher collected data using the questionnaires, focus group discussions and in-depth interviews. There were 240 respondents for the survey. Four (4) focus group discussions and eight (8) in-depth interviews were held. Respondents included youth both regular and irregular, some NGO's and health professional.

The findings indicate that the youth are very aware of the disease (HIV/AIDS), but their attitudes are not up to expectation. The reasons were that, the youth were aware that condom prevents the transmission of HIV/AIDS; they also know where to purchase condom but the majority of them do not use it always. The reason for not using condom most often relates mainly to sexual in-discipline and wrong perception about who can possibly be infected with the disease.

The study also shows that whilst radio and television programmes have played a significant role in shaping behaviour and HIV/AIDS prevention among the youth, consistent education is lacking among the out-of-school youth because the majority of them do not benefit from these programmes. The reason is that they do not have access to radio and television and even the few who have, get so tired after the day's activities that they retire to bed early. In almost all the focus group discussions, participants indicated the need for feedback on educational programmes; thus increase in face-to-face fora for the youth to clear most of the misconceptions of HIV/AIDS. HIV/AIDS prevention programmes must be participatory and must involve the youth.

CHAPTER ONE

INTRODUCTION

The human immune deficiency virus (HIV), which causes AIDS, has brought about a global epidemic far more extensive than what was predicted even a decade ago. It is now estimated that the number of people living with HIV/AIDS at the end of the year 2001 stands at 40 million. This is more than 50 percent higher than what World Health Organisation's (WHO) global programme on AIDS projected in 1991 on the basis of the data then available (WHO, 2001).

The history of HIV/AIDS began in United States where doctors noticed an increasing frequency of an unusual form of pneumonia in the early 1980's. Patients were dying because their immune systems were unable to combat pneumonia. The first victims were young homosexuals. Thus, the early suggestion of the name for the disease was GRIDS (Gay Related Immune Deficiency Syndrome). Cases were soon found in people other than homosexuals.

In 1982, United States Centres for Disease Control coined the name AIDS – Acquired Immune Deficiency Syndrome (Barnett and Blaikie, 1992). AIDS is a viral disease caused by human immune deficiency virus (HIV). HIV destroys the body's defensive mechanism against diseases. It

does not kill directly; it opens the way for other infections that do kill, as the body becomes decreasingly able to master its defences.

HIV is transmitted from one person to another via the medium of body fluid such as semen, vaginal secretions and blood (WHO, 1990). Before the first case of HIV was reported in Ghana in March 1986, most Ghanaians thought that AIDS was a disease that affected Americans and Ghanaian who travel abroad. The disease was considered to be far removed from the daily lives of ordinary Ghanaians. A decade later it emerged that this assumption was wrong. However, this realisation came at a cost to some individuals and families. Since then the disease has been reported from all parts of the country and in the middle of 1995, 15,980 people had been officially diagnosed sero-positive out of estimated population of 16.5 million (MOH, 1995).

AIDS when first identified in Ghana was viewed as a health problem that required the resources and energy of the Ministry of Health alone to tackle. It later became clear that the epidemic was affecting all areas of our economic and social life and that it required a sustained multi-sectoral effort to combat it.

Between 1986 and the end of December 1998, 29,550 AIDS cases had been reported to the Ministry of Health. However, there is much more to

the epidemic than the number of reported cases. It is known that most AIDS cases are not reported. According to the Ministry of Health (1999) this happens for several reasons:

- Some people never seek hospital care for AIDS or have access to health service facilities.
- Some physicians or nurses may not want to record a diagnosis of AIDS because of the stigma attached to the disease.
- People with AIDS do not die from the virus but from the opportunistic infections (such as tuberculosis) before they are ever diagnosed as having AIDS.
- Private laboratories do not report all cases of HIV/AIDS and are not required to do so.

The true number or figure of cumulative AIDS cases in Ghana is not known but, according to projections, the total was more than 114,000 by the end of 1998.

In Ghana as in the rest of Africa, two modes of transmission account for most new HIV infection in the country: heterosexual contact and mother-to-child (MTC) transmission. Besides sexual contact and MTC transfer, HIV can also be transmitted through contaminated blood, for example, through transfusions or needles or blades that have been in contact with the blood of an HIV-infected person (MHO1990, 1999)

The majority of infections are transmitted through heterosexual contact. Although the probability of transmitting HIV during intercourse can be quite low, a number of factors increase the risk of infection dramatically.

One is the presence in either partner during unprotected sex of a sexually transmitted disease (STD) such as syphilis or gonorrhoea. These diseases form ulcers and sores that facilitate the transfer of the virus. A 1996 study by the Ministry of Health Research Unit, estimated that pharmacists in Accra were treating between 50,000 and 90,000 STD cases each year. This means that a lot more people are HIV/AIDS potential.

A study of commercial sex workers in Accra and Tema also indicated that three out of four were infected with an STD. Another contributing factor is a large number of sexual partners (Anarfi and Kannae, 1999)

Many children are infected through mother-to-child transmission. They receive the infection from their mothers during pregnancy, at the time of birth or through breast milk. About 30 – 40 percent of infants born to infected mothers will themselves be infected. The other 60 – 70 percent will not become infected, but are at risk of becoming orphans.

It is clear that other modes of transmission contribute to the spread of the disease in Ghana. Nonetheless, it is still important to guard against contaminated blood and reused needles and blades that might transfer the virus. It is also especially important to stop some traditional practices, such as female circumcision, that involve cutting and the potential exposure of the blood to HIV.

After transmission of HIV, a person does not develop AIDS immediately. There is often a lengthy period from infection with HIV to development of the disease AIDS. This period may span from two to twelve years, while others may develop AIDS within two or three years and die soon thereafter. The average time from infection with HIV to development of the disease AIDS is about eight years. That is, on average, a person does not develop AIDS until eight years after becoming infected. For most of this period the person may not even be aware that he or she is infected. This contributes to the spread of HIV, since the person can transmit the infection to others without knowing it. People with full-blown AIDS, of course, remain infectious. No one is quite sure why some infected individuals develop AIDS at a slower or faster pace than others. In countries where the overall health of the population is poor, they may have shorter incubation periods on average than countries with better health conditions. For children, the incubation period is much shorter because their immune system is not fully developed. Most infants who are infected at birth develop AIDS within two years and die soon thereafter (MOH/NACP, 1999).

Thus the major problem with the AIDS pandemic rests with young adult HIV carries. Since the majority of cases are sex-related, it could be deduced that the real threat of the disease rests with the sexually active in the Ghanaian society. As far back as the 1960s, Ghanaians considered

attitude towards sex neither sacred nor sinful. Sex as at the time and even now was seen, as a fundamental aspect of life and every normal human being should practice it. Persons who claim to be celibate were either disbelieved or never regarded as abnormal: one who does not engage in sex must be impotent or a witch.

The view that sex is a normal activity does not, however, result in complete openness about sexual affairs. Nor does it mean that there are no rules to regulate sexual behaviour. In fact, the rules are rather strict: Girls should not indulge in sex before they are married and certainly not before their menarche.

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. HIV/AIDS has a profound impact on social and economic development of a country 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 orphanages and family life where traditional family 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 the increase in opportunistic infections resulting from AIDS is expensive to manage. Population growth is affected, especially the age distribution,

as the peak ages for AIDS cases in Ghana is 25-34 for females and 30-39 for males. No sector is left out of the impact. Women can be especially vulnerable to the HIV/AIDS epidemic. Special mention needs to be made of AIDS at the work places and people living with AIDS, which is gradually becoming a complex dilemma in Ghana, especially, in respect to the private sector and human rights.

Youth Policies

Ghana has had a number of legislative instruments designed to protect the youth from neglect and abuse. Although these legislative instruments may seen not to have direct relationship with the reproductive health of the youth, there is a degree to which these legislative instruments may be said to affect reproductive health issues of the youth.

The Education Act of 1961 (Act 87) for instance, which makes basic education compulsory and free, "except for a token fee paid by pupils for the use of a free text book scheme" ensures that as many Ghanaian youth as possible go to school. Once they are in school, the youth have the opportunity to learn a lot of things including issues that deal with their reproductive health. Many youth in Ghana especially those in the urban areas are required by necessity to earn their own upkeep and are sometimes even required to contribute to family incomes. They therefore engage in commercial activities on the streets, where especially the girls

are exposed to all sorts of physical, emotional as well as psychological exploitation from adults, which may affect their reproductive health.

The Labour Decree of 1967 (NLCD 157) prohibits the economic exploitation of children by employment, but permits employment where such employment is with the consent of the child's own family and "involves light work of an agricultural or domestic character only."

The 1992 constitution of Ghana and the Children's Act of 1998 (Act 560) have reinforced several legislation designed in the past to protect the country's youth including adolescents. The Constitution has given parliament the right to enact other laws if and when the need arises.

A draft on adolescent reproductive health policy for Ghana has been in existence since November 1996. This policy aims at promoting the physical, mental and social well-being of adolescents in Ghana through programs that address adolescent and youth sexual and reproductive health issues, such as early pregnancy, abortion, and sexually transmitted diseases including HIV/AIDS. It hopes to achieve these objectives through the promotion of responsible and healthy reproductive and sexual behaviour such as abstinence, safer sex practices and family planning for the sexually active adolescents and the youth.

According to a report prepared for the Third African Population Conference in 1999, the reproductive health needs for adolescents in sub-Saharan Africa have largely been ignored.

The field of adolescents' 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. 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 and other sexually transmitted diseases, and unplanned pregnancies among young people. For young people who are just starting out on their 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 of the other person. 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, the suggestion of the use of condom may by perceived as a mark of distrust and look like a way of complicating the situation further. By their nature, getting access to condom may 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 diseases including HIV/AIDS, because they are

sexually active at younger ages than previous generations (Adomako, 1993).

Given the enormity of this problem, there is a compelling case for empirically examining this pandemic especially in terms of attitude and behavioural changes as a function of HIV/AIDS educational efforts.

Research Problem

Most literature on HIV/ AIDS has indicated that knowledge and awareness of the disease is almost universal. It is estimated that about 99% of the Ghanaian population have knowledge on HIV/AIDS (MHO, 1999). This knowledge has been expected to bring about the desired behaviour change necessary to bring the HIV/AIDS menace under control. However, it has become increasingly clear that changing behaviour to slow the spread or limit the extent of transmission will remain problematic for the foreseeable future. The first and probably the most important line of defence against HIV/AIDS is a cure or vaccine which is still elusive. Thus, interventions have in most cases focused on increasing awareness and knowledge of HIV/AIDS.

It has however; become evident that increase in knowledge is not enough to change behaviours. This is because instead of people changing their behaviours and thereby reducing the spread of HIV/AIDS, the disease is

rather spreading at an alarming rate; there is no corresponding positive change in attitude towards the risk factors of AIDS. For example, about 29,550 people were infected in 1998 but it is estimated that in the year 2000 about 75,600 Ghanaians were infected with the disease. This means that people's behaviours have largely not changed. It appears that HIV/AIDS prevention efforts cannot rely on simply promoting awareness creation on the disease. Following from the above, the need to understand the factors that strongly influence a person's decision to change (or not to change) a given behaviour is of utmost importance. This is because records indicate that in Ghana, sexual transmission (heterosexual) accounts for 75 to 80 percent of the estimated 47,444 HIV infections (Ministry of Health, 1999). The negative impact of the disease on individuals, households, and the society at large amply justifies the need for a thorough research work on the problem for its effective and efficient control and eventual eradication.

Objectives

The main objective of the study is to examine whether education on HIV/AIDS has been translation into behaviour change, in bringing the infection under control. Specifically the study seeks to:

1. Find out people's perception of what constitutes risk behaviours in relation to HIV/AIDS.
2. Examine the knowledge level of HIV/AIDS among the youth.

3. Examine the attitude of the youth towards HIV/AIDS.
4. Enquire about the importance the youth attach to the HIV/AIDS education given to them.
5. Find out whether they understand the HIV/AIDS education/information given to them.
6. Identify the possible processes for controlling the spread of the disease.

CHAPTER TWO

HIV/AIDS in Sub-Saharan Africa: An Overview

This chapter focuses on studies done on HIV/AIDS in sub-Saharan Africa. The region remains the most severely affected by HIV\AIDS. Approximately 3.4 million new infections occurred in 2001, brining to 28.1 million the total number of people living with HIV\AIDS and 2.3 million died of AIDS in 2001 in the region.

The region is experiencing diverse epidemic in terms of scale. HIV prevalence rates have risen to alarming levels in parts of southern Africa, where the most recent antenatal clinic data reveal levels of more than 30% in several areas. In Swaziland, HIV prevalence among pregnant women attending antenatal clinics in 2000 ranged from 32.2% in urban areas to 34.5% in rural areas; in Botswana, the corresponding figures were 43.9% and 35.5%. In South Africa's KwaZulu-Natal Province, the figure stood at 36.2% in 2000.

At least 10% of those aged 15-49 are infected in 16 African countries, including several in southern Africa, where at least 20 percent are infected. Countries across the region are expanding and upgrading their responses. However, the high prevalence rates mean that even

exceptional success on the prevention front will now only gradually reduce the human toll. This notwithstanding, in some of the most heavily affected countries there is growing evidence that prevention efforts are bearing fruit. One new study conducted in Zambia by UNAIDS/WHO, shows urban men and women reporting less sexual activity, fewer multiple partners and more consistent use of condoms. This is in line with earlier indications that HIV prevalence is declining among urban residents in Zambia, especially among young women aged 15-24 (UNAIDS/WHO, 2000).

According to the South African Ministry of Health, HIV prevalence among pregnant women attending antenatal clinics reached 24.5 percent in 2000. About one-in-nine South Africans (or 4.7 million people) are living with HIV/AIDS. Yet, there are possibly heartening signs that positive trends might be increasingly taking hold among adolescents, for whom prevalence rates have dropped slightly since 1998. Large-scale information campaigns and condom distribution programmes appear to be bearing fruit. In South Africa, for instance, free male condom distribution rose from 6 million in 1994 to 198 million five years later. In recent surveys, approximately 55 percent of sexually active teenage girls reported that they always use a condom during sex. Progress is also being made on treatment and care. For example in the southern African region, countries like Botswana have begun providing antiretroviral

drugs through its public health system, with a reduction of drug price negotiated with pharmaceutical companies.

According to the AIDS Epidemic Update (2001) the national adult prevalence rates of 5 percent mark in the year 2000 in five West African countries, namely, Burkina Faso, Cameroon, La Cote d' lvoire, Nigeria and Togo, are booting their spending on HIV/AIDS and extending their responses nation-wide. This year, Nigeria launched a US$240-million HIV/AIDS Emergency Action Plan. Determined prevention efforts in Senegal continue to bear fruit, due to the prompt political support for its programmes.

On the eastern side of the continent, the downward arc in prevalence rates continues in Uganda, the first African country to have subdued a major HIV/AIDS epidemic. HIV prevalence in pregnant women in urban areas has fallen for eight years in a row, from a high of 29.5% in 1992 to 11.25% in 2000. Focusing heavily on information, education and communication, and decentralised programmes that reach down to village level, Uganda's efforts have also boosted condom use across the country. In the Masindi and Pallisa districts, for instance, condom use with casual partners in 1997-2000 rose from 42 percent and 31 percent, respectively, to 51 percent and 53percent. In the capital, Kampala, almost 98 percent of sex workers surveyed in 2000 said they had used a condom the last time they had sex (UNAIDS, 2001).

Despite such success, huge challenges remain. New infections continue to occur at a high rate. Most people with HIV do not have access to antiretroviral therapy. Already, by the end of 1999, 1.7 million children had lost a mother or both parents to the disease. Providing them with food, housing and education will test the resources and resolve of the country for many years to come (UNAIDS, 2000).

Uganda's experience underlines the fact that even a rampant HIV/AIDS epidemic can be brought under control. The axis of any effective response is a prevention strategy that draws on the explicit and strong commitment of leaders at all levels, that is built on community mobilisation, and extends into every area of the country (UNAIDS, 2001).

Although Africans are exceptionally vulnerable to the epidemic, millions of African women are dangerously ignorant about HIV\AIDS. According to UNICEF, more than 70 percent of adolescent girls (aged 15-19) in Somalia and more than 40 percent in Guinea Bissau and Sierra Leone, for instance, have never heard of AIDS. In countries such as Kenya and the United Republic of Tanzania, more than 40 percent of the adolescent girls harbour serious misconceptions about how the virus is transmitted. One of the targets fixed at the UN General Assembly Special Session on HIV/AIDS in June 2001 was to ensure that at least 90 percent of young

men and women should, by 2005, have the information, education and services they need to defend themselves against HIV infection. As in other regions of the world, most countries in sub-Saharan Africa are far from fulfilling that pledge (UNAIDS, 2001).

The most pathetic of all is that, the vast majority of Africans living with HIV do not know they have acquired the virus. One study has found that 50 percent of adult Tanzanian women know where they could be tested for HIV, yet only 6 percent have been tested. In Zimbabwe, only 11 percent of adult women have been tested for the virus. Moreover, many people who agree to be tested prefer not to return and discover the outcome of those tests. However, other obstacles remain. Another study in Abidjan, La Cote d' lvoire, shows that 80 percent of pregnant women who agree to undergo HIV test return to collect their results. However, of those who discover they are living with the virus, 50 percent return to receive drug treatment for the prevention of mother-to-child transmission of the virus (WHO/UNAIDS, 1997).

More than half of the women who know they have acquired HIV, and who were surveyed by Kenya's Population Council this year, said they had not disclosed their HIV status to their partners because they are afraid it would expose them to violence or abandonment. Not that voluntary counselling and testing services are in shot supply across the region, but

stigma and discrimination continue to discourage people from discovering their HIV status (Population Council, Kenya 2001).

AIDS has become the biggest threat to the continent's development and its quest to bring about an African Renaissance. Most governments in sub-Saharan Africa depend on a small number of highly skilled personnel in important areas of public management and core social services. Badly affected countries are losing many of these valuable civil servants to AIDS. Essential services are being depleted at the same time as state institutions and resources come under greater strain and traditional safety nets disintegrated. In some countries, health-care systems are losing up to a quarter of their personnel to the epidemic. People at all income levels are vulnerable to these repercussions, but those living in poverty are hit hardest. Meanwhile, the ability of the state to ensure law and order is being compromised, as the epidemic disrupts institutions such as the courts and the police. The risks of social unrest and even socio-political instability should not be underestimated (UNAIDS, 2001).

As a result, accumulating over the past year have been many encouraging developments. Thirty- one countries in the region have now completed a national HIV/AIDS strategic plan and another 12 are developing such a plan. Several regional initiatives to roll back the epidemic are under way. Some, such as those grouping countries in the

Great Lakes region, that is, the Lake Chad Basin and West Africa, are concentrating their efforts on reducing the vulnerability of refugee and other mobile populations. The political commitment to turn the tide of AIDS appears stronger than ever. Gatherings such as the 2000 African Development Forum meeting last December, and the Organisation of African Unity (now African Union) Summit on HIV/AIDS, tuberculosis and other related infectious diseases in April 2001, appears to be cementing that resolve. At the latter meeting, Heads of State agreed to devote at least 15% of their countries' annual budgets to improve health sectors. Fewer than five countries reached that level in 2000 (UNAIDS, 2001).

Young People at Risk

In the worst affected countries young people are especially at risk. People continue to be at risk for HIV throughout their sexually active lives. However, an effort to promote safer sexual behaviour is crucial for young people. Prevention efforts also seem to have a greater chance of success among younger people than among people whose sexual habits are well ingrained. For example, following active condom promotion and education campaigns in schools and among young groups, dramatic declines have been recorded in infection rates among teenagers in Uganda and Tanzania (UNAIDS, 2000).

In sub-Saharan Africa, as in many countries in the industrialised world and elsewhere, people embark on their sexual lives when they are in their teens. High levels of teen pregnancy, and of pregnancy outside of marriage, show how sexually active young people are, and how few of them use condoms. If young people are having unprotected sex with several partners, or if their single partners have ever had other partners, they are exposed not just to pregnancy but also to infection with sexually transmitted diseases including HIV.

Recent HIV surveillance data has shown the age this exposure can occur and how devastating its consequences can be for the continent. For example, over 4 percent of both boys and girls aged 12 to 14 in one community study in Rwanda tested HIV positive and in South Africa, the number of pregnant girls under the age of 15 tested for HIV in 1997 was relatively small, but a distressing 5-9 % of them were found to be HIV positive. Among the far greater number of nearly 13% pregnant South Africans who tested HIV positive were in their late teens.

Generally, girls often become infected with HIV at a younger age than boys. A recent community-based study conducted in one of the areas in Kenya, shows that 22% of 15-19 year old girls were already infected with HIV, as compared with just 4% of boys of the same age. In a Zambian study of young city-dwellers in the same age group, HIV infection was reported in 12% of the girls and 4% of the boys (UNAIDS, 2000).

A study done in Ethiopia found that 35% of young women aged between 20-24 years were infected. This is three times higher than the 10 percent rate among the young men. This age gap at infection suggests that young girls are getting infected through sex with older men. Many girls may choose such relationships because they come with gifts, money or other favours attached. Some will simply have been powerless to resist. In the Democratic Republic of Congo, the proportion was close to a third. As infection rises in the general population, so does the likelihood of encountering an infected partner early in one's sexual life. So over time, new infections become increasingly concentrated in the youngest age groups. A recent study in Malawi also indicates that HIV infections were occurring in younger women (UNAIDS/WHO, 1997; 2000).

Children Affected By HIV/AIDS

Africa is experiencing a growing tide of children living in AIDS affected households or attempting to survive after the death of both parents from AIDS. Often, the extended family itself is decimated by AIDS and is no longer able to cope. But institutions are not the answer because of the scale of the problem but rather solutions have to be found in the community (UNAIDS, 2001).

In Zimbabwe, people are rising to the challenge. Many village heads have designated land to be cultivated by all villagers to feed orphans and families of those suffering from debilitating illness, usually AIDS-related.

Despite the undeniable effects of AIDS, silence, born of shame and blame, continues to shroud the epidemic in many of the hardest-hit countries.

A recent study of voluntary counselling and testing offered to pregnant women in developing countries found that in many places with extremely high HIV prevalence, women refused testing or did not return for their results. This was the case even when interventions that might help them give birth to a healthy baby were being offered to those who tested HIV-positive. In Cote d'Ivoire, for instance, fewer than half of more than 13,000 pregnant women in two study sites accepted to be tested and then came back for their results. More worrying still, in a majority of sites it was the HIV positive women who were less likely to return. This correlation was seen in South Africa's Soweto, too, where almost all pregnant women in the study agreed to be tested, four-fifths overall came back for their test results, but only half of those who were HIV-positive sought out their results. These systematic differences suggest that women, who may be aware that they have been exposed to infection, or who have taken risks, shirk from learning their HIV status. There is

evidence that the fear and denial provoked by AIDS extends even to people working in the health sectors (UNAIDS, 2001).

One study in Southern Africa sought to record the number of needle stick injuries in Primary Health Care Clinics. Researchers found almost none- an unlikely scenario in overworked clinics with poor facilities. Senior staff then explained that, under clinic policy, anyone who reported a needle stick injury had to undergo HIV testing to measure the danger sero-conversion through exposure to infected needles. Nurses did not report needle stick injuries because they did not want to be tested.

Silence can continue to reign even when people with HIV are ill and dying. Because AIDS is just the name for cluster of diseases that immune deficient people develop, patients and their carers can choose to view the illness as just tuberculosis, diarrhoea, or pneumonia.

"For too long we have closed our eyes as a nation, hoping the truth was not so real", South African President Thabo Mbeki told South Africans in October – 1998 that "At a time we did not know that we were burying people who had died from AIDS. At other times we know, but chose to remain silent".

With this major speech, South African's leadership joined those who have spoken out loudly and clearly about AIDS, have sought to demystify it, and have encouraged discussion about safe sex everywhere from the classroom to the boardroom. It is in such countries, of which Uganda is

probably the best-known example in the developing world, that most progress has been made not just in putting a brake on new infections, but in ensuring the well being of those people who are already living with the virus (UNAIDS, 1999).

Economic Impact of HIV/AIDS

Since many economies in the region are in a state of flux, it is hard to determine exactly what the impact of HIV is on national economies as a whole but the impact of the disease is being felt in many countries across the world. Southern Africa continues to be the worst affected area, with adult prevalence rates still rising in several countries. But elsewhere, also, in countries often already burdened by huge socio-economic challenges, AIDS threatens human welfare, developmental progress and social stability on an unprecedented scale. However it is clear that businesses are already beginning to suffer. For example, in Zimbabwe life insurance premiums quadrupled in just two years because of AIDS deaths.

Some companies have reported a doubling of their health bills. In Botswana, companies estimate that AIDS – related costs will soar from under one percent of the wage bill now to five percent in six years time, because of the rapid rise in infection in the last few years. In Zambia, one large company reported in 1995 that its costs from AIDS illness and

death exceeded its total profits for the year. There has been a similar report from a large Tanzanian company. Prevention programmes for workers have been shown to cut costs as well as infections (UNAIDS, 1999).

The AIDS epidemic has a profound impact on growth, income and poverty. It is estimated that the annual per capita growth in half the countries of sub-Saharan Africa is falling by 0.5-1.2% as a direct result of AIDS. By 2010, per capita GDP in some of the hardest hit countries may drop by 8% and per capita consumption may fall even farther. Calculations show that heavily affected countries could lose more than 20% of GDP by 2020. Companies of all types face higher cost in training, insurance, benefits, absenteeism and illness. A survey of 15 firms in Ethiopia has shown that, over a five-year period, 53% of all illness among staff was AIDS related (UNAIDS, 2001).

AIDS has brought about an index of existing social and economic injustices in the world; the epidemic is driving a ruthless cycle of impoverishment. People at all income levels are vulnerable to the economic impact of HIV/AIDS, but the poor suffer most acutely. One quarter of households in Botswana, where adult HIV prevalence is over 35%, can expect to lose an income earner within the next 10 years. A rapid increase in the number of very poor and destitute families is anticipated. Per capita household income for the poorest quarter of

household is expected to fall by 13%, while every income earner in this category can expect to take on four more dependants as a result of HIV/AIDS.

In sub-Saharan Africa, the economic hardships of the past two decades have left three-quarters of the continent's people surviving on less than US$2 a day. The epidemic is deepening their plight. Typically, this impoverished majority has limited access to social and health services, especially in countries where public services have been cut back and where privatised services are unaffordable.

In hard-hit areas for example, households cope by cutting their food consumption and other basic expenditures, and tend to sell assets in order to cover the costs of health care and funerals.

Studies in Rwanda have shown that households with an HIV/AIDS patient spend, on average, 20 times more on health care annually than households without an AIDS patient. Only a third of those households can manage to meet these extra costs (UNAIDS/WHO, 1999; 2001).

According to a new United Nations Food and Agricultural Organisation (FAO) report, seven million farm workers have died from AIDS-related causes since 1985 and 16 million more are expected to die in the next 20 years. Agricultural output, especially staple products cannot be sustained in such circumstances. The prospect of widespread food

shortages and hunger is real. Some 20% of rural families in Burkina Faso are estimated to have reduced their agricultural work or even abandoned their farms because of AIDS. In 15% of these instances, children are removed from school to take care of ill family members and to regain lost income.

Families often remove young people (girls and boys) from school to care for sick relatives or assume other family responsibilities, jeopardising their education and future prospects. In Swaziland, school enrolment is reported to have fallen by 36% due to AIDS.

Meanwhile, the epidemic is claiming huge numbers of teachers, doctors, extension workers and other human resources. In some countries, health-care systems are losing up to a quarter of their personnel to the epidemic. In Malawi and Zambia, for example, five-to-six-fold increases in health worker illness and death rates have reduced personnel, increasing stress levels and workload for the remaining employees.

Teachers and students are dying or leaving school, reducing both the quality and efficiency of educational systems. In 1999 alone, an estimated 860,000 children lost their teachers to AIDS in sub-Saharan Africa. In the Central African Republic, AIDS was the cause of 85% of the 300 teacher deaths that occurred in 2000. Already, by the late 1990s,

the toll had forced the closure of more than 100 educational establishments in that country. In Zambia, teacher deaths caused by AIDS are equivalent to about half the total number of new teachers the country manages to train annually (UNAIDS, 2001).

Replacing skilled professionals is a top priority, especially in low-income countries where governments depend heavily on small number of policy-makers and managers for public management and core social services. In heavily affected countries, losing such personnel reduces capacity, while raising the costs of recruitment, training, benefits and replacements. Such actions might include fast-track training, as well as the recruitment of key civil servants and the reallocation of budgets towards the most essential services (UNAIDS, 2001).

According to the UNAIDS/WHO (2001), in the worst affected countries, steep drops in life expectancies are beginning to occur, most drastically in sub-Saharan Africa, where four countries (Botswana, Malawi, Mozambique and Swaziland) now have a life expectancy of less than 40 years. Were not for HIV/AIDS, average expectancy in sub-Saharan Africa would be approximately 62 years; instead, it is about 47 years. In South Africa, it is estimated that average life expectancy is only 47 years, instead of 66, if AIDS were not a factor. The number of African children, who had lost their mother or both parents to the epidemic by the end of

2000, stands at 12.1million. This number is forecasted to more than double over the next decade. These orphans are especially vulnerable to the epidemic, and the impoverishment and precariousness it brings.

As more infants are born HIV-positive in badly affected countries, child mortality rates are also rising. In Zimbabwe for example, it is estimated that 70% of deaths among children under the age of five are due to AIDS.

Unequal access to affordable treatment and adequate health services is one of the main factors accounting for drastically different survival rates among those living with HIV/AIDS in rich and poor countries and communities. Public pressure and UN-sponsored engagements with pharmaceutical corporations (through the Accelerating Access Initiative), along with competition from generic drug manufacturers, has helped drive antiretroviral drug prices down. But prices remain too high for public-sector budgets in low-income countries where, in addition, health infrastructures are too frail to bring life-prolonging treatments to the millions who need it.

HIV has penetrated every country across the globe. But it is painfully clear that one continent is far more touched or hit by the epidemic then any other. Africa is home to 70 percent of the adults and 80 percent of the children living with HIV in the world, and has buried three-quarters of more than 20 million people world-wide since the epidemic began.

CHAPTER THREE

SITUATIONAL ANALYSIS OF HIV/AIDS IN GHANA

HIV/AIDS Prevalence in Ghana

Adult HIV prevalence according to the Ghana AIDS Commission (GAC) and the Ghana National AIDS Control Programme (NACP) is **3 percent**. This is lower than previous estimates. The prevalence rate in 2000 was 4.6 percent based on projections using 1984 census data. The new prevalence rate (3 percent) is based on the most recent census data carried out in 2000. The actual 2000 census figures are lower than previously projected resulting in a lower prevalence rate.

Table 1: HIV/AIDS prevalence and Number of reported AIDS cases between 1990 and 2001

	1990	1992	1994	1995	1996	1997	1998	1999	2000	2001
HIV/AIDS prevalence	.7	4.6	2.4	3.2	3.6	3.6	N/A	4.6	4.6	3%
Number of reported AIDS cases	2013	2606	2330	2578	3295	3833	4854	6289	6289	5184

(Based on UNAIDS, 2000 Epidemiological Fact Sheet for Ghana and NACP data, 2001)

HIV prevalence is lower in Ghana than in surrounding countries such as Cote D'Ivoire at (10.76 percent), Burkina Faso (7.17 percent), Liberia (8.2 percent), Sierra Leone (6 percent) and Togo (5.98 percent). Ghana is experiencing a higher prevalence rate compared to countries such as Senegal (1.4 percent), Niger (2 percent) and Guinea (1.54 percent).

Number of People Living with HIV

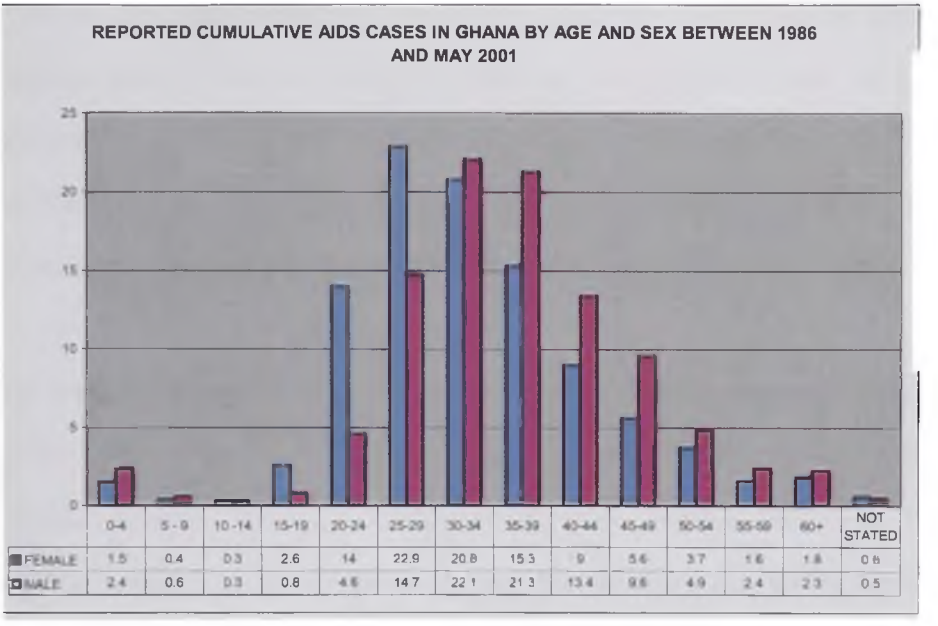
Ghana conducts sentinel surveillance in 22 selected sites across the country representing both urban and rural areas. The calculated prevalence of HIV is collected on pregnant women as part of the standard antenatal care. This provides regular and up-to-date data on the prevalence and number of people infected in the country. Several stakeholders interviewed mentioned that there may be underreporting. This could be attributed to the limited number of test kits available in the regions and other logistical problems such as transporting blood to the regional hospitals on a timely and regular basis.

The number of people living with AIDS as of October 2001 was 48,771 (National Aids Control Programme, 2001). This is only the "tip of the pyramid" since there may be more people infected with HIV but has not yet developed full -blown AIDS. The NACP estimated that the number of actual cases is closer to 185,000 (as of Dec. 2000) since only 30 percent

of cases are reported suggesting that there are closer to 350,000 current HIV infections within the country.

Gender disaggregated data reveal that over 54.55% of women and 4.07 percent of children are HIV/AIDS infected in Ghana (UNAIDS/ECA, 2000). The female to male ratio in 1987 was 6:1 and 2:1 in 1999 suggesting that the gender gap is closing. More than two thirds of the reported AIDS cases are females. This pattern may be due to the high proportion of commercial female sex workers returning from countries during the early stages of the epidemic (NACP, 2001). The pattern may also be due to the fact that females do not make decision on sex. Figure 1 presents the percentage of cumulative AIDS cases in Ghana by age and sex.

Figure 1: the percent of cumulative AIDS cases in Ghana by age and sex.



(NACP, Dec. 2001)

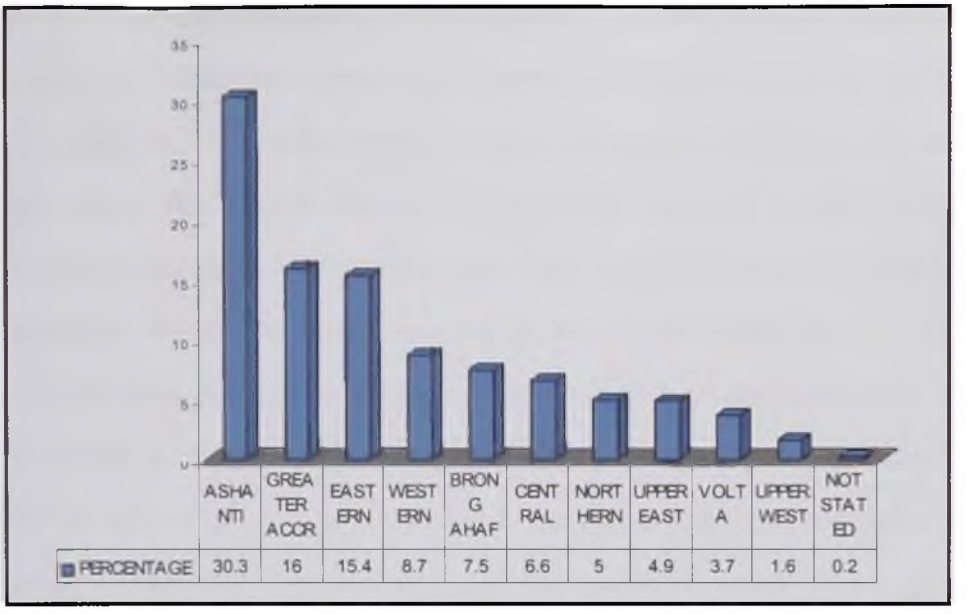
The peak age groups of the epidemic are between 30 to 34--- the peak age groups for women is 25 to 34 and for men between 30 –39. "The number of reported AIDS cases for females in the 15 to 24 age group is much higher than for males in the same group due to the early sexual activity of young girls and the fact that many girls have older male partners (NACP, 2001)." Children between the ages of 5 to 14 are considered by Government as the "window of hope" since this age group can be taught to protect themselves before they become sexually active.

Prevalence across regions

The HIV prevalence varies across the regions since there are several levels of infection in different parts of the country. According to NACP, Eastern region has consistently reported the highest levels of HIV infection followed by the Volta, Greater Accra, Western, Ashanti and Central regions. The gap is narrowing between the regions as the epidemic progresses (NACP, 2001).

The regional disparity is quite different across the 10 regions of the country with respect to the cumulative number of AIDS cases with the Ashanti, Greater Accra, Eastern and Western regions recording the highest number of AIDS cases. Figure 2.0 provides the latest figures related to the cumulative number of AIDS cases by region (NACP, 2001).

Figure 2: Reported cumulative AIDS cases in Ghana by region



(NACP, December 2001)

The 2000 Sentinel Surveillance Report (NACP) reveals that the median prevalence rate is 3.0 percent in Ghana's southern belt, 2.1 percent in the middle belt and 1.4 percent in the northern belts. Women in Agomanya in the Eastern region have an extremely high prevalence of 7.8 followed by Hohoe (5.0 percent) and Ho at 4.2 percent in the Volta regions. (MOH/NACP, 2001; Tadefa-Kubabom et al, 2001)

Factors affecting the spread

Mobility and prevalence of sex worker have been identified as factors increasing the spread of HIV/AIDS in West Africa.

These factors are all poverty related and are caused by socio-economic status of people engaged in these activities. The Ashanti and Eastern regions are experiencing the highest levels of HIV/AIDS infection due to the migratory and trading activities, which bring people from around the sub region. The Ashanti Region of Ghana is the centre of marketing and transmigration between Burkina Faso, Togo, Mali and other West African countries. Several "truckers" and sexual transactions take place in this area. Studies by this researcher suggest that the high prevalence of HIV/AIDS in Eastern Region has been due to the historical migration of girls to La Cote D'ivoire as sex workers. The region has the highest rate of teenage pregnancy and several traditional practices, which expose girls to sexual activity at an early age (Casely-Hayford/UNAIDS, 2001).

The Volta region bordering on Togo, has one of the highest rates of infection (5.98%). There is a high level cross- border trading activities between Togo and Ghana.

The Greater Accra Region has an increasingly high level of HIV/AIDS due to the presence of sex workers. According to some studies, 73 percent of sex workers in urban areas are HIV/AIDS infected (Deceuninck et al, 2000) apart from the normal channels of Mother-to-Child- Transmission (MTCT), blood transfusion and other means.

AIDS Deaths and Orphans

Today AIDS in Ghana accounts for 4 percent of all the deaths in the country. AIDS is expected to be the leading cause of death by 2014 accounting for 22 percent of all deaths. The low prevalence scenario at an HIV prevalence rate of 4 percent, forecasts the annual number of deaths to reach 305,000 by 2014 an increase of 36,000 over the normal death rate. Under the low prevalence scenario the cumulative number of AIDS death will be 614,000 by 2014. The number of AIDS orphans would rise to 236,000 in 2014 from the current 170,000.

The high prevalence scenario with HIV prevalence at 9 percent by 2014 would mean that 344,000 people would die by 2014 an increase of 75,000 per year over the normal death rate. The cumulative number of AIDS deaths would reach 817,000 (NACP, 2001). The number of AIDS orphans would rise to 390,000 under the higher prevalence scenario. The impact of the epidemic is particularly severe on the productive population between the ages of 15-49.

This situation requires at the very least a basic care and support programme to be developed with particular attention on children and a comprehensive programme to mitigate the social and economic impact of the epidemic.

High-risk groups

High-risk groups are highly mobile people often engaged in seasonal and yearly migration patterns within Ghana and neighbouring countries. HIV/AIDS prevalence among commercial sex workers is as high as 75.8 percent in Accra/Tema and 82 percent in Kumasi according to the latest sentinel surveillance survey. This is a high increase according to the historic figures, which revealed that in 1988 Ghana had less than 2 percent infection rate among sex workers and 30 percent in 1993. Deceunick et al, (2000) found that out of a sample of 335 female sex workers in Accra, 76.6 percent were infected with the disease.

The focus of most research over the last ten years has been on the professional and commercial sex worker. Studies are beginning to reveal that a much larger undocumented population of women are involved in informal, occasional or clandestine sexual activities, which are referred to as "transactional sex".

Studies at the tertiary educational level in Ghana reveal an alarming rate of transmission among university students (Anarfi, 2000). The "sugar daddy" syndrome has been stimulated by the pressing economic needs of girls inside and outside the formal schooling system. Recent studies conducted across the country revealed that a high proportion of girls at senior secondary school level are forced to engage in transactional sex in order to feed and clothed themselves (Casely-Hayford and Wilson, 2000).

More research is needed to determine the extent of this phenomenon where young girls sell themselves in return for economic favours from informal or casual relations with boyfriends.

Truck drivers and mobile populations have also been identified as one of the most high-risk groups in Ghana according to the World Bank Study on Mobility (World Bank, 2000).

Modes of transmission in Ghana

Heterosexual contact accounts for most of the infections in Ghana followed by Mother –to- Child-Transmission (MTCT) due to HIV/AIDS infection at the time of pregnancy, at the time of birth or through breast-feeding. Modes of transmission are important for analysis since programmes to slow the epidemic should focus on different approaches to prevention. Table 2 below shows the different modes of transmission of HIV/AIDS in Ghana.

Table 2: Modes of Transmission in Ghana

Main mode of transmission	**Percentage of HIV/AIIDS infections**
Sexual transmission (Heterosexual)	75 to 80%
Mother to Child Transmission	15%
Contaminated Blood and Blood products	5%

(NACP, 2001)

Some modes are easier to arrest than others. For instance mother-to-child transmission has been eradicated in most of the developed world but remains a significant problem in Ghana as well as other African Countries. The contamination of blood is also a channel, which can be stopped if blood is properly screened. Currently, only 70 percent of blood is being screened for HIV/AIDS and other infectious diseases (NACP, 2001).

Availability of Condoms

Most emphasis on preventive activities in Ghana is focused on changing behaviour within the youth and adult population. Several media campaigns are currently running which use intensive communication strategies to reach youth and adults.

Studies in Ghana indicate that 95.3 percent of men and 90.5 percent of women know about condoms but only 20 percent have ever used a condom. Several large agencies are involved in the sale and promotion of condoms including the Ministry of Health, the Ghana Social Marketing Foundation (GSMF) and the Planned Parenthood Association of Ghana (PPAG).

The sale of Condom from Government sources decreased by 19 percent in 1999 from 2,126,171 in 1997 to 1,723,958 (FHI 2001). Sale of Condom from private sources such as, the Ghana Social Marketing Foundation increased by 70 percent between 1997/2000. The increased in condom sales by the private sector are attributable to the communication strategies such as "Stop Aids Love Life" Campaign, which started in Feb. 2000.

According to the Ghana Demographic and Health Survey (1998) the private sector is the major provider of condoms (50 percent) while only 16 percent of men use brands marketed by the Ministry of Health and Government of Ghana.

Vulnerability Context In Ghana

The age groups, which are considered most vulnerable, are girls between the ages of 15 to 18 who are six times more susceptible to contracting HIV/AIDS than their male counterparts (Casely-Hayford/UNESCO,

2001). According to NACP, the "Window of Hope" is between 5 to 14 years of age. Children's moral values and behaviours can be easily influenced before they become sexually active.

Women are said to be vulnerable to HIV/AIDS due to their biological make-up and social reasons. Socially women are unable to protect themselves. Gender differences in access to economic and educational opportunities reinforced by cultural practices and attitudes promote the transmission of HIV/AIDS (NACP 2001). This is particularly the case for women and young girls in Ghana where we find increasing levels of poverty and HIV/AIDS transmission.

Approximately 42 percent of Ghanaians live under the poverty line (Ghana Poverty Reduction Strategy 2002-2004). Majority of them live in the three northern regions. Poverty in Ghana is predominantly a rural phenomenon affecting mainly food crop farmers and women. There is increasing migration patterns within the country particularly for women and girls from the north who migrate to the south in search of economic opportunities. The "Kayayoo" or head carriers are one such group who often live on the streets at night, which makes them vulnerable to HIV/AIDS. Studies reveal that these girls migrate on seasonal basis and are often exposed on the streets and in market places where they become pregnant.

Ghana has embarked on an intensive analysis of its poverty situation over the last year culminating in the Poverty Reduction Strategy: 2002-2004. The document does place some emphasis on the need to focus on HIV/AIDS across the sectors but more work is needed to ensure HIV/AIDS is mainstreamed in the strategy. This is elaborated in section 3.2 of this report.

Another dimension of Ghana's vulnerability context is the relationship of STDs to HIV infection. The prevalence rate for HIV among STD patients and blood donors is 17 percent and 4 percent respectively (UNAIDS 2000). The Family Health International situational assessment reported that in Accra alone, pharmacists treated between 50,000 to 90,000 cases of STD in a year (Family Health International, 2001). STD cases reported by public health facilities were only between 1,089 and 2,906. The FHI report suggests that there has been very poor treatment of STIs in Ghana. There is a high level of STDs in the country, which should be part of any strong prevention programme. WHO's regional strategy clearly outlines the need to attack both STIs and HIV in a consistent manner.

Socio-Economic Context

Ghana faces serious social and economic challenges due to the very low rate of literacy particularly among females in the country (59 percent). The country also has a very high rate of child mortality, poverty and poor health access. This scenario makes out-of-school youth highly vulnerable to HIV/AIDS and children and women susceptible victims.

> HIV/AIDS threatens to erode some of the quality of life indicators Ghana has been able to achieve over the last decade. For instance the gains made in overall life expectancy will not take place as expected due to the high death rates and declining age of death caused by the HIV/AIDS scourge. AIDS accounted for about 3.5 percent of deaths in 1994 and is projected to reach 18 percent by 2004 and 33 percent by 2014 (Ministry of Health, Ghana 2000).

Ghana experiences a high incidence of poverty particularly within the Northern, Central and Volta regions. It is likely that children who lose their parents to HIV/AIDS will need support if they are to remain in school and this is going to be a burden on the country. Already there is a very fragile context in which children are undernourished, lack medical attention and often are deprived of their basic rights such as education. With the onslaught of HIV/AIDS families and communities will find it increasingly difficult to provide for their children and special programmes

(preferably home-based) will have to be developed to cater for these groups.

Poverty assessments conducted in the country reveal that many of the productive labour force have migrated to urban centres leaving children and the elderly in deprived rural areas (Korboe, 1998). This vulnerable context will be further deepened if children are not given proper moral education and training at a young age in order to make the right choices and prevent the spread of the disease. Interviews with several civil society stakeholders indicate that youth groups, religious groups, and traditional leaders are playing a significant role in creating awareness among the youth. Educational Packages such as the "Journey of Hope" and other AIDS awareness packages will be essential for the young who are our "Window of Hope".

Ghana has also been going through a process of decentralisation, which places more emphasis on district-based development with the District Assembly as the key agency for development at the district level. The District Response Initiative (DRI) an HIV/AIDS capacity building programme assists districts to analyse their situation, build capacity and identify actions, which are timely and appropriate for their areas.

The Impact of HIV/AIDS in Ghana

There are very few impact studies available on HIV/AIDS in Ghana. The impact on the private sector appears to be the only research conducted to date on HIV/AIDS. The Futures Group and the Economic Commission on Africa have identified some of the economic and social impacts in Ghana.

According to the National AIDS Control Programme (2001) and Casely-Hayford (2001), recent estimates in Ghana reveal that in the health sector, cost for treating opportunistic infections for an AIDS patient ranges from 4.2 million cedis per year that is (US$ 595) or (US$ 54.34) per episode of illness. Health care expenditures are set to increase from about 59 billion cedis in 1999 to over 167 billion cedis in 2014.

The number of tuberculosis cases has also rapidly increased. A study by NACP estimates about 30,000 people with tuberculoses in 2000 of which between 14 to 23 percent can be attributed to HIV\AIDS.

Not enough data have been collected on the impact that HIV\AIDS will make in the education sector. Projections from UNICEF estimate that Ghana's enrolments in basic school will decline as a result of HIV\AIDS. A large number of teachers will also become infected by HIV\AIDS further eroding the valuable human resource base. Also a large number

of orphans are affected in their access to education. Currently 119,400 orphans are in Ghana.

There are particularly harsh impacts on children. Child mortality will increase instead of decline in Ghana due to the increases in Mother-To-Child-Transmission. Child mortality rates were set to reduce from 110/1000 live births to 51/1000 live births by 2010. Current child mortality rates are projected to at 75/1000 live births. (Ministry of Health, Ghana 1999)

The impact of HIV/AIDS is also being felt in most sectors of society particularly at the local level. Government is aware of the potential impact HIV/AIDS will have on the economy and has made several statements to alert the populace on the impact HIV/AIDS will have, if not controlled and abated.

National AIDS Policy, and Strategic Set up

This section outlines the main agencies involved in the planning and mitigation efforts to control HIV/AIDS in Ghana. The establishment of the National Advisory Commission on AIDS (NACA) in 1985 was the first national response by government on HIV/AIDS issues. In 1987 the National AIDS Control Programme (NACP) was established under the Ministry of Health for both the implementation and co-ordination of programmes. The NACP, Public Health and Reference Laboratory are

responsible for monitoring HIV/AIDS prevalence in Ghana. Sentinel surveys are conducted on a regular basis.

There have been several plans developed by the Government of Ghana/Ministry of Health and National AIDS Control Programme and its stakeholders over the last 10 years including the short-term plan, and medium term plans1 and 2. In March 2000, the government and the technical working group on HIV/AIDS conducted a situational analysis. In June 2000, the UN Thematic Working Group completed a response analysis. The UN Thematic Working Group helped to spearhead the strategic planning process out of which flowed the HIV/AIDS Ghana Strategic plan developed over an 18-month period. The National Draft policy on HIV/AIDS and STI was published in August, 2000.

UNAIDS was instrumental in spearheading these planning processes along with the NACP. UNAIDS helped to set up the basic structures required for a multi-sectoral approach to combating the epidemic. The UN Thematic Working Group was established in 1996 along with the establishment of a Ghana UNAIDS office. In 2000 the group was expanded and now includes the MOH, bilateral and multi-lateral agencies as well as NGOs.

The group comprises a larger set of stakeholders who are more focussed on implementation. These have helped to collect data and strategise on

HIV/AIDS prevention, management and care programmes with the Ghana AIDS Commission, National AIDS Control Programme and Ministry of Health (Ghana HIV/AIDS strategic framework, 2001-2005).

In September 2000 the National AIDS Commission was launched by ministerial decree as a supra agency to help co-ordinate the growing number of HIV/AIDS interventions in the country. This body forms the highest policy making body and comes directly under the Office of the President (Ghana HIV/AIDS strategic framework, 2001-2005).

The Ghana AIDS Commission is mandated to direct and co-ordinate all HIV/AIDS activities. The membership includes:

- Representatives from all ministries, department and agencies (MDA's)
- Organised labour
- Ghana Employers Association
- National Population Council
- National Council on Women and Development
- PLWHA
- National House of Chiefs
- Selected individual and co-opted members

The Ghana AIDS Commission (GAC) is responsible for providing leadership in the national planning programmes, co-ordinate the national response and mobilise and manage resources and monitor their allocation and utilisation. It is also to foster linkages and networking among stakeholders (Ghana HIV/AIDS strategic framework 2001-2005).

Ghana HIV/AIDS Strategic Plan Objectives

The Ghana HIV/AIDS Strategic Framework (2001-2005) proposes a multi-sectoral and multi disciplinary response to confront the disease. It provides broad guidelines for sector ministries, agencies, district assemblies, the private sector and NGOs in order to evolve programmes.

Main Objectives and Specific Objectives

1. Prevention of new infections:

   Increase the median age of first sex from 17 to 18 years, to achieve reduction in number of sexual partners and Increase the use of condoms from 15% to 30%.

2. Care and support.

   Improve the service delivery and mitigate the impact of HIV\AIDS, strengthen the capacity of Health care providers to care for people living with HIV\AIDS (PLWHA), provide good quality home based care for PLWHA and AIDS orphans promote positive attitudes and a supportive environment and promote self-care and self-reliance for PLWHA.

3. Enabling Environment.

   Create an enabling environment for the implementation of the strategic framework, to enact and enforce legislation to facilitate the provision for care and support for PLWHA and research, monitoring and evaluation.

KEY STRATEGIES

Promote safer sexual behaviour including condom use among the 15 to 49 age groups, improve the STI management, reduce the mother-to-child transmission, promote voluntary counselling and testing of individuals especially the youth, Improve the institution care including access to drugs for PLWHA, promote community and social care and support including home based care, and effective linkages between institutional and home-based care providers, review existing clauses and engage policies to protect the rights of PLWHA, promote the stricter enforcement of HIV\AIDS related laws and policies and to advocate for the elimination of negative socio-cultural practices that promote the spread of HIV\AIDS and formulate clear co-ordination and implementation data to strengthen the human resources and Mobilise resources to implement the framework and build capacity to undertake HIV\AIDS related research.

Programme Target Group

The National policy targets the youth, women, commercial sex workers, mobile and migrant population and the general public.

People living with HIV\AIDS and their relatives.

All health care providers, Health care institutions, Laboratory services and the civil society.

CHRAJ, Ministry of Justice, Parliament, judiciary, Ghana Prison Service and Ghana Health services.

Universities, Researchers and Ghana AIDS Commission.

Below is Table 4 indicating HIV/AIDS target group both in the Poverty reduction strategy (2002-2004) and the Ghana HIV/AIDS strategic framework (2001-2005).

Table 3: Ghana's HIV/AIDS Targets

Key Target	**2000**	**2004/2005**
Reduction of new HIV infections among 15-49 age groups.		25%
Improve the service delivery to 50% of PLHWA		50%
Promote condom use to avoid HIV/AIDS for Women Men	 6% 14%	 15% 25%
Improve Health Facilities with adequate arrangement to care for PLWHA		30%
Establish a well managed institution arrangement for the control and co-ordination of HVI/AIDS		

The Government is planning to expand the response to HIV/AIDS at both local and national level through the involvement of all key stakeholders including religious groups, the media and community organisations. Emphasis is also being placed on high-risk groups to prevent the spread of HIV/AIDS and priority intervention areas are being given to the:

- Prevention of new transmissions including awareness creation direct service delivery and supporting high risk groups

- Providing support to people living with HIV/AIDS (PLWHA and their families)
- Laying an effective institutional foundation.

Other key areas identified will be the promotion of girls' education and job creation in rural areas to arrest the problem of out of school youth.

The Ghana HIV/AIDS Strategic Framework identifies several challenges, which have characterised HIV/AIDS financing including lack of funding and access to funds particularly for the NGO sector. This was confirmed in several interviews with the NGOs in the sector.

Ongoing Challenges and Risks in Response

Several stakeholders have commented on the need for a much more co-ordinated effort regarding HIV/AIDS interventions particularly at the regional and district levels. The District Response Initiative is a timely and effective approach to meeting these concerns. It provides the basic capacity needs of district agencies if HIV/AIDS is a menace and provides the skills to co-ordinate efforts (Ghana strategic framework, 2001-2005).

National and Local Responses to HIV/AIDS

Ghana is one of the few countries within the sub-region with all the necessary structures in place to combat the epidemic. Over the last 10 years Ghana has put in place several mechanisms to ensure a systematic and co-ordinated HIV/AIDS response. These include:

- National HIV/AIDS policy

- HIV/AIDS Policy across all the sectors
- High level structure to support the response to HIV/AIDS
- National Strategic Plan on HIV/AIDS
- Supported a budget for implementation of the Plan

Ghana ranks next to Senegal and Nigeria in leading the national response to HIV/AIDS in West Africa. These countries have all the necessary structures, processes and plans in place to combat the HIV/AIDS. Now is the time for action and reflection (Ghana HIV/AIDS strategic framework, 2001-2005).

The President and the ministries, departments and agencies have been leading the way in the fight against AIDS. All the ministries, departments and agencies have been tasked to ensure that a portion of their annual budgets includes activities for HIV/AIDS prevention. There have also been several funds committed to support these initiatives. Some of the key elements of the Ghana Government's commitment have been the establishment of the Ghana AIDS Commission under the office of the President and the inclusion of HIV/AIDS line items in all ministry budgets for the 2001 budget. Some ministries have allocated as much as 5-10 percent of their entire budgets to these activities (Ghana HIV/AIDS strategic framework, 2001-2005).

Current Educational Campaigns

HIV prevention programmes began with a focus on increasing awareness about the mode of transmission and prevention. Mass education for HIV prevention took many forms and is often seen as a key component of a comprehensive AIDS prevention programme. Mass media, for example, is directed to the general public and aim at teaching people essential facts, promoting healthy behaviour, quieting anxiety about casual transmission and preventing discrimination.

There have been several information campaigns over the last two years using radio and television to create awareness of the risk of HIV/AIDS. The most popular has been the "Stop AIDS Love Life Campaign" by John Hopkins University (JHU), Ghana Social Marketing Foundation (GSMF) and Ministry Of Communication (MOC) which has focussed on youth (15 24) and adults. More recently John Hopkins University has launched another campaign called the "Journey of Hope" which is a multi media kit containing games to help people, especially the youth to make choices and think about their future and the risks of HIV/AIDS. This kit is now being introduced into one of the components of DANIDA's Transport Sector programmes on a trial basis.

There are two large campaigns currently running in the country aimed at different target groups. The "Stop AIDS Love Life" campaign has been operational since February 2000 and is using popular media targeting a variety of audiences especially the youth (15 – 25 years of age). The

campaign messages include: theme stops, testimonials, and generic adverts, brand adverts, HIV\AIDS music video, and the traditional ruler's initiative. This campaign promotes two themes, that is, Abstinence Mutual Faithfulness and Condom use. Under the Stop AIDS Love Life campaign, HIV adverts feature HIV positive persons talking about living with the virus thereby putting human face to HIV\AIDS, and whipping up compassion for those already affected with disease. The campaign used traditional rulers because in Ghana, chieftancy wields significant social influence.

The journey of hope is an educational tool on HIV\AIDS for training trainers, which is used for all levels of society. This is a new campaign, which uses a tool kit of activities for social groupings.

Peer-to-Peer education is proving to be one of the most effective approaches used by NGOs and other agencies. UNICEF has initiated a programme called the SARA project, which is primarily focussed on girls between the ages of 10-15 years of age. It uses magazines, videos and posters to convey stories of young girls on reproductive health themes. Ghana Social Marketing Foundation in its attempt to reach out to the youth, uses an educational entertainment approaches by tracking the youth in areas where they can be found (i.e. clubs, discos, churches, beaches etc). It integrates HIV\AIDS awareness into the entertainment

programmes when possible and uses popular youth figures to promote messages.

The USAID "Policy Project" has also introduced advocacy and information packages to convey key messages to policy and decision-makers. The training package contains updated information, which is used by trainers in the country. Family Health International has also developed information/training packages for private sector trainers.

The HIV\AIDS strategic plan outlines the need to reduce the MTCT rates by 30 percent by 2005 as one of their main goals. Significant effort will be needed to implement policies and protocols related to MTCT. For instance, there is the need to build capacity of the Ministry of Health and relevant stakeholders, create awareness on the risk of MTCT and improve access to counselling services for mothers (Ghana HIV/AIDS strategic framework, 2001-2005).

Conclusions

It is more important than ever that Ghana mounts an expanded response to the epidemic, especially to prevent the spread of HIV among vulnerable groups including adolescents and young adults

Youth particularly appear to be the most important target group for prevention and control of HIV/AIDS in the short and long term.

Stakeholders interviewed as part of this study stated consistently that the youth between the ages of 15-24 are the most vulnerable and most receptive to change. This group and the pre-youth should be targets for many of the activities since they will soon enter the world of work. The Window of Hope, (children between 5-14 year) should also be a major target group using in-school and out-of-school approaches.

CHAPTER FOUR

LITERATURE REVIEW AND CONCEPTUAL FRAME WORK

Literature Review

This chapter focuses on studies conducted by researchers on HIV/AIDS and the conceptual framework.

There is a large volume of literature on HIV / AIDS. However, studies focusing on the education on HIV / AIDS and attitudinal change among the youth are relatively few. Nevertheless, a number of studies are of great importance to this study. Such studies include those on sexuality, migration and AIDS, sexual networking in high-risk environment and its implication for the spread of HIV / AIDS, sexual behaviour and attitudes towards AIDS, the influence of perceptions on behaviour, and the knowledge, attitudes and practices related to AIDS among young people.

By the end of 2001, it was estimated that a total of 18.8 million people worldwide had died from AIDS since the beginning of the pandemic, and an additional 40 million were then living with HIV. However, unlike the Black Death (1347 – 51) and the influenza epidemic (1917-19), each of which lasted only a few years, HIV infection and the AIDS pandemic have been with humankind for at least 25 years (Caldwell, 1995). The key distinction however is that HIV/AIDS has a long incubation period and a long morbidity phase.

Misconception

HIV/AIDS is one disease that has been surrounded by so many views and misconceptions. Health experts and combatants at the forefront of the battle against the disease have raised concerns over this as impeding prevention activities.

Since HIV/AIDS first came into international recognition in 1981, people have held several views about it. The popular view in the Western world was that the disease originated from Africa, probably to confirm the popular saying that 'everything bad comes from Africa'. It was viewed initially as a 'specific cause of death' and like any other cause of death, it ought not to be isolated for special attention.

The many misconceptions held by people include the false idea that the disease is for some particular group of people. In New York City in 1986, it was reported that when outreach workers began to talk to the Hispanic Community about HIV/AIDS, the response was: 'Why are you talking to us about this? It's a disease of whites, of homosexuals and drug addicts. We don't have these kind of people here' (Quinn, 1999).

A survey conducted in Japan showed that even though most of the respondents were aware that HIV/AIDS could not be contracted from swimming pools or lavatory seats, still people had an aversion for pools

and lavatories in places frequented by foreigners. In their view foreigners were potential AIDS carriers (UNAIDS, 1999).

In Peru, even though male youth deem themselves as vulnerable to the HIV infection, they still hold the view that the disease is a 'gay' or 'whore' disease. Consequently they can avoid infection by not having contact with gays or prostitutes but can still have sex with only well-known friends or nice girls (UNAIDS, 1999).

In Africa, like in other parts of the world, there are many views and misconceptions about the epidemic. According to the *Ghanaian Times* of June 21 2001, in some parts of Africa, there is the belief that having sex with a virgin or an extremely old woman can cure an infected person. Some also believe that drinking bits of bleached water can cure them. To this category of people, the bleach can kill the virus once exposed to it. Most people are also reported to associate the disease with foreign travel. Therefore, they erroneously believe that people who have not traveled outside the country are AIDS-free. The Ghanaian Minister of Health observed that, for most Ghanaians, the narrated cases of the impact of HIV/AIDS appeared remote and cautioned that with the Ministry of Health's estimates of 500,000 HIV infected Ghanaians as at 1999, the disease was gaining root as a difficult-to-control epidemic (Daily Graphic, 2001)

A survey conducted by the National AIDS Control Programme of Ghana indicated that about 58 percent of males in the country did not see themselves as being at risk. This misconception is seen as having serious implications for the country particularly because of high-risk behaviour among the youth (MOH, 1999)

There are yet some people in Africa who believe that the disease belongs to some racial groups and therefore, think that they could avoid it once they distance themselves from that group of people. For example in Nigeria, a Lagos-based prostitute was reported to have said: 'Although white clients generally pay better than their black counterparts, I will never go to bed with a white man unless he wears a condom. As far as I am concerned, AIDS is a white man's disease' (UNAIDS, 2000).

Some people, according to the *Ghanaian Times* (June 2001), hold the view that fat people and healthy-looking people do not have the virus. Because of this, some people feel fine and secured when they have sex with fat men and women. For the people who think this way strongly believe that they can lead any sort of life and still remain free, because AIDS is for the other man or woman on the street. All these views and misconceptions, only serve to worsen the AIDS crisis all over the world.

Research in east Africa has proven that a lot of these misconceptions were changing. For example, Caldwell (1997) found in East Africa that

the majority of respondents knew that AIDS was not caused by witchcraft, nor brought about by worry and neither was it curable. The disease was also freely discussed among friends. They also knew that looking healthy did not necessary mean that one was free from the AIDS virus. The risk associated with sexual behaviour was also highly recognised.

Among college students in Ethiopia, knowledge about methods of AIDS prevention had increased by 18 percent from the previous year whilst awareness of condoms as means of prevention increased by 15 percent. Similar patterns have also been observed in Zambia and Nigeria among university students. A high percentage of the people were able to identify the preventive measures as well as the destructive consequences of the epidemic in their households and communities.

There is evidence to show that this awareness level is not confined to urban communities alone. In East Africa more than 90 percent of the people were reported to be aware of the causes and means of HIV/AIDS transmission (UNAIDS, 1999).

In Ghana, the well known sexual risk activities, such as unprotected sex with multiple or casual partners are commonly practiced. Erroneous belief about HIV/AIDS, such as the notion that one can avoid contracting

AIDS by avoiding sex with a prostitute from La Cote d' Ivoire, are common (Johnson et al, 1988).

Anarfi (1995), in his study of AIDS patients, found that patients had few misconceptions about ways of HIV transmission.

These misconceptions contribute to report a low level of perceived risk and a false sense of security.

Attitude and Behavioural Change

In the face of absence of appropriate care, the level of HIV infection continues to climb globally, especially in developing countries, and there are no indications as to how long the AIDS pandemic will continue. While the regions of Africa (most affected by HIV/AIDS) are home to approximately, 180 million people, (just 3 percent of the world's population) they have about 55% of the world's HIV/AIDS cases (Caldwell, 1995).

Caldwell (1995) again, points out that HIV/AIDS epidemic proportions among the general adult population in parts of sub-Saharan Africa has developed and is supported by the significant level of multi-partner heterosexual relations among males and to a lesser extent females. He states also that a considerable proportion of men have sex with prostitutes, and have levels of long term, untreated genital ulcerating disease (GUD).

Katende et al (1993), in their study on the influence of perceptions on behaviour in Ghana reported that in the early 1990, data on AIDS knowledge, attitude and practices in Ghana had demonstrated the effect of individual perceptions on condom use among 15-30 year olds. More people who considered AIDS to be a major health problem used condoms than those who did not consider it to be a very important problem.

An evaluation of mass media campaign to prevent AIDS among young people aged 15-30 in Ghana by McCombie and Anarfi (1992) indicated that there was increased awareness of AIDS as a serious disease, an improved understanding of the length of the incubation period, and a reduced belief in a cure.

In the past people considered sexual intercourse before puberty rites as a crime. But this offence had lost some of its gravity with the influence of christianity, education, urbanisation and migration. It has also been discovered that christians and people with no religion were more sexually active at younger ages than other religions (Anarfi, 1993)

It has also been established that messages on sex and transmission of HIV/AIDS impact behaviour change positively. On the other hand, evidence gathered indicates that exposure to messages that try to heighten fear in the populace may be counterproductive and promote

negative perceptions of HIV/AIDS. (Adih and Alexander,1998; Bosompra, 1993)

In Zambian urban areas, an examination of the sexual networking and activities of urban youth, both in school and out-of-school, suggests that sexual matters are discussed with close friends of the same sex and peer group, or with cousins who are of the same age. 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 (Kalunde, 1997).

In his examination of the opinions on AIDS prevention and education among pupils aged 17-25, in rural South Africa, Peltzer (2000) concluded that isolation of HIV positive people as a means of protecting oneself from contracting the disease was of prime importance to respondents.

Some researchers have argued that the predominant emphasis in education programmes on safe sex, such 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. Secondly, 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 therefore concluded that young men and women when they become sexually active do not always act rationally and that consideration should be given to the social context within which young people conduct their sexual lives (Hillier et al, 1998).

In South Africa, it was reported that most of the youth did not use condoms because it was unavailable. This stemmed from the fact that people simply did not have the courage to ask for condoms at pharmacies and clinics. It was therefore concluded that young adults might not seek reproductive health service, 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). However, it is becoming clearer that condom usage for the youth may not be a straightforward issue.

A Malian survey in 1999, reported that lack of information was one obstacle to reproductive health. Other obstacles included distance to health services, lack of contraceptive methods and cost (UNAIDS, 1999).

Even when the youth have accurate knowledge about HIV, they often do not heed warnings to reduce risky sexual behaviours. Some young people 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.

Petosa et al (1990) intimates that many adolescents hold serious misconceptions that could lead to unintentional risk behaviour. It has been found by Villarruel et al (1998) that, HIV prevention interventions need to include information about specific risk behaviours such as using condoms. Adolescents and their peer educators should use relevant approaches to reduce HIV infections among the youth identified specific information that will increase perception risk of HIV and the development of condom use skills.

Reproductive health survey in Ghana found out that overall, there was high awareness of HIV/AIDS among the youth. The survey also found that knowledge and awareness of 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 ranged from about 40-50 percent. Also less than 20 percent of males and females use condom at first sex (GSMF, 2000).

Also in Uganda for example, knowledge about condoms was high, and both men and women had positive attitude towards it. However, while almost all young men and women knew that condoms could prevent HIV/AIDS, less than 13 percent of males and virtually no females (fewer than 1 percent) admitted using condoms. Despite this gap, knowledge continues to play a key role in HIV/AIDS prevention (Harrison et al, 2001; Hillier et al, 1998).

Using theories of health behaviour, Keller (1993) conducted a study aimed at advancing the understanding of risk-taking regarding human immunodeficiency virus (HIV) infection among young adults. He found that for many, the reason for risk-taking was that sexual intercourse was more often than not unplanned or spontaneous. On the other hand, others were prepared to take such risk based on the belief that the potential sexual partner was not infected with HIV.

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

Despite the growing knowledge of HIV/AIDS among people all over the world, evidence suggests that people are not necessarily taking up safer sex practices, even among the high-risk groups. The kind of attitude people have towards the epidemic is highly influenced by their cultural and religious beliefs (Vargas, 1999).

Research conducted by Awusabo-Asare et al, (2000) in Cape Coast, Ghana, discovered a belief among high-risk people that, "All die be die" (which literally means, "every death is death"), implying that the cause of one's death did not really matter. Therefore, "if one dies of AIDS, it is not a big deal." Such attitude to death in the era of AIDS point to apparent misunderstanding or lack of motivation for behavioural change in the existing socio-economic circumstances. According to Awusabo-Asare et al, (2000) many young people interviewed saw abstinence from sex as the surest protection against HIV/AIDS, but had been unable to abstain from it. Thus, they were not able to follow what they considered the right course of action. Some people, according to them, believe that AIDS can be contracted no matter what one does, if he/she is predestined to be infected, he/she would be infected anyway. Therefore, attitude towards condom use as a means of preventing HIV/AIDS infection, to these people, were frequently found to be negative.

Reports have it that, despite the high level of awareness of AIDS and its modes of transmission, only 23 percent men in Ibadan, Nigeria believed that they were at risk of contracting the disease. They were sufficiently aware that unprotected sex, and multiple sexual partners, puts them at risk of HIV/AIDS infection, but most of them still felt that they were not at risk. Their major reason was that their partners were trustworthy. Series of similar researches conducted among men in other parts of Nigeria have revealed that most of the respondents still feel that they are not at risk of AIDS, despite the near-universal knowledge that AIDS is real, deadly and incurable. This is due to the fact that some believe that the disease is one of the causes of death, while others feel that it is a supernatural disease. Others also feel that traditional doctors, faith healers or even modern doctors can cure it (Orubuloye et al, 1993).

Health workers and people living with HIV/AIDS, have varying attitudes towards the epidemic. In a report published by Anarfi et al (1995) Health workers in sub-Saharan Africa perceived themselves as being at high risk of HIV infection but some fail to take the necessary precautions against being infected. This is attributed to circumstances that may surround the case in question, lack of protective clothes, inadequate tools and equipment or not adhering to known safety measures. Some are also reported to have said that if they knew of an HIV/AIDS infected person, they would not perform surgery on them. About 35 percent of 111

physicians and another 35 percent of 95 percent nurses interviewed in Nigeria shared this view. This showed that in spite of the high level of awareness of the disease through numerous educational campaigns, people's attitudes towards the epidemic still leaves much to be desired. This implies that one of the most important factors that will determine the spread of AIDS is sexual behaviour, which has been found to be related to various demographic and socio-economic characteristics.

Occupation is considered to exert some influence on the degree of sexual network. Generally, studies have indicated that occupations that allow mobility, or in the services are at risk of sexually transmitted disease infection. These people have higher frequency of partner change (Caldwell et al, 1993; 1995).

Evidence suggests that movement patterns of infected people are important conduits of infection from one place to another (Barnett and Blaikie, 1992). The circulation of African elites between the capitals of Africa, and at an earlier point of the AIDS pandemic between United States and Africa, have been claimed to be one pattern of movement responsible for the early diffusion of AIDS (Orubuloye et al, 1995). The circulation of prostitutes between cities and their homes in rural areas also seems to have a factor in urban-urban and urban-rural spread of the disease (Barnett and Blaikie, 1992). Truck drivers have been cited as

significant vectors of the spread of the disease, particularly along the high way linking Nairobi through Kampala and West towards Kigali (Nzyuko et al, 1991). There has been rising of sero-prevalence along this route. In such areas there has been also increase in mortality.

Studies carried out in most part of Africa have shown that marital status play an important role in influencing the number of sexual partners an individual not currently married has. Never married, divorced, widowed and separated persons have more sexual partners than the married. A study on extramarital sexual behaviour in 14 developing countries from Africa, Asia and South America found that proportion of non regular partners in 12 month preceding the survey varied considerably by current marital status for both sex (Cleland et al, 1995). The proportion of formerly married reported the highest irregular partners followed by never married people and least were the currently married people. The study also found that in Uganda and Rwanda women who were separated, widowed or divorced had a significantly higher level of HIV infection than currently married or cohabiting women (Dyson, 1992).

Polygyny has also been one of the risk factors associated with the transmission of sexually transmitted diseases. Caldwell et al, (1993) found that polygynously married women had more extramarital sexual partners, particularly women who received little assistance from their

husbands. Under such conditions other wives of the husband are also at risk of contracting HIV/AIDS. This was also confirmed by Cleland et al, (1992).

In many societies, urbanization increases opportunities for sexual encounters. Urbanization favours transgression of more restrictive traditions that exist in some rural areas. As more people marry late and more relationships become informal, higher risk behaviours tend to concentrate in cities and towns. Concentration of people with different socio-economic characteristics, and traditions (cultural values) in cities and towns are reasons for these behaviours (Cleland et al, 1992).

Age has also been found as one of the determinants of sexual behaviour. Young people are more sexually active than old people. Usually young people are assumed to have more sexual partners and high frequency of sexual intercourse than their older folks. A relatively consistent age distribution of HIV infected persons has been found in sub-Saharan Africa cities. The epidemic principally affects very young children and middle age adults. From 5 to 10 percent of infants in urban areas are found to be HIV positive, and the highest sero-prevalence level falls within the ages 20-24 for women and 25-29 for men, or the ages 25-34 in some populations (United Nations, 1994; Cleland, 1992).

It has been found that there is a relationship between level of education and sexual behaviour and risk of HIV infection. As argued, education has a modest effect on health knowledge, which involves avoidance of risky sexual behaviour and thus reduces sexually transmitted infection. Cleland (1992) found that condom use among people with formal education was higher than with no formal education.

On the contrary, Barnett and Blaikie (1992) found out that higher socio-economic status is associated with more frequent sexual partner change and the ability to travel to other urban centers (of infection). There is considerable evidence that higher HIV infection rates are found in those with higher socio-economic status and education. For example, in Rwanda, Barnett et al found that in a sample almost one third of HIV positives had been through secondary or higher education, while in a Zambian sample 33 percent had spent 14 years of education or more and about 24 percent between 10 and 14 years. These studies suggest that the higher the level of education the higher the risk of HIV infection.

There is evidence of discrepancies in the reports of sexual activity by men and women. Results generally indicate that men are found more in casual relations than women. Reports of lifetime number of sexual partners are also higher among men. This global differential between men and women tends to be consistent across all age groups. However

some studies show that women enter into sexual relations at lower age than men (Carael et al, 1992).

Throughout the centuries, religion and individual sexual practices have been associated. Religion plays a major role in attempting to mould behaviours by spelling out the "Divine Commands". According to Johnson et al (1988) religions suggest that premarital coitus is not preferential behaviour and emphasize the sinfulness of the act.

Education on AIDS has been the only way to prevent the spread of the disease. Educational programmes aim at informing people on how HIV/AIDS is transmitted and ways of avoiding exposure to HIV infections. Studies have indicated that the level of awareness of AIDS is high. However, application of the knowledge is very low. Kapinga et al, (1995) found out in a study on AIDS in Tanzania that almost all the respondents knew about at least one mode of HIV transmission. However, about 42.8 percent cited condom use as a way of preventing HIV infection and only 4.6 percent of the women interviewed reported using condoms on a regular basis and 19.8 percent on occasional basis. About 58 percent of the women reported that they did not use condoms because men did not like them. These findings indicate that AIDS prevention activities have been only partially successful in reaching

women at high-risk. These have been confirmed by other researches conducted by Stewart (1995), and Anonymous (1995).

A study on AIDS patients in Ghana found that, 89 percent of the patients were aware of AIDS before getting infected and 80 percent knew that AIDS spreads through sexual intercourse, and few mentioned other modes of transmission (Anarfi, et al, 1995).

Studies have come out with reasons why people do not using condoms, despite the high level of AIDS knowledge. For example, a study by Paulo Kishinds (1995) found out that, all the girls were aware of AIDS and knew that it could be transmitted through sexual intercourse. They also knew that AIDS had no cure or vaccine, and they could avoid catching AIDS and prevent its spread by using condoms during sexual intercourse. But only a few had ever used condoms during sexual intercourse although they were available free from the hospitals. Reasons given for not using condoms were that clients claimed that the condom reduced sexual excitement.... A widespread view among women was that a condom can split off a client and lodge itself in the woman's uterus, causing sterility. It was also believed to cause vaginal itching...The belief that the particular individual was not in imminent danger of catching HIV/AIDS.

These girls claimed that when they suggested use of condoms to their clients, they were rejected for someone wiling to have sex without condom. This meant loss of potential earnings. Also bar girls indicated that they would not refuse unprotected sex if the price was right (paid big amount) and they believed that one's manner of death was pre-ordained, and that no human act would change it. A few of the bar girls believed that since the incubation period is long, a cure could be found before they develop full-blown AIDS. Pamela et al (1994) found similar situations in USA, England, Brazil, San Pedro Macon's and San Cristobal in the Dominica Republic, Indian and Indonesia.

This implies that those most at risk of acquiring AIDS are people with multiple sexual partners, their spouses and their unborn children. It is thus true to say that one of the most important factors that will determine the future course of the pandemic is a sexual behavioural change, particularly the proportion of the adult population with multiple sexual partners (World Bank Country Study, 1992).

Studies conducted around Lake Victoria in Mwanza and Kagara region by Barongo et al, (1992) have demonstrated that sexual behaviour was the key determinant of the risk of HIV infection.

Cleland et al (1992) have stated that pending the development of an effective vaccine or therapy for HIV/AIDS, behavioural change is the only means of averting the continued spread of the disease. They urge that

the advent of effective biomedical prevention is unlikely to bring a complete solution to the problem, unless it is accompanied by changes in sexual behaviour. However, Anarfi (1999), indicates that an understanding of the transmission of AIDS will to a large extent, depend upon our knowledge of the behaviour, social and cultural factors that determine people's risk of infection, in particular their perception and attitude towards sex and their sexual habits.

Based on a review of anthropological and socio-cultural studies on sexual behaviour, networking and the transmission of HIV, Dyson (1992) hypothesizes that coital frequency and a greater number of partners are related to a decline in customary restraints on sexual behaviour. Dyson suggests that change in the notions of what constitutes acceptable patterns of sexual behaviour has resulted from a wider worldview that is migration, education, urbanization and media, among others.

It has been suggested that risk behaviour is a function of risk environments. Barnett and Blaikie (1992) have suggested that an interlocked set of economic, social and political processes led to the development of high-risk environment in which AIDS could manifest itself in the particular way that it has in Buganda. They argue that by the early 1980s the social, political and economic landscape exhibited symptoms of differentiations and contradiction that provided a fertile

environment for the spread of HIV. They suggest that circumstances in which economic insecurity for women and their attempts to cope with this through various types of liaison with men, create the social relations characteristic of a focus of infection in this environment.

There is encouraging evidence from literature available on HIV/AIDS and safer sex that intervention programmes to influence behaviuor change can be effective. In Zimbabwe, 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 used 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.

In this review it is being inferred that the level of HIV/AIDS education does not shape sexual behaviours. However, behaviours are shaped and conditioned by the environment within which people operate. It is within this context that this study is set.

Conceptual Framework

As HIV/AIDS prevention has become more complex and extended beyond increasing awareness and knowledge of the disease, the effort to reduce its spread is now propelled by behavioural factors. Theories about how individuals change their behaviour have been the foundation for most HIV prevention efforts all over the world. These theories have been generally created using affective-motivational and cognitive-attitudinal constructs (King, 1998). Researchers have developed several models that look at behaviour risk and HIV infection as it pertains to health and illness. These models clarify our understanding of human behaviour in health care situations. Some of these are described below.

Health Belief Model (HBM)

According to this theory, perceptions determine the likelihood of individuals adopting or maintaining safer sexual practices. Thus, if people perceive they are threatened by HIV/AIDS and think they can take action to prevent becoming HIV-positive, they are likely to have safer sex. Despite the usefulness of the model it has been criticised, however, that as a psychological model it does not take into consideration other factors, such as environmental or economic factors that may influence health behaviours. Also it does not incorporate the influence of social

norms and peer influences on people's decisions regarding their health behaviours (AIDSCAP, 1996; FHI, 1996; 1997).

Theory of Reasoned Action (TRA)

According to this theory, the strength of people's intentions has the most influence over their choices about risky sexual behaviour. This strength of intentions results from their attitudes towards unsafe sexual practices, their perceptions of other people's opinions of such unsafe behaviours, and their evaluation of those opinions. Some limitations of the TRA include the inability of the theory, due to its individualistic approach, to consider the role of environmental and structural issues and the linearity of the theory components (Kippax and Crawford, 1993).

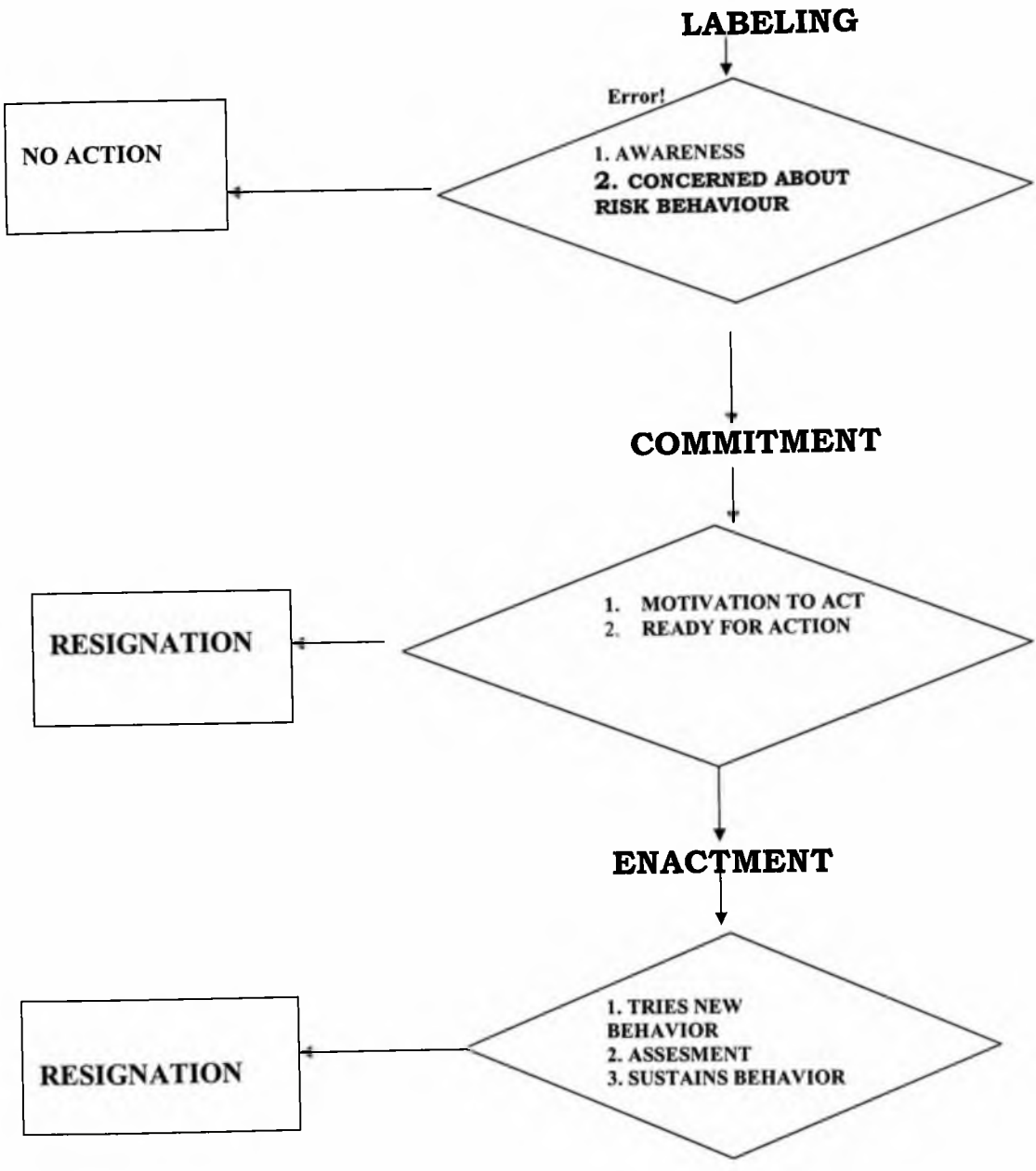
The Stages of Change Model

This theory suggests stages a person must pass through in order to change risky behaviour. While these stages may not accurately describe the behaviour change process in all situations or different cultures, they do suggest a strategic framework for developing interventions. These stages indicate that information dissemination alone does not constitute an effective prevention programme. While enhanced awareness and knowledge of health risks are important preconditions for change, knowledge in and of it has never proven to be the chief motivator for change.

As a psychological theory, the stages of change model focuses on the individual without assessing the role that structural and environmental issue may have on a person's ability to enact behaviour change. In addition, since the stages of change present a descriptive rather than a causative explanation of behaviour, the relationship between stages is not always clear. Finally, each of the stages may not be suitable for characterising every population. Generally, models of behaviour change focus on stages that individuals pass through while trying to change their 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 (AIDSCAP/FHI, 1996).

The AIDS Risk Reduction Model (AARM)

According to Catania et al, (1990) this model was developed exclusively for AIDS. The model uses constructs from the belief model and the social cognitive theory to describe the process individuals or groups pass through while changing their behaviour with regards to the risk of HIV. The model identifies three stages through which risk for HIV transmission can be reduced. These include behaviour-labelling commitment to change and taking action. The framework below shows how the AIDS Risk Reduction Model operates.



The model is based on the premise that to avoid disease, in the first stage, there should be recognition of a problem and labelling of one's behaviour as high risk by the individual. Knowledge about how HIV is transmitted, perceived HIV susceptibility, as well as aversive emotions influence how people perceive AIDS. If individuals do not perceive or label their behaviour as high risk, then there will be no action to be taken.

Commitment is the second stage, it is about making a commitment to reduce high-risk behaviour such as sexual contacts and also to increase low risk activities once high risk is labelled. If at this stage, an individual perceives the seriousness of the condition (that AIDS is serious, and how hard life would be if he/she gets it) then the person is motivated to act through the perceived risk and benefits, and to make a commitment through skills required to enact behaviour change. The commitment of an individual is shaped by four main factors: perceptions of enjoyment, self-efficacy, and social norms and aversive emotions. If one labels high-risk behaviour but makes no commitment to change there will be a feeling of resignation. The last stage is to take action to change.

At this stage, there should be information seeking, obtaining remedies and enacting solutions to change behaviour, at this point, aversive emotions, sexual communication, help-seeking behaviour and social factors will affect people's decision-making process (Catania et al, 1990).

In general the AIDS Risk Reduction Model emphasises the goal of understanding why people fail to progress over change process. A general limitation of AIDS Risk Reduction Model is its focus on the individual. Despite its limitation, the AIDS Risk Reduction Model is relevant to this study. It provides the framework for assessing how the youth perceives their sexual behaviour, the kind of information is available to enable the youth make a commitment to alter their high-risk behaviour and the kind of protection to adopt for themselves.

CHAPTER FIVE

RESEARCH METHOD AND DATA ANALYSIS

Introduction

This chapter deals with the method of data collection and the data analysis. The chapter begins with the target group, sampling, and an analysis of the socio – demographic characteristics of the respondents. This is followed by a discussion of respondents' knowledge on HIV\AIDS and their attitude towards the disease.

Target Group

The youth are a critical group in the growth and development of every country. Thus the potential of HIV/AIDS transmission among them is of concern. Consequently the need to bridge the gap between knowledge and practice of the youth cannot be over emphasised. Young people account for a fairly large proportion of the population of Ghana. An estimated 31 percent of the total population, aged between 10-24 years with a median age of 17.5 years constitute a proportion of young people. 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 and inexperienced and are vulnerable when it comes to safer sex practices. Young people as a group tend to be uninformed or misinformed about

sex and reproductive health and are reluctant to take action to protect themselves. As a distinct group, information to the youth should be fashioned to suit their worldview.

The main target population for the study is the out-of-school young men and women aged between 15 and 35 years in the study areas. They were divided into two categories: those in formal training as apprentices in various trades such as dressmaking, carpentry, auto-mechanics, hairdressing and the like are termed as the 'regular youth'. Those who are not in any formal training, otherwise known as street children, are termed 'irregular youth'. The survey targeted 240 youth in three suburbs. For the purpose of obtaining some of the more traditional views of and attitudes towards the subject matter, people aged more than 35 years were interviewed. They constituted one FGD session.

Sampling

The communities were purposively selected for the study. The first step in the sampling process was the selection of the study area and as already indicated the choice of Mamobi, New Town, and James Town was greatly influenced by the activities of the Salvation Army, Muslim Relief Association and GSMF which were engaged in HIV/AIDS education in these areas. The second step in the process was the selection of the actual respondents. Quota sampling was used to pick 80 respondents

from each of the community, (40 regular youth and 40 irregular youth). The Table below shows how the 240 respondents were distributed.

Table 4: SAMPLING

COMMUNITY	REGULAR YOUTH	IRREGULAR YOUTH	TOTAL
MAMOBI	40	40	80
NEW TOWN	40	40	80
JAMES TOWN	40	40	80
TOTAL	120	120	240

HIV/AIDS is a sensitive issue and acquiring data on it can be problematic. In most societies in Ghana, for example, there is very little or no intergenerational discussion about sexual matters. To circumvent this, a mixture of methodologies were used but with more emphasis on qualitative methods. That is, both the quantitative and qualitative approaches of social research were employed in the data gathering process.

In the quantitative survey, the main tool for data collection was a questionnaire structured to cover the themes of the research, people's perception of what constitutes risk behaviour in relation to HIV/AIDS,

the causes of the spread of HIV/AIDS despite the high knowledge, and processes of controlling the spread of the disease.

Most of the questions were open-ended to allow respondents the leeway to state their views on the issues. Before the final version of the questionnaire was adopted, it was pre-tested in a community not included in the final sample, and some modifications were made to reduce questions attracting high 'no-response' rate.

In the administration of the questionnaire, no preliminary approach was made to the community announcing the research programme. This was to avoid the situation where people would be forewarned that an investigation on HIV/AIDS was about to take place and whereby arouse the curiosity of those to be interviewed. The purpose and importance of the research was explained to respondents and their co-operation solicited. Respondents were also assured of the confidentiality of information provided before the interview. All the questionnaires were researcher-administered.

The quantitative data collected was complimented by a qualitative method to put the data collected into its proper context. As Roche (1991: 131) points out::

> "The appeal of qualitative methods in social science research is that they allow the researcher to explore, with greater richness and vividness of detail, the type and quality of response and also allow greater interaction between the researcher and his subject. Such close interactive involvement is generally precluded in quantitative methods of investigation".

Two main methods of qualitative data collection were employed. These are in-depth interview and FGD. In the in-depth interview some key Non-Governmental Organisations (NGO's) working with the youth on HIV/AIDS education were interviewed. Also some doctors and nurses who are experienced and better informed on the disease were interviewed. The interview generally had no pre-defined set of questions or topics to enhance the flow of communication. The respondents were taken through an unstructured form of interview individually on the various themes of the topic of the study.

Focus Groups Discussion (FGD's) was organised to put some of the observations acquired through the quantitative survey in their proper social context. Focus Group Discussion (FGD) was utilised to its maximum in this study. The FGD involved a discussion among selected groups, based on their age, and sex. The selection of the discussants

was based on a screener, which was used to ensure homogeneity of participants. That is to say, each group consisting of nine and eleven members who were of the same age group, sex and had a fair knowledge on the issues to be discussed, were selected as participants. In all four sessions of FGD were held to cover the target population.

The researcher was the moderator who introduced issues to be discussed and directed the tempo of discussion. Particular attention was paid to points where discussants held common views and where disagreements were expressed. In the latter, the views of the majority and those of the minority were noted. A tape recorder was used to record the discussion after the moderator had sought the consent of the discussants.

The qualitative information acquired provided a great deal of insight, which put some of the major variables observed during the survey in their proper social context.

This was done after the recorded information from the discussions had been transcribed.

DATA ANALYSIS

Age of respondents

Age is an important variable in a study on HIV/AIDS. This is because ages 15 – 34 have been identified as the period within which the youth is vulnerable to HIV\AIDS disease (MOH, 1999). According to Anarfi (1995) most HIV/AIDS infected people are within the 15-34 age groups. The vulnerability of people in the age group is explained by the fact that this is the age where men, boys, girls and women alike are most sexually active. It is, therefore, important for any research on HIV\AIDS to take cognisance of this fact. By the research design, the 240 respondents of the survey were mostly within this age range. Below is the age distribution of respondents.

Table 5: Age Distribution of Respondents

AGE	FREQUENCY	PERCENTAGES
15-20	100	41.7
21-25	73	30.4
26-30	47	19.6
31-35	20	8.3
TOTAL	240	100.0

The data in Table 4 show that, at least two in five of the respondents (41.7 percent) were between ages 15 and 20. Analytically, people within this age group are most prone to HIV\AIDS as they are easily lured into sexual relationship by luxury items, money and exciting dates by men who may be having more than one sexual partner. Such relationships often have implications for HIV\AIDS infection. It is also significant to point out that only 8.3 percent of the respondents were within the 31 to 35 year- age group. The underlying reason for this arguably, is that most people enter into apprenticeship training at a younger age, that is, from ages 15 to 22. By age 26 and above they become trade masters. Thus the research targeted apprentices and petty traders in the study area.

Sex Distribution

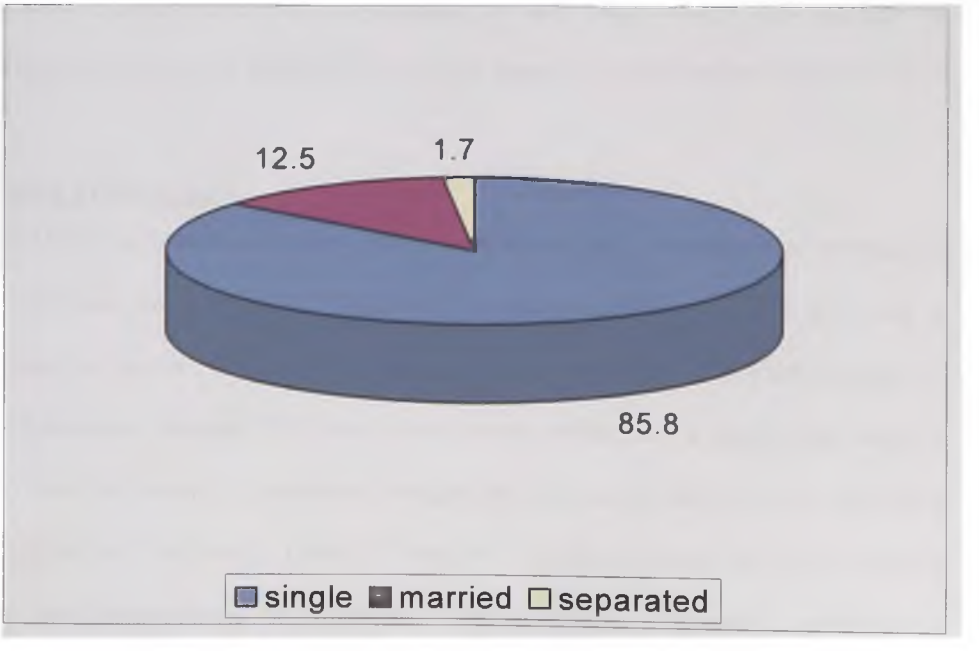
The sex distribution of respondents shows that 51.7percent were males and 48.3percent were females. This sex distribution is at variance with the sex ratio of Accra metropolitan area for the year 2000, which was 1,658,937 made of up 817,404 males and 841,533 females (GSS 2002). This is so because there were more male oriented jobs in the study area than those of females. For example, it is quite uncommon to find female mechanics, barbers, construction workers etc. According to Ninsin (1991) males predominate in activities that require greater physical strength for execution while females are mostly associated with household chores and less exacting activities.

Marital status

Marriage is the recognised institution for the establishment and maintenance of family life all over the world. Marriage is regarded as a union in which the couple has gone through all the procedures recognised in society for the purposes of sexual intercourse raising family, or companionship (Nukunya, 1969: 88-90). It was in this light that marital status of respondents was investigated.

Marital status was the next socio-demographic variable investigated. The distribution of this variable is presented in figure 4 below.

Figure 3: Marital Status of Respondents



The data indicate that only 12.5 percent were currently married, 85.8 percent were single and 1.7 percent separated. This implies that an overwhelming majority of respondents (87.5 percent) were not likely to have socially binding sexual relationships, as it was only through marriage that such binding sexual relationships were established. Consequently, respondents may have multiple sexual partners at any given time or over a period of time. The implication is that when one person is infected, he/she is likely to infect several others.

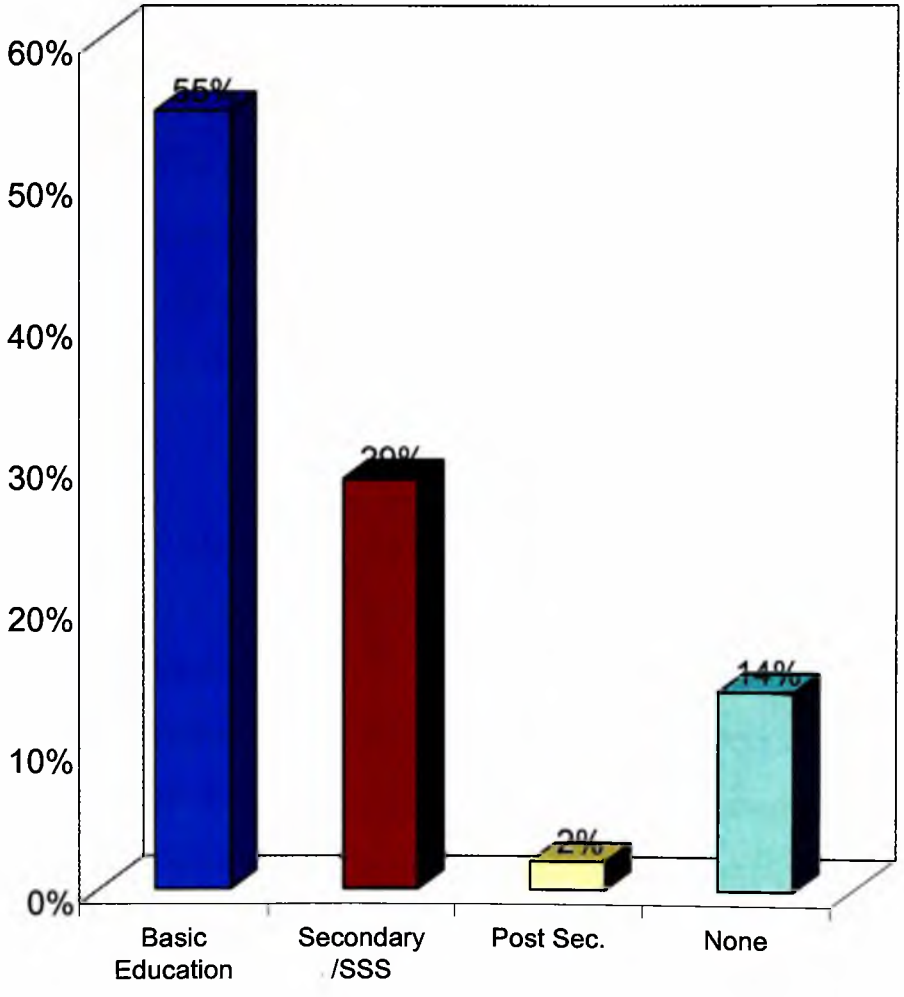
The situation as presented by the marital status of respondents is not surprising considering the fact that the study focused on the youth. It is believed that in Ghana, most people do not marry early. This is more so when the person is learning a trade in order to earn income in the future.

Level of education

In AIDS studies, as in many other health studies, one's level of education is crucial for the degree of one's awareness: education is seen as a potential factor in social change especially with regards to attitudinal or behavioural change. The level of one's education has a significant impact on his/her attitude towards pregnancy and other sex related activities (Nabila and Fayorsey, 1996). It was for this reason that the study looked at the educational background of respondents. Figure 5 provides a

pictorial representation of the data on educational characteristics of respondents.

Figure 4: Educational Level of Respondents



The data show that 14 percent of the respondents have had no formal education whatsoever; 55 percent had basic education (that is, primary, junior secondary or middle school education but had not necessarily completed); 29 percent have had senior secondary education and 2 percent have had post secondary education.

The educational background of respondents reveals that most of them were fairly educated and were likely to be conversant with the issues investigated. This is because respondents with no formal education are more likely to frown upon open discussions on sex, as they probably believe it is immoral to talk about it in public.

Occupation

The next socio – demographic variable investigated was the occupation of respondents. It is argued that sexual promiscuity, which is a necessary but not sufficient factor for HIV/AIDS infection, is often caused by economic problems. As one Moslem respondent put it: "The majority of the cases (promiscuity) can be attributed to hardship or poverty, because some of the girls do not get parental support and therefore in their times of need, they feel it is right to get 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." Women, especially, engage in sex trade as a means of economic survival. As in one of the focus group

discussions with seamstresses, a discussant stated two poverty-related sources for indulging in sexual activities:

> *"For some of us, sexual activity occurs when we drop out of 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 and what their 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 women with HIV virus.

Men on the other hand, who are gainfully employed and are economically capable, engage in entertainment activities that have implications for sexual relationships (i.e. night clubs, night beach entertainment etc). For example, truck drivers are known to be important conduits for the spread of HIV/AIDS in Nairobi, Kenya (Nzyuko et al, 1991; Anarfi, 1995). It follows that the level and type of occupation of people become significant in their likelihood to engage in sex and

exposure to HIV/AIDS. It is based on this that the occupation of respondents is explored.

Table 6: Occupation of Respondents

OCCUPATION	FREQUENCY	PERCENTAGE
Petty trader	80	33.3
Shop attendant	35	14.6
Hair dressing	30	12.5
Dressmaker (Apprentice)	29	12.1
Mechanic (Apprentice)	29	12.1
Construction work	20	8.3
Barber	7	2.9
Driver's mate	5	2.1
No job	5	2.1
Total	240	100.0

The data indicate that one third of the respondents (33.3 percent) were petty traders. The petty traders deal in items ranging from food to dog chains and sell their wares by the roadside. It is believed that these groups of respondents do not earn enough profit. During the night they may be too tired to stay awake and take part in any educational campaign. Some may also not have access to television or radio to enable them watch or listen to any of the HIV educational programmes. Likewise, those under apprenticeship quite often get home late and tired

and may therefore not be in a position to watch television or listen to the radio where most of the HIV/AIDS educational campaigns go on.

Religion

Another socio – demographic variable of importance to this study is religion. The African is inclined to religion, and relates it to every aspect of social life. This has been underscored by a number of scholars such as Mbiti (1976) and Assimeng (1981) who argue that the African is notoriously religious and religious activities permeate the activities of every African. Clarke (1930: 431) reinforces this view.

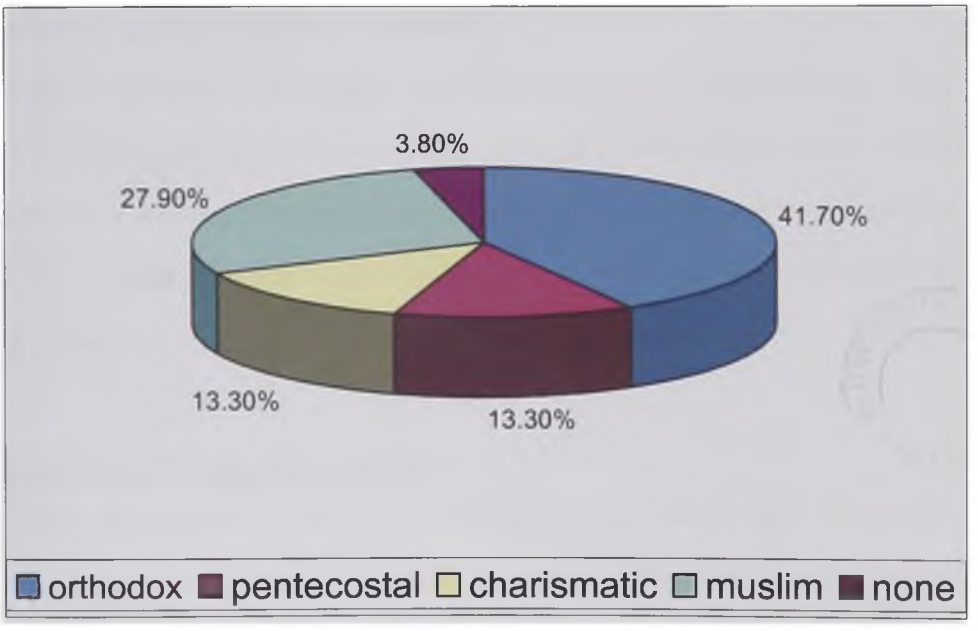
> "In Africa, religious dogma and practice lie at the very core of all aspects of culture and no study of the family, law, economics, demographic... systems of education could be adequate that did not start with an account of native belief in religion".

In the Ghanaian society, a person lives in a social collectivity in which religion plays a defining role in terms of interpretation of the person's place in the universe. It is undeniable that religious values constitute the modes of thoughts, behaviour, and attitude towards events and activities. Hence, the desire to or not to indulge in unprotected sexual behaviour in Ghana may be influenced by one's religious beliefs and practices. Christians, for example, are known to consider premarital sex as sinful, and reject it on strict religious grounds and so do Muslims. It is against this background that the study investigates the religious affiliation of respondents.

An examination of the religious affiliation of respondents indicates that 68.3 percent of them were Christians, and 27.9 percent are Muslims; 3.8 percent did not claim any religious affiliation.

In further analysing the religious affiliation of respondents, it was found that 27.9 percent were Muslims and 68.3 percent were Christians who were categorised into Orthodox, Pentecostal and Charismatic.

Figure 5: Religious Denomination of Respondents



It is conjectured that the Pentecostals and the Charismatic are stricter with the enforcement of their dogma whilst, the Orthodox churches (Methodist, Presbyterian, Anglican etc) were softer with enforcement of their dogma. However, all Christians accede to God's commandment

against pre and extramarital sexual relations "Thou shall not Commit Adultery" and "Thou Shall Not Covet Thy Neighbour's Wife". (Exodus 20 verses 14 and 17) The injunction then is to keep coition within the framework of marriage.

Islamic doctrine is also against both premarital and extramarital sexual behaviour. The Islamic doctrine say's "Only your wives are lawfully to sex" (Johnson et al, 1988). In more subtle fashion, adultery also disturbs relationships, and religions are concerned that the family as a unit should be prevented from disintegration.

In sum, the socio – demographic characteristics of the respondents reveal that we are dealing with people, the majority of whom have some formal education and are religious and also are within sexually active age group. It is against this background that we now examine respondents' knowledge of and attitude towards HIV\AIDS pandemic.

Level of awareness of AIDS

Public awareness of AIDS is an important prerequisite for behavioural change. Levels of awareness provide a measure of both the impact of past information campaigns carried out by governments, non-governmental organisations, the mass media, and of the magnitude of the challenges lying ahead.

Awareness of AIDS, in this study, is based on the number of respondents who replied positively to the question "Have you ever heard of an illness

called AIDS?" and those who spontaneously mentioned AIDS when asked whether they had heard about diseases that could be transmitted through sexual activity. The level of awareness was generally high in the study area. As the data reveal, almost all the respondents (99.6 percent) have heard of AIDS. This is in conformity with the national HIV/AIDS awareness figure, which stands at 99 percent as at the year 2000 (MOH, 2001). This is to be expected especially because the study area has been exposed to several HIV/AIDS interventions. This is also in line with findings in other parts of the world (UNAIDS 2000).

In assessing the knowledge level of respondents on HIV/AIDS, series of questions were asked. To begin with, respondents were to state how they would know if someone has HIV\AIDS. The Table below shows the distribution of the various responses

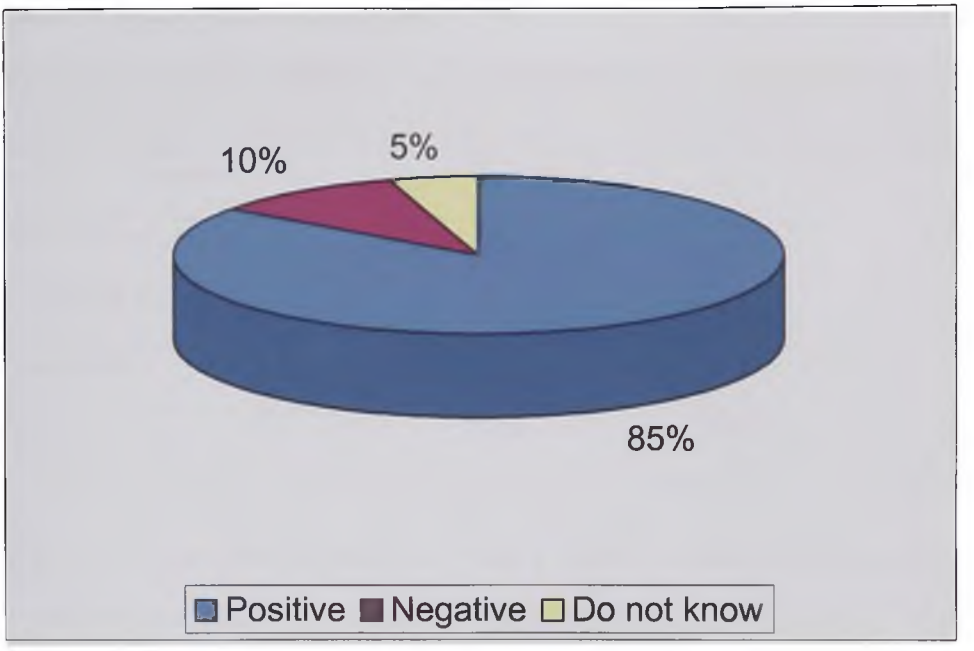
Table 7: Mode of Identification of HIV/AIDS Infected Person

MODES	FREQUENCY	PERCENTAGE
By appearance	73	30.4
Self disclosure	43	17.9
AIDS test	13	5.4
Can not tell	111	46.3
Total	240	100.0

The data gathered indicate that for 30.4 percent of respondents, identification is by the appearance of the person. In probing this response, respondents gave their indicators as leanness and frequent sickness as signs of a person who has AIDS. On the other hand, 17.9 percent of the respondents indicated that, only an infected person could tell them. However, 5.4 percent stated that this could only be done in the hospital. Finally, 46.3 percent of the respondents stated that they by themselves could not tell if someone has AIDS. In the focus group discussions, participants were unanimous that the educational campaigns on television mostly showed pictures of tiny sickly-looking persons as those diagnosed as HIV positive. For this reason, they think or feel that anybody who has AIDS should look sick just like what they see on the television. Thus the HIV/AIDS educational campaign is misleading people to think that it is only sick people and often slim/skinny people who have the virus.

It is also inferred from the Table that, only 23.3 percent were able to state more accurately how an HIV infected person could be identified. These were those who indicated that HIV test and self-disclosure were their modes of identifying sero-positives. It is therefore concluded that a large majority of respondents still have misconceptions about the disease.

Figure 6: Possibility of a Healthy Looking Person's Sero-Positivity



When respondents were asked whether it was possible for a healthy looking person to be HIV\AIDS positive, the data indicate that as many as 85 percent of respondents answered in the affirmative, and 10 percent of them answered in the negative. A few of them (5 percent) said they did not know whether healthy looking person could be carrying the virus.

HIV/AIDS is not an airborne infectious disease. By far, the mode of transmission of the virus as identified by scientific studies is by conscious human activities. Any attempt to deal with the menace should therefore ensure that the citizenry is aware of the causes of infection so

as to evolve ways of preventing infection. The table below shows respondents knowledge on the mode of transmission of HIV/AIDS.

Table 8: Mode of Transmission

MODE OF TRANSMISSION	FREQUENCY	PERCENTAGE
Sexual intercourse	155	64.6
Blood transfusion	80	33.3
Untreated sharp instrument	2	0.8
Cannot tell	3	1.3
Total	240	100.0

At a glance, the data presented in Table 7 show respondents' perception of the various modes by which HIV\AIDS spread. The majority of the respondents (64.6 percent) identified sexual intercourse as the main mode of transmission of the disease; one-third of them (33.3 percent) identified blood transfusion as the mode of transmission while only 2 respondents identified the use of untreated sharp instruments. Only 3 respondents did not indicate any mode of transmission. The data as presented implies that respondents tended to place much emphasis on sexual transmission to the detriment of other modes such as mother-to-child transmission (M.T.C) this may be as a result of inadequacies in the HIV/AIDS educational campaigns. Another reason may be that

respondents were only stating the modes by which they thought they could be infected by HIV.

There is a dictum that says that prevention is better than cure. The incurable nature of HIV/AIDS makes prevention the most important means of controlling the menace. Most international and national organisations/institutions involved in the fight against the disease recommend prevention as a principal means of dealing with HIV/AIDS. Principal among the organisations are Ghana AIDS Commission etc. It is in the light of the above that the study sought to identify the prevention modalities known to respondents. Thus, respondents were asked to state the means by which the disease can be prevented. The Table below shows the distribution of responses.

Table 9: Modes of Prevention of HIV/AIDS

MODES	FREQUENCY	PERCENTAGE
Condom	102	46.6
Abstinence	87	39.7
Avoid sharp instrument	15	6.9
Single sexual partner	10	4.6
Avoidance of untreated blood	5	2.2
Total	219	100.0

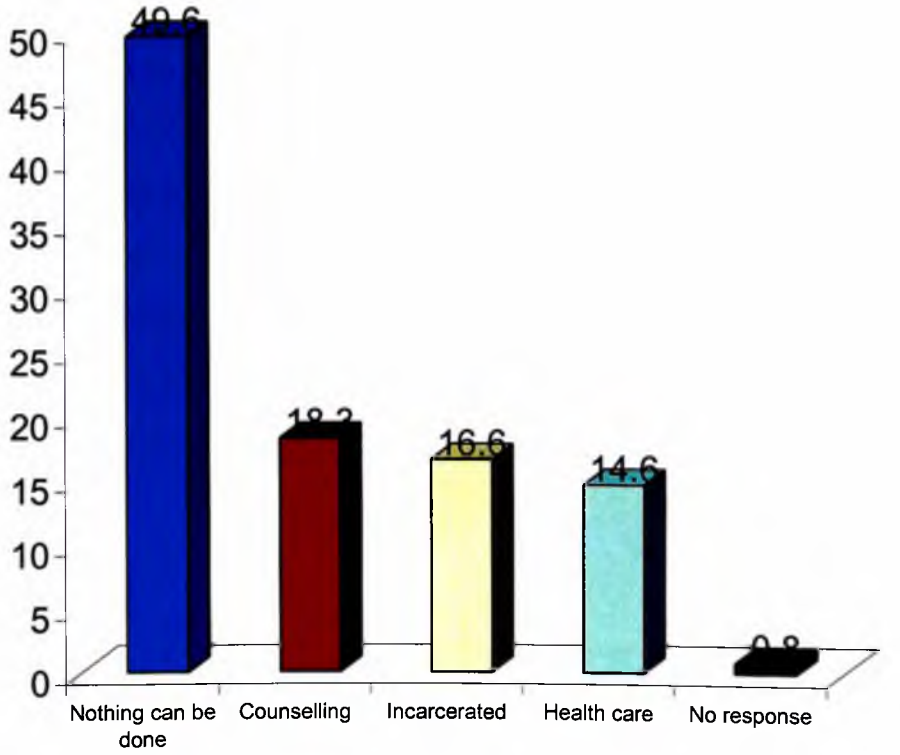
The data indicate that almost all of respondents (100 percent) were of the belief that the disease could be prevented. On the preventive mechanisms, those that relate to sexual intercourse were prominent. These were the use of condoms and abstinence both recording a total of 86.3 percent of the responses. On the type of prevention, about 46.6 percent identified the condom as a means of preventing the virus. The popularity of condom can be attributed to the intensive campaign mounted on its use as a preventive measure for the control of the dreadful disease, HIV\AIDS. As part of the campaign on the prevention of HIV\AIDS, a commentator in a Ghanaian weekly newspaper, *the Spectator,* of April 1996, described a man who carries with him a condom wherever he goes as "the best gentleman". The aggressive sensitisation of the Ghanaian public on the need to use condom for casual sex accounts for high knowledge of condom among the respondents. Indeed, a female

respondent indicated that an advertisement on condoms that says *"if it's not on it's not in"* interests her so much that she has adopted it as a condition for sexual intercourse with her partner. On the other hand, 39.7 percent of respondents indicated abstinence as a means of prevention. In a focus group discussion, female discussants who were mainly apprentice, were of the opinion that *"abstaining from sex was not just because of HIV/AIDS but because they were learning a trade and would not want to be pregnant"*. Their male counterparts on the other hand, were of the view that they were *"not ready to take care of a family and would want to finish their courses before indulging in sex"*. Others also abstained because of their religious belief in purity before marriage and not because of AIDS. Another 6.9 percent indicated they avoid used sharp instruments as a means of prevention, whilst 4.6 percent indicated keeping only one sexual partner as a means of prevention. Only 2.2 percent indicated avoidance of untreated blood as a means of prevention. The low response rate on avoidance of untreated blood transfusion as a means of precaution can be attributed to two factors. First, blood transfusion is a medical way of healing the sick in hospitals and is done under scientific conditions with all the necessary precautions to avoid infection. It is therefore unthinkable, especially amongst the lowly educated population that it can be a serious source of transmitting HIV/AID. Secondly, in most HIV/AIDS prevention campaigns, very little prominence is given to the factor as a serious means of transmission.

This may be attributed to the scientific nature of the mechanism as explained above.

The danger posed by HIV/AIDS to mankind is that it has no known cure. As a result, any campaign that is not able to make this clear to people is bound to fail in eliciting the right response. It is based on the above that respondents' views on treatment options available to sero-positives are analysed.

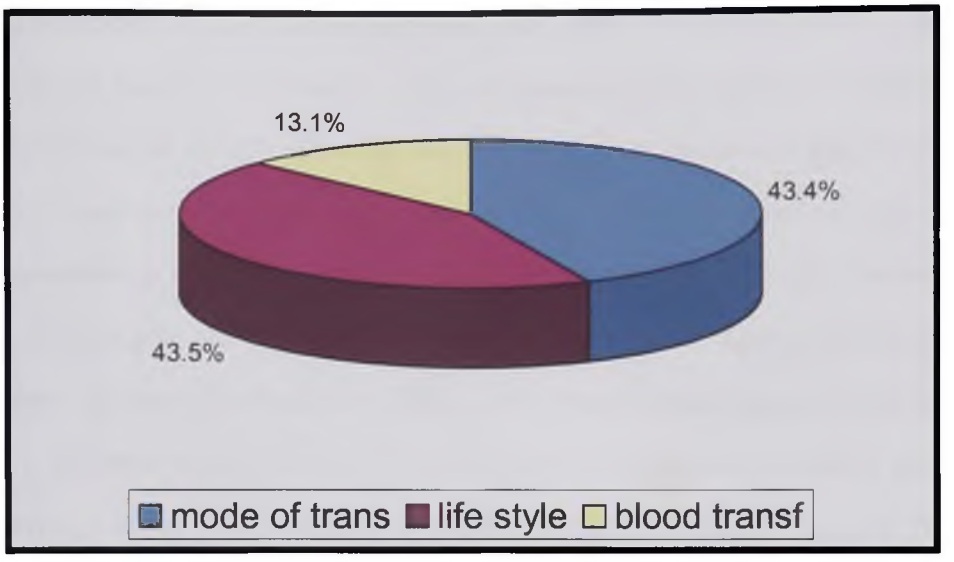
Figure 7: Treatment Options Available



In the opinion of 49.6 percent of respondents, nothing could be done; that is to say, the person will die eventually from the disease. Another 18.3 percent indicated that such a person would have to be counselled and advised in order not to spread the disease to other people. Further, 16.6 percent indicated that such a person should be incarcerated (quarantined) in order not to infect other people; and 14.6 percent advocated health care for such persons because appropriate health care was crucial for the survival of infected persons.

Having ascertained respondents' knowledge on the modes of transmission and treatment options available, the researcher additionally investigated respondents' perceived chances of contracting AIDS. In response to this, 41.4 percent perceived themselves at risk. In contrast, 59 percent did not deem themselves at risk of contracting the virus. Further probing to determine why the 41.4 percent perceived themselves at risk, Figure 8 below was generated.

Figure 8: Respondents Who Stand At Risk

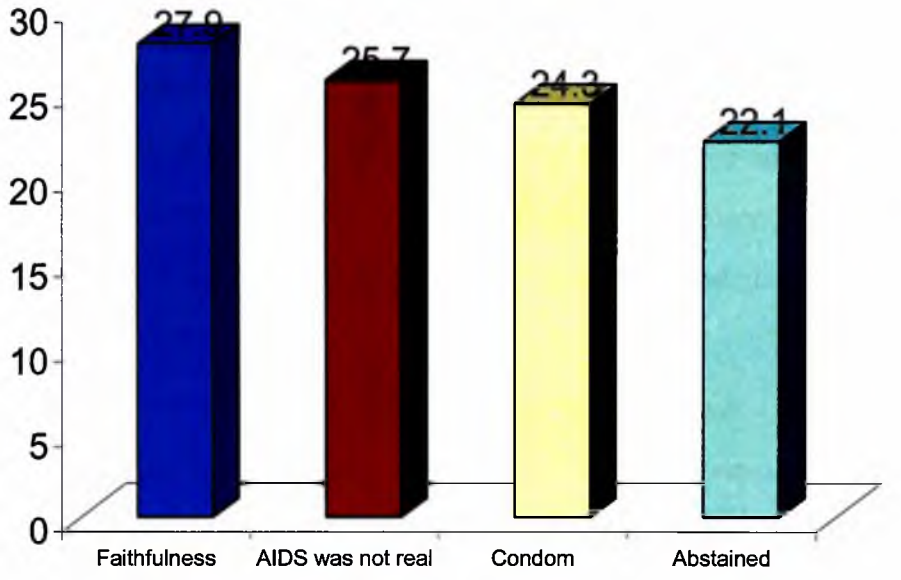


Of those who thought they were at risk, 43.4 percent said that the various modes of transmission meant that one could easily contract the disease. On the other hand, another 43.5 percent alluded to their partners' lifestyle as placing them at risk. In a focus group discussion, female participants said that although being faithful was very important, the fact remained that their sexual partners may not necessarily be faithful. As one female discussant put it *"It is good to be faithful but how can one be sure that his or her partner was also faithful? You cannot be with him all the time"*

Other participants were of the view that one cannot tell for certain that all salons sterilise their sharp instruments properly and this could be disastrous to ones health. Others were also of the opinion that the condom was not hundred percent safe because it could burst. Moreover there was no specific time for sex. As one male discussant put it *"The urge may come at the time one does not have a condom. One will thus be compelled to have sex without it."* Others however reported that condom does not give the expected satisfaction. The other significant reason given by some discussants was that they had multiple sexual partners. On the other hand, 13.1 percent said they could contract the AIDS virus through blood transfusion, over which they have little or no control. The data suggests that even though respondents have realised that they were at risk, they were at the labelling stage of the model used in the conceptual framework, and have not changed their attitude.

Turning to the respondents who do not see themselves at risk, the reasons given are presented in Figure 9 below.

Figure 9: Respondents Who Stand No Risk



It is observed from figure 8 that as many as 27.9 percent of the respondents emphasised faithfulness. They were faithful to their partners and so there was no cause for alarm. One-quarter of them (25.7 percent) said they did not believe AIDS was real. Logically, then, they could not be infected with a disease that did not exist. Another 24.3 percent of them indicated that they used condom anytime they had sex, whilst 22.1 percent said they abstained from sex.

A critical analysis of the situation as presented above raises a few concerns. The very first observation is the risk posed to the group which doubt the existence of the disease. Since this group does not believe in the existence of the disease, they are unlikely to adopt any of the

measures deemed appropriate to prevent the spread of the disease. Analytically, therefore, this group of respondents has not even begun the process of attitude change.

The second observation concerns those who claim to be faithful. Even though faithfulness is seen as a means of preventing the spread of the disease, it is only effective when practised by both partners. Therefore, faithfulness really has significance for both married couples and unmarried people.

This group is at the second stage of the conceptual model (process of attitude change) but the action they have taken is not adequate to take them out of risk. Following from the above, only those who abstained have the right attitude towards the prevention of HIV/AIDS. Evidently, the perception of a majority of respondents exposes them to certain level of vulnerability. Putting the two together, the majority of respondents are either at the first stage of the model in the conceptual framework or have not began the process at all.

Studies in Africa and Asia suggest that currently married people have fewer sexual partners and therefore lower risk of contracting HIV than unmarried people (Dyson, 1992; Cleland et al, 1992). In order to find the influence of marital status on respondents' perceived risk, the following table was generated.

Table 10: Marital status by risk of contracting the AIDS virus

Marital Status	Risk of contracting the AIDS virus		
	Yes	**No**	**Total**
Married	14 46.7%	16 53.3%	30 100%
Single	84 41%	121 59%	205 100%
Separated	1 25%	3 75%	4 100%
Total	99 41.4%	140 58.6%	239 100%

The Table 10 above suggests that respondents share similar views about the risk of contracting the AIDS virus. Less than 50 percent of the respondents perceived themselves as being at risk of contracting the AIDS virus. It is significant to note that the majority of respondents who are not currently married did not think they stand any risk of contracting the AIDS virus. Obviously, if one does not think that he/she is at risk, there would be little or no motivation to change one's attitude. Thus the knowledge acquired would not be put to good use. Attitudinal change would, therefore, not occur.

There have been several educational campaigns over the last years using radio, television, billboards among others to create awareness of the risk of HIV/AIDS in Ghana. The most popular has been the one dubbed "Stop AIDS Love Life" by John Hopkins University (JHU), Ghana Social Marketing Foundation (GSMF) and Ministry of Communication (MOC) which has been carried out since February 2000. Refer to pages 49 and 56. To find out how effective the campaign has been, respondents were asked whether or not they had any knowledge of any campaign on AIDS and whether they understood the message. The responses given indicate that 86.3 percent were aware of some HIV/AIDS campaigns, as against 13.8 percent who were unaware of any of the campaigns. In the focus group discussions, almost all the discussants indicated they understood the educational campaigns on HIV/AIDS.

Sources of information

The next issue investigated was the major sources of information available to the respondents. Mass media (Radio, television, and newspaper), friends, and health officers were identified as the sources of information. More specifically, the data indicate that 77.5 percent of the respondents had their knowledge on HIV\AIDS through the mass media. Radio is by far the most often cited source of knowledge about AIDS. The influence of the mass media is not unexpected, because in Ghana, the use of the mass media as a means of disseminating information on

HIV\AIDS to the public is enormous. This is evidenced by the numerous daily advertisements carried by the print and electronic media. The influence of the mass media in the HIV campaign in Ghana has been boosted by the proliferation of FM stations following the liberalisation of the airwaves in the 1990s.

Apart from the mass media, friends and peers proved to be one of the most important sources of AIDS information in the country. At least 15 percent of the respondents heard of AIDS from friends and peers. Also in almost all the focus group discussion held, participants indicated that they heard of HIV/AIDS from friends. Participants were probed further to find out what happened to them when they first heard of AIDS. Almost all of them side they did not understand it and did not see the importance of it, but just saw it as any disease.

However, a few (1.3 percent) respondents mentioned other sources of information; clinics and health workers. However, 6.3 percent could not identify any source of knowledge on HIV\AIDS. The low response on information from health workers can be attributed to the fact that most of our respondents, who are unmarried and very youthful, do not have regular visits to the health institutions to be acquainted with the educational campaigns carried by the health workers. They may therefore seek clarifications from persons they deem knowledgeable. In a

situation where experts do not do this, a room is created for the perpetuation of several misconceptions.

Attitudes of Respondents

Current prevalence rate of the disease in Ghana is estimated at 3.6 percent, which means that about 200 people get infected everyday. It is projected that if this trend continues, by the year 2004 the prevalence rate will be 6.5 percent and 9.5 percent by 2014 if adequate measures are not taken to curb the spread of the disease (MOH 2000). While public awareness of AIDS is a necessary condition for behavioural change, actual change depends to a greater extent on the accuracy of information on the disease including the modes of contracting and preventing AIDS. It is believed that people's attitudes are influenced to a large extent by their beliefs, which in turn are influenced by the availability of accurate or inaccurate information.

To find out whether respondents' attitudes had been influenced positively by the information they had received, a series of questions were asked to ascertain their degree of belief in the information targeted at the public.

When asked if they believed that about 200 people were being infected with the disease daily, majority of respondents (54.6%) were of the opinion that the estimate could be a true reflection of the situation. However, the remaining (45.4%) viewed the estimate as unrealistic.

In assigning reasons for the responses 29.1 percent of respondents saw no reason why authorities would concoct any figure just to deceive people. As a male discussant put it, *"What will the medical officers achieve in fabricating such a figure"?* Supporting this view, 2.1 percent indicated that there has not been any change in the sexual life of people. On the other hand, 47.7 percent did not believe the estimate because they thought it was unrealistic. As remarked by one respondent, *" If 200 people get infected everyday the whole population of Ghana would have been infected by now."* Finally, 21.1 percent did not believe the figure because to them, the educational campaign on AIDS was going on well and therefore were of the view that more people had changed their sexual attitude.

According to the experts, however, the 200-persons per day estimate is rather conservative. They argue that the situation is, therefore, more grave than presented by the 200- victims-a-day estimate. Viewing this against the backdrop that almost half (47.7 percent) of respondents do not think the situation is that serious, raises some concern.

The significant issue here is that once the reality is distorted by whatever reason, the required response would not be forthcoming. Thus one should not expect any appreciable change in the attitude of respondents as a result of their inaccurate assessment of the gravity of the HIV/AIDS menace.

An analysis of respondents' attitudes towards those infected with the disease reveals that, most of them (81.9 percent) were willing to care for an AIDS infected relative. On the other hand, 18.1 percent were not willing to take care of an AIDS infected relative.

Among those willing to take care of an AIDS infected relative, 29.1 percent were willing to do so because they believed they would not be infected with the disease. Another 39.5 percent indicated that they would offer care because the infected person is a relative who needed care and who should not be abandoned just because he/she was an AIDS patient. This is an indication of strong social ties that may defy any health concerns. The importance of social obligation has been underscored by Danquah (1952:5-8) when he noted that:

> "Obligation is not imposed by any written law other than that which is more inexorable, namely, moral obligation. This means a binding force of what is right, of what ought to be done, whether we like it or not...The Akans have however a great sense of social duty and their attachment to the family is astonishingly strong."

Also, 30.8 percent stated they would care for a relative with AIDS because it is not in all cases that the infected person gets infected through promiscuous life. This is an indication that at least some respondents understand the campaign to reach out to HIV/AIDS infected persons with love and care.

Among the 18.1 percent not willing to care for an AIDS relative, 51.2 percent of them feared being infected with the disease. This position was summed up by a considerably educated male discussant thus: *"They are always telling us new revelations about the disease and it seems they are playing shifting poles with us. Why would I risk taking care of an infected person only for them (the experts) to tell us one day that touching an AIDS infected person would make you get infected?"* However, 37.2 percent were not willing to do so because they did not have time to care for such a person, whilst 11.6 percent were not willing because caring for the AIDS infected person is perceived as a difficult task. This suggests that the educational campaign on AIDS has not gone down well with most of the people of Ghana. Though the percentage of those unwilling to care for AIDS victims constitute just a small section of the respondents (i.e. 18.1 percent), it is still significant to note that in spite of the numerous HIV/AIDS educational campaigns, some people are lagging behind in the education on care and love for HIV/AIDS patients.

Among those who have heard of the disease, almost all (99.6 percent) were aware that AIDS is fatal. However, it is only a minority who did not hold that belief. This group thinks that AIDS is never or only sometimes fatal.

Condom is probably accepted as the middle point between two extremes namely absolute abstinence from sex and uncontrolled sex. According to medical experts, even though the condom is not a full-proof protection against contracting the HIV virus, it represents a protection for those who may wish to enjoy sex without contracting AIDS.

Historically, condom was developed as a family planning method but was later discovered as a means of preventing STIs. When the HIV menace began, condom was then seen as the only means by which those who could not put an end to promiscuity could save themselves from falling prey to the HIV epidemic. Regular use of condom is obviously an attitude, which is in itself a result of perception. To find out respondents' attitude towards the use of condom, series of questions were posed. Among the questions asked were; do you know condom? Would you buy a condom? Would you use a condom each time you have sex? How often do you use condoms? The responses are presented in Table 8 below.

Table 11: Attitude of Respondents to the Use of Condom

Question	Yes	No	Row Total
Do you know about condom?	96.2% 231	3.8% 9	100.0% 240
Do you know where to buy condom?	93.7% 225	6.3% 15	100.0% 240
Would you buy a condom for yourself?	45% 108	55% 132	100.0% 240
Did you use condom the last time you had sex?	39.2% 94	40% 96	79.2% 190
Would you use condom each time you have sex?	43.3% 104	47.1% 113	90.1% 217

On the question whether one would use condom each time they had sex, 104 respondents (43.3 percent) answered in the affirmative while 113 respondents (47.1 percent) answered in the negative. This indicates that in spite of the pronounced education on condom use as a means of preventing HIV/AIDS, most people do not adhere to the campaign. This may be attributed to the attitude of most people to condom use *"that its messy nature does not enable users to derive the maximum sexual feeling when used"* (Kenyah, 1999:98-99.) Thus, the use of condoms culturally, creates some conflict about sexual intercourse as men and women have

certain expectations to meet during sex. However, the high percentage of people who use condom during sexual intercourse (43.3%) from the study area is commendable as it is higher than the national average of 38.9 percent (MOH, 1996).

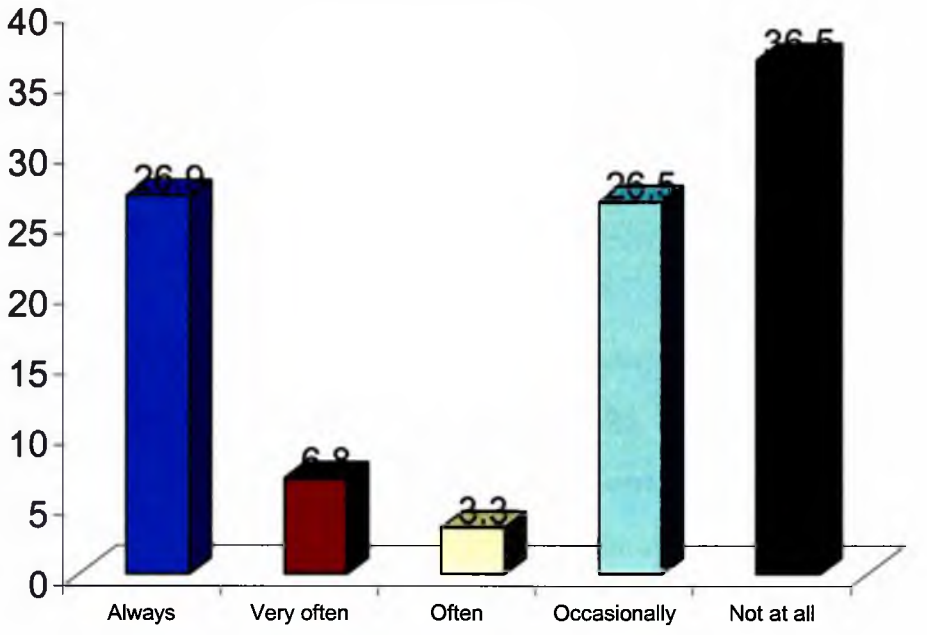
All those who answered negatively to any of the above questions can be said to have an inappropriate attitude as far as AIDS prevention is concerned. In relation to our conceptual framework, this group of respondents falls within the first stage of the model (labelling) where the individual has not perceived vulnerability to this particular health problem and so have not changed his/her attitude. Many of the respondents (43.3 percent) can be said to have perceived their sexual behaviour as placing them at risk of contracting the AIDS virus. As such, they have taken action to change their sexual behaviour by using condoms each time they had sex. This group of respondents falls within the second stage of the model (commitment).

From the information in the Table the vast majority of the respondents, (96.2 percent) know about condom; 93.7 percent know where to purchase condoms; 45 percent were willing to buy condoms and 39.2 percent used condom the last time they had sex. In their study on knowledge, attitude and practices relating to AIDS among the youth in Ghana, McCombie and Anarfi (1992) found among their respondents, that only 13 percent reported using condom at their recent sexual

intercourse. It therefore appears that there has been an improvement in the use of condoms (39.2 percent).

An interesting observation from the data is that, with regard to actual use of condom, the percentage was the lowest amongst all the responses given (i.e. 39.2 percent for those who used condom the last time they had sex). The interpretation given to this situation is that, in theory, respondents are well informed but only a few of them are willing to put this information into practice. It can therefore be concluded that knowledge or information alone is not enough to bring about changes in the attitudes of the respondents. What then is the real attitude of respondent's towards the use of condom?

Figure 10: How Often Respondents Use Condom



Thirty six point five percent, who stated 'not at all' in the figure above represents those who claim they have never had sex, are abstaining from sex as well as those who do not use condoms because they are married. Analytically, apart from those who claim to use condoms always (26.9 percent), the rest (66.7 percent) who use condom very often (6.8 percent); often (3.3 percent); occasionally (26.5 percent) and not at all (36.5 percent) could be at risk of contracting the disease. This is because according to the information available, it takes but one sexual intercourse for a person to contract the disease. Therefore, inconsistency in the use of condom is as dangerous as not using it at all.

Among the reasons assigned for the infrequent use of condoms were that condoms were mainly used for casual sex, to prevent pregnancy or were absolutely disliked because it did not give the expected sexual excitement. This is consistent with the findings of McCombie and Anarfi (1992), where condoms were used to prevent pregnancy more than to prevent AIDS.

From the analysis of the responses above, one can say that, those who simply dislike the use of condom, are faithful, think condoms are expensive or think there are bad chemicals in condoms do not have the required attitude towards the prevention of AIDS. Surprisingly only 26.9 percent of the respondents have adopted the right attitude towards the use of condom to prevent the spread of the disease (AIDS); they claim they always use condom.

To ascertain the impact of age on condom use, the age group of respondents was analysed alongside their attitude towards the condom. The table below represents the correlation between age and condom usage.

Table 12: Correlation between Age Groups and Frequency of Condom Usage

Bivariate Correlation	**Questions**	**Frequency of condom usage**	**Age Groups of Respondents**
Pearson correlation	Freq. of condom use Age Groups	1.000 **0.058**	**0.058** 1.000
Siq. (2-tailed)	Freq. Of condom use Age Groups	0.392	0.392
N	Freq. Of condom use Age Groups	240 240	240 240

According to Table 12, the bivariate correlation analysis did not register any significance between the age groups and the frequency of condom usage. The relationship between age and frequency of condom use though weak is positive. The implication is that a slight increase (5 percent) in age would result in a corresponding increase in condom use. Thus, as one moves from age 15 to 20 there is a slight increase of (5 percent) in the usage of condom. It can be said that age group is not a determinant of condom use.

It has been found that there is a relationship between level of education and sexual behaviour and risk of HIV infection. As argued, education has a modest effect on health knowledge, which involves avoidance of risky sexual behaviour and thus reduces sexually transmitted infection. It has also been found that condom use among people with formal education was higher than with no formal education (Cleland, 1992).

However, other evidence suggests that the higher the level of education the higher the risk of HIV infection (Barnett and Blaikie 1992). To find out the impact of education on respondents the following correlation was generated.

Table 13: Correlation Between Educational level and frequency of condom usage.

Bivariate	**Questions asked**	**Frequency of condom usage**	**Educational level of Respondents**
Pearson correlation	Freq. Of condom usage Educational level	1.000 **-0.043**	**-0.043** 1.000
Significant (2-tailed)	Freq. Of condom usage Educational level	 0.528	0.528
N	Freq. Of condom usage Educational level	240 240	240 240

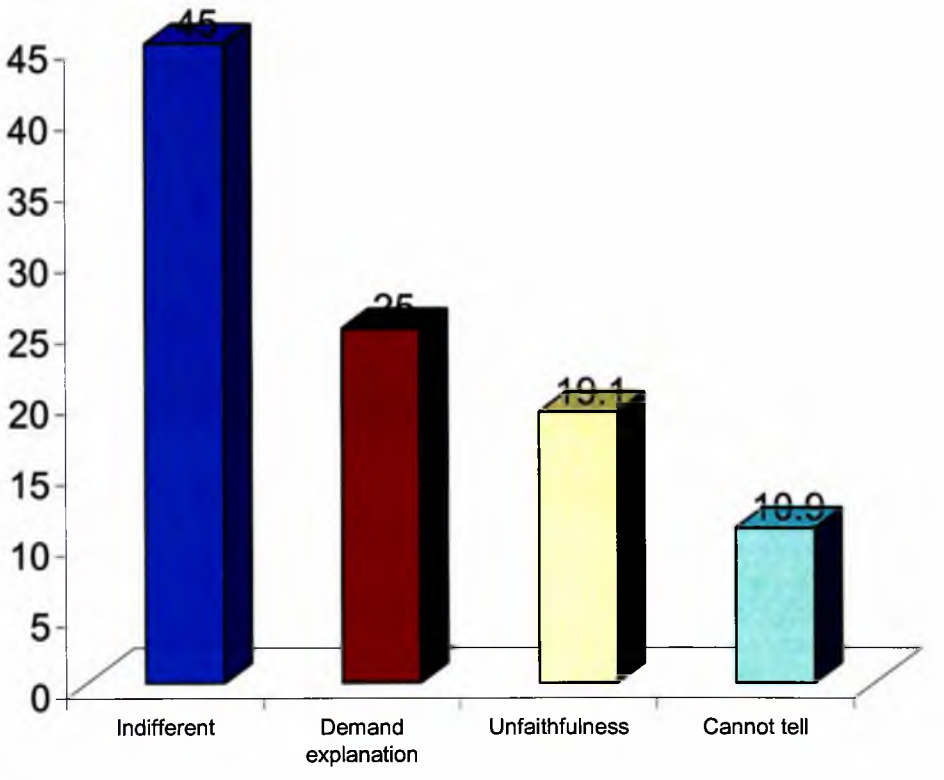
The above Table indicates that no significant difference was recorded between educational level and frequency of condom usage when the data was subjected to bivariate correlation analysis. The relationship is weak (4%) and negative. The implication is that as one's educational level increases, the usage of condom reduces by negative 4 percent. It is conjectured that people with no formal education tend to guard well with what they believe in. For example, in some part of Africa, there is the belief that having sex with a virgin or an extremely old woman can cure an infected person (*Ghanaian Times of June 2001).* Some also associate the disease with foreign travel. Also in Nigeria, a prostitute was reported to have said that although white clients generally pay better than their black counterparts, she will never go to bed with a white man unless he wears a condom. With such a belief it would be very difficult to disabuse people's minds about HIV/AIDS.

On the other hand, educated people tend to be more adventurous and would want to verify whatever information given them before accepting them. These findings are not in conformity with findings from the Demographic and Health Survey (GSS 1998; Cleland 1992).

It is conjectured that a person's attitude to any phenomenon is not influenced by his/her opinion or reaction to the phenomenon in question only but also by his/her reaction to other people's opinions and perceptions on the phenomenon. To better determine the attitude of

respondents towards condom, they were to indicate what their reaction would be should they find their sexual partners having condoms. These responses are graphically presented below.

Figure 11: Reaction to Partner Having Condom



Data show that, 45 percent claimed they would be indifferent. These respondents are those who use condoms with their partners. Hence, they are comfortable with their partners keeping condoms. As one female respondent observed; "*He keeps his stock of condoms and I keep mine so*

I'd rather be surprised if he has none on him at any given time." It is also observed that, 25 percent said they would not be happy and would demand an explanation from their partner; 19.1 percent responded that they would not trust their partners anymore if they found condoms with them. To them it suggests that the partner is having a sexual affair with someone else. However, 10.9 percent said they could not tell what their reaction would be.

Respondents were to indicate whether in their estimation, there has been a shift in their sexual behaviour as a result of AIDS campaigns. The Table below is a representation of responses generated.

Table 14: Change in Sexual Behaviour of Respondents

Change In Sexual Behaviour	Frequency	Percentage
Faithfulness	97	40.3
Abstinence	32	13.4
Condom use	33	13.8
Reduction in sexual activities	10	4.2
No response	68	28.3
TOTAL	240	100.0

From the data presented above, it is observed that 28.3 percent of respondents did not give any response. This implies that respondents have not changed their sexual behaviour. Of the remaining, faithfulness to partner was the most frequently (40.3 percent) cited behavioural

change, whilst 13.8 percent cited abstinence and 13.4 percent also cited the use of condom. Only 4.2 percent indicted that they have restricted sexual activity to one partner. Faithfulness seems to be the dominant behavioural change. However, focus group discussants were unanimous in their views that faithful does not mean that one does not use condom. Thus respondents could be faithful but at the same time be using condom. That is to say, change in sexual activity is not unidirectional but could be a combination of several activities. Participants in the focus group discussion made an interesting statement that when they first heard of HIV/AIDS, because they did not understand the intensity of it, it did not influence them to change their sexual behaviour. But for them, now the message seems clear and their behaviour is gradually changing. To ascertain the relationship between sex and behavioural change, the sex of respondents was cross-tabulated as presented below

Table 15: Has your knowledge about AIDS changed your sexual behaviour by sex.

Has your knowledge about AIDS changed your sexual behaviour	Sex		Total
	Male	Female	
Yes	99 56.9%	75 43.1%	174 100%
No	20 32.8%	41 67.2%	61 100%
Total	119 50.6%	116 49.4%	235 100%

The Table above indicates that more men than women have changed their behaviour. A large majority of men (56.9 percent) reported they had changed their sexual behaviour to avoid AIDS. In contrast, 43.1 percent of female respondents made a behavioural change. Overall, the range was wider for male respondents. This discrepancy could possibly reflect the fact that larger proportions of males than females were engaged in risky behaviour. It could also be a reflection that women are dependent and weak sex negotiators. This position makes them unable to protect themselves from HIV. This is consistent with findings of the Demographic and Health Survey (GSS, 1998) and of Casely-Hayford and UNESCO 2001).

Experts on HIV/AIDS talk about behaviours such as sticking to one and regular sexual partner, regular use of condom, patronage of injections in main stream health institutions, caring and living with an AIDS patient as very low risk factors in contracting the disease. On the other hand, sharing needle with an HIV positive person, multiple sexual partners and irregular use of condom place an individual at the top-most risk of contracting the disease.

To find out whether respondents were well informed of the risk that is involved with some activities, respondents were to categorise the risk levels on a scale of one (1) to five (5), where (1) is the highest risk. The responses generated are presented in the table below.

Table 16: Perceptions of Youths' Risk level of the Following Activities.

Activity	Frequency	Percentage
Single sex partner and regular use of condom	239	91.6
Single sex partner and irregular use of condom	239	56.5
Multiple partner with regular use of condoms	239	72.8
Multiple partners with irregular use of condoms	239	91.6
Patronage of salons with irregular sterilised equipment	239	90.0
Patronage injections outside main stream health institutions	239	92.5
Caring for an AIDS patient	239	74.8
Living with an AIDS patients	239	67.4
Sharing needles with an HIV positive	239	94.6

It is observed from the result of the analysis that the majority of the respondents are aware of the risks associated with the activities listed above. It is therefore inferred from the table (above) that respondents'

knowledge on HIV/AIDS is quite high because of their ability to determine high and low risk activities. As 91.6 percent of the respondents perceive a 'single sex partner and regular use of condom' as posing a low risk to contracting the HIV AIDS virus. It is also significant to note that 74.8 percent and 67.4 percent of the respondents respectively view 'caring for AIDS patients' and 'living with an AIDS patient' as medium risk. This situation is not peculiar to respondents as Anarfi (1995) and Johnson et al (1988) also reported such a situation among Ghanaians.

On the threat posed by HIV/AIDS, 67.9 percent of respondents observed that the threat of AIDS was largely because of the absence of a cure for the disease.

On the contrary, 32.1 percent of respondents were of the view that AIDS posed no threat to them at all. This is based on the fact that they always protect themselves from contracting any sexually transmitted disease by the regular use of condom. Others felt that being faithful to their partners was enough to insulate them from AIDS.

For 24.6 percent of the respondents, AIDS does not really exist so there is no chance that they would be affected by it, whilst 15.6 percent indicated that because they abstain from sex, the disease cannot threaten them in anyway.

It must be affirmed, however, that the respondents in giving their reasons, concentrated only on sexual transmission of the disease. Given that sex is but only one means, albeit the predominant means of AIDS infection, it stands to reason that the AIDS campaign has tended to be targeted more at sexual behavioural change to the neglect of other modes of transmission. Another important observation is fidelity. People believe that by being faithful to their partners, they are safe from the disease. The truth of the matter, however, is that unless their partners are also faithful to them, they still stand the risk of being infected by the unfaithful partner. However, almost one in four of the respondents (24.69%) still do not believe AIDS is real. This calls for a lot of concern.

Relating the responses to our conceptual framework, these groups of respondents are still at the zero level of the framework. Thus they have not begun the process that will bring them to the point of attitudinal change needed to bring the disease under control. Thus they do not see any risk. Consequently, they do not see any need for changes in their sexual behaviour.

CHAPTER SIX

CONCLUSION AND RECOMMENDATION

CONCLUSION

The study started on the premise that education on HIV/AIDS does not reflect the desired attitudinal change among the youth. Accordingly, the study tasked itself with the search for the reasons why education on HIV/AIDS is not yielding the desired attitudinal or behavioural change. To attain the above, the objective was categorised into various themes. There was an enquiry into the demographic characteristics of the youth, their perception of what constitutes risk behaviour in relation to the disease, their knowledge about it, and their attitude towards the disease. In doing this, emphasis was laid on their major source of information on the disease and the importance they attach to the information given them. Of particular interest to the study was whether the youth understand the education or information on HIV/AIDS, and also whether the information gets to all the youth particularly, the out of school youth.

In search for the above objectives, both primary and secondary sources of data collection were employed. The rationale was to examine a wide array and varied data on the phenomenon under study. Thus, theoretical presentations and other commentaries on the subject matter were

combined with first hand information obtained from a field survey in an attempt to arrive at a concise and coherent study material.

Major Findings

The findings indicate that respondents have some formal education; 55 percent of them have at least basic education and are religious. They are also within the sexually active age group. For example, 41 percent are within age 15-20. The most popular occupation among them were petty trading, shop attendants and hair dressing, among others.

The level of awareness of HIV among respondents is quite high as the majority of them could identify behaviour patterns that are high as well as low risk. Respondents were also able to positively identify the modes of transmission and prevention of the disease. However, most of them could not exactly indicate the means by which an HIV infected person could be identified, as most of them could not tell that self-disclosure and HIV test are the only means of knowing another person's seropositivity.

On the modes of transmission, none of them could mention mother-to-child transmission as one of the means of transmission of HIV. The condom and abstinence was also found as the most popular modes of prevention of HIV/AIDS.

Among respondents who do not see themselves as standing any risk, faithfulness, non existence of AIDS, constant use of condom and abstinence were the widely held views in a descending order.

The study also shows that most respondents acquire their first hand information on HIV from their peers, radio and television. Even though these play a significant role in the attempt at preventing HIV, the electronic media, especially, is unable to provide more explanation because of the absence of feedback. This is where peers step in to provide further information. Thus the role of health workers who are well-versed in matters on HIV have minimal role to play in the dissemination of information.

It has also been observed that the attitudes of respondents have not changed to commensurate their level of awareness of HIV. Only a few (39.2 percent) used condom during their latest sexual intercourse. Also, just 26.9 percent of them profess to use condoms always as against 36.5 percent who do not use condoms at all. The findings also suggest that there is a negative relationship between education and condom use: "the higher one's education the less he/she is week to use condom" this seems to be the practice. However, older people are a little more likely to use condoms. Respondents also have a positive attitude towards those living with HIV/AIDS and are prepared to assist such people.

It is also concluded that respondents are very much aware of what constitutes risky behaviours as far as HIV is concerned. However, there is a laxity in their commitment to change their attitude. Thus, majority of the respondents are in the first stage of the model used, namely, labelling.

On the other hand, some have moved to the second stage of commitment. Unfortunately, some of the measures adopted are not good enough as responded by those who have chosen the path of faithfulness.

To correct the situation, it is suggested that policy makers rethink the notion of just providing information on the risks associated with certain behaviours and expect people to change their attitudes. More needs to be done to motivate people to change their attitudes in this direction,

RECOMMEDATION

The observations made so far pre-empt the need for a further thorough research that will facilitate arriving at clear – cut conclusions. This recommendation is based on some salient observations made during the course of the study. A case in point is the often-made assumption that the youth feel more comfortable with themselves when discussing sexuality issues. However, the outcome in almost all the focus group discussions indicates that whenever somebody who is perceived to be experienced in sexual activities speaks the rest listens attentively. This

particular case reinforces the point that peer education programmes will go a long way in strengthening the conviction of the youth that HIV/AIDS is real and can affect anyone and for that matter there is the need to protect themselves and their future. Training programmes on negotiating skills to insist on condom use should be included as part of the peer education. The selection of the peer educators must, however, be done carefully to win the confidence of the youth. They should also be youth who have had experience of peer pressure, life set-backs as a result of sexual experience and not people who are proud and like to dominate or control. This particular case reinforces the need for additional research on the phenomenon, as data obtained does not lead to the drawing of enough conclusive observations. Such a research should have ample representation of the peer educators. This will help validate whatever claim made.

Secondly, the youth have identified strongly with stories of how people get HIV/AIDS. Many of the questions that the youth have may not be included in most frequently asked questions. These unanswered questions and the list of reasons why the youth do not always use condom can be used as a basis for designing an HIV/AIDS prevention education programmes targeting the youth. A participatory HIV/AIDS educational programme targeting the youth using drama and role-play approach will open opportunity for clarifying these types of issues. It will

also provide opportunity for several practical scenarios of the situation and also motivate the youth to adopt the desired behavioural or attitudinal change.

Thirdly, any HIV/AIDS project that intends to implement a comprehensive programme should include activities on self-esteem, micro-enterprise to mobilise and support the youth with income generation and skills development programmes at all level in order to contribute to the fight against HIV/AIDS.

Finally, it has been observed that several HIV/AIDS control programmes are going on in Ghana. In the Greater Accra Region where this study was conducted, several HIV/AIDS educational programmes are being conducted by different organisations. With this reason, there is duplication of activities and conflicting messages. In view of this, there is the need for the different organisations and institutions involved to network and collaborate with each other in order to pull resources and avoid duplication of activities and conflicting messages.

It is recommended that additional research be conducted to find out the how's and the why's people may choose the left side of the critical model (inaction) and try to remedy the situation.

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APPENDIX A

SAMPLE QUESTIONNAIRE

Background

1. Age:..... 2.Sex Male □ Female □

3. Marital Status:
   Married □ Single □
   Widowed □ Divorced □

4. Educational Level:
   Primary Completed□
   Primary Incomplete□
   Middle School/J.S.S. Completed □
   Middle School/J.S.S. Incomplete □
   S.S.S. Completed □
   S.S.S. Incomplete□
   Training□
   Post secondary□
   Others Specify .....

5 a. Main Occupation.....

b. Subsidiary Occupation .....

6. Religious Denomination:

Knowledge

7. Have you ever heard of AIDS?

Yes □

No □

b. If yes, from which source?

Radio □ Television □

Brochure □ Poster □

Health Worker □ Friends □

Newspaper □ Others Specify.....

8. How would a person know he/she has HIV/AIDS? .....

.....

9. How would you know that some one has HIV/AIDS? .....

.....

.....

10. Is it possible for a healthy looking person to be carrying HIV/AIDS?

.....

11. How does AIDS spread? .....

.....

.....

12. Is there any means to prevent contracting HIV/AIDS?

Yes □

No □

b. If yes, how? .....

13. What can be done once a person contract the AIDS virus?.....

.....

.....

14. Do you stand any risk of contracting the AIDS virus?

Yes □

No □

b. If yes, why? .....

.....

.....

c. If No, why not?.....

.....

.....

15. Have you experience any HIV /AIDS campaign?

Yes □

No □

16. Did you understand the education campaign?

Yes □

No □

a. If No, what don't you understand?.....

.....

.....

Attitudes

17. Do you believe that about 200 people get AIDS daily?

Yes □

No □

b. Give reason(s) for your response .....

.....

.....

18. Would you take care of a relative who has AIDS?

Yes □

No □

a. If Yes, why .....

b. If No, why .....

19. Do you know about condoms?

Yes □

No □

20. When was the last time you had sexual intercourse .....

b. Did you use a condom?

Yes □

No □

21. Do you know where to buy condoms?

Yes □

No □

b. If yes, please state place(s) .....

22. Would you buy a condom for yourself?

Yes □

No □

b. Give reasons .....

23. How often do you use condom?

Always □ very often □

Often □ Occasionally □ Not at all □

b. Give reason(s) for choice above .....

.....

24. Would you use condoms each time you have sex?

Yes □

No □

b. Give reason(s) .....

25. How would you react if you found condoms with your sexual partner?

.....

26. Has your knowledge about AIDS changed your sexual behaviour?

Yes □

No □

b. If yes how? .....

27. Has your knowledge about AIDS changed your general behaviour?

Yes □

No □

b. Why? .....

28. Do you think that children should be educated on sex and HIV/AIDS?

Yes □

No □

b. At what age should education begin? .....

c. Who should do the education?.....

29. On a scale of one(1) to five(5) indicate the risk level of the following: One represents the highest risk.

i. Single sex partner and regular use of condom □

ii. Single sex partner and irregular use of condom □

iii. Multiple partners with regular use of condom □

iv. Multiple partners with irregular use of condom □

v. Patronage of salons with irregular sterilized equipment □

vi. Patronage injections outside main stream health institutions □

vii. Caring for an AIDS patient □

viii. Living with an AIDS patients □

ix. Sharing needles with an HIV positive person □

x. Sharing improperly sterilized salon instruments of an HIV positive person □

30. How would you rate the knowledge level of Ghanaians on HIV/AIDS?

Very high □ high □ some what high □

Low □ very low □

1. Do you think that Ghanaians have generally altered their attitudes towards sex in the past decade?

Yes □

No □

b. Give reason(s) .....

.....

.....

32. Do you perceive to be threatened by HIV/AIDS?

Yes □

No □

33. If yes, how are you threatened by HIV/AIDS?

.....

b. IF no, how are you not threatened by HIV/AIDS?

.....

34. Do you perceive that your sexual behaviour places you at risk of HIV infection? Yes □ No □

b. If Yes, why?.....

c. If No, why?.....

35. Do you believe that most people get HIV/AIDS infection through sex?

Yes □

No □

Appendix B

FOCUS GROUP DISCUSSION /IN-DEPTH INTERVIEW GUIDELINES

Introductory remarks (to be made by facilitator)

Welcome participants and introduce myself and note taker.

Thank everyone for coming

Explain the purpose and producers of group discussion.

Explain purpose of note taker

Introduce Ground Rules

That everyone's opinion and ideas are important.

There are no right or wrong answers

All comments, positive or negative is welcome.

Participants should feel free to disagree with each other.

Please speak one at a time.

Warm up questions

- What are the most important health problems in Ghana today? Anything else? Why do you think they are important?
- What are the most important health problems in this community?
- What one health problem is the most serious? Why do you say that?
- (If HIV/AIDS is not mentioned) what about HIV/AIDS?

Probe for reasons for answers

- What causes disease?
- How do people get disease?
- How does disease affect a person?
- How can disease be prevented?

HIV/AIDS Awareness and knowledge

- What do you know about HIV/AIDS? What causes HIV/AIDS? How is it spread?
- How do people get it?
- How did you first learn about HIV/AIDS? (TV, Radio, friends, health workers?)

Manifestation

- How can you tell someone has HIV/AIDS? What are the signs and symptoms of HIV/AIDS? Anything else?

Treatment

- How is HIV/AIDS treated?
- Where can one go for treatment?
- In your opinion how long does treatment take?
- Is there a cure for HIV/AIDS?

Prevention

- How can HIV/AIDS be prevented? Are there any other ways?

Risk perception

- How concerned are you about HIV/AIDS? WHY/WHY NOT?
- Do you think you are personally at risk of HIV/AIDS? Why?
- (If yes) what are you doing about this?

Risk Behaviour and Condom

Now I will like to move to a different topic. (DISTRIBUTE CONDOMS TO PARTICIPANTS) Do you know what these are?

- Condoms can prevent pregnancy, is there anything else they can do? (PROBE HIV/AIDS)
- Have any of us ever used a condom? (IF YES) Did you use it to avoid a pregnancy or prevent a disease (or both)?
- Was it with your regular/steady partner or was it in a more casual relationship?
- Are you using a condom now? (IF NO) why not?
- Would you like to show me how a condom is used? (DISTRIBUTE DUMMIES)

HIV/AIDS Perception

- Do you personally know someone who has AIDS?
- Has this changed what you feel or think about the person?
- Has it changed what think about the person?
- What do you personally think about HIV/AIDS (PROBE EXTENSIVELY)
- If you had to rank all the diseases you know from first to tenth, first being the most serious, how would you rank HIV/AIDS? (SHOW CARDS)

Sources of Information

- How do you normally hear or learn about health issues? (PROBE)
- Which of these would you say you prefer? Why? (PROBE FOR credibility, accuracy, availability etc)
- Do you ever discuss HIV/AIDS with your friends? (IF YES) what do you talk about?
- When you first heard of HIV/AIDS, what were you told? How did you feel when you heard this? Did it help to change your behaviour? What about your friends? How would you have liked to lean about HIV/AIDS?

Beliefs about Sexuality

- In your view what do people understand by sexuality?
- How are the sexual beliefs in you community?
- What would you describe as normal sexual behaviour?
- What sexual behaviour will not be seen as normal?

Suggestions

- Is there anything you would have liked to say which you just remembered?
- How do you think people in this community would like to know about HIV/AIDS?
- What in your view would they like to know?
- Is there anything you will like to tell us about HIV/AIDS?

Thank everyone for participating.

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