UNIVERSITY OF CAPE COAST

GENDER ROLES AMONG THE KROBO AND GURENE ETHNIC GROUPS AND THEIR IMPLICATIONS FOR HIV AND AIDS INFECTION

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BY

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A THESIS SUBMITTED TO THE DEPARTMENT OF GEOGRAPHY AND TOURISM OF THE FACULTY OF SOCIAL SCIENCES, UNIVERSITY OF CAPE COAST IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE AWARD OF A MASTER OF PHILOSOPHY DEGREE IN GEOGRAPHY

JULY 2009

DECLARATION

I hereby declare that this thesis is the result of my own original research and that no part of it has been presented for another degree in this University or elsewhere, except for literature quoted from other published sources and of which due acknowledgement has been made.

Signature …… **Date** ……
(JUSTICE OFOSU DARKO FENTENG)

SUPERVISORS' DECLARATION

We hereby declare that the preparation and presentation of the thesis were supervised in accordance with the guidelines on supervision of thesis laid down by the University of Cape Coast.

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PROFESSOR A.M. ABANE - PRINCIPAL SUPERVISOR

…… **Date** ……
PROFESSOR MANSAH PRAH - SUPERVISOR

ABSTRACT

There are striking statistics and issues about women, their sexual rights and HIV/AIDS around the globe, in Africa and Ghana. Women's exposure to the danger of contracting HIV/AIDS is reinforced by their lack of the right to negotiate for safe sex. The study focused on the Krobo and Gurene ethnic groups in Ghana. It sought to assess the gender roles among the Krobo and Gurene people and their implications for HIV/AIDS infection. Also, it identified some of the sociocultural practices of the two ethnic groups which inform their sexual roles and decision making as well as assess the relationships between these roles and HIV/AIDS infection.

In all questionnaires were answered by 290 respondents. In addition, focus group discussions were held for respondents aged between 14 – 35 years and 36 and above years. Assemblymen were also interviewed. The chi square statistic and cross tabulation were used to analyze the data gathered. From the study, it is clear that there are striking ethnic differences in gender roles in Ghana. This has gone a long way to affect sex and sexuality among the two ethnic groups under study. Also, an explicit gender analyze must be incorporated into issues of economic and social change. There is the need for tapping the good aspects of our cultural heritage for the common good of curbing the HIV pandemic in the society.

It is the necessity for one to understand the cultural, social, economic and political as well as biological and demographic factors shaping gender roles and sexual behaviour. Likewise, education and advertisement on HIV/AIDS must be culture - centred and gender based to help address the menace.

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DEDICATION

I dedicate this work first to my dearest wife Mrs. Lydia Akua Manu and my children Justice Kwesi Prempeh Fenteng, Emmanuel Kofi Fenteng and Daisey Akyena Adofoh Fenteng.

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CHAPTER ONE

INTRODUCTION

Background to the Study

Gender is a term used to separate human beings into two main groups-male and female (Moser, 1993). The basis of the distinction is based on biology - sex. However, gender also has a social meaning given to being either a woman or man in a particular society, and the expectations held as to the characteristics, aptitude and the likely behaviour of women and men (Young, 1993). Gender is therefore not a set of physical traits or physiological features, but rather the product of social organization, which is constituted through social interaction and expressed as a set of behaviours, which are exhibited or portrayed as people interact with each other, whether they belong to the same sex or to the opposite sex.

Gender behaviour and its specific expressions vary from culture to culture and over time (Laslett and Brenner, 1989). Hence, the basis of gender difference is related mainly to the expectations that society holds for females and males. Such expectations are translated into roles, which are the societal duties or responsibilities of females and males, and viewed not simply as different, but unequal. On several occasions and in most places, the work, personality traits, ideas and even virtues

ascribed to women have been viewed as less desirable and less worthy than those attributed to men.

Gender-related factors shape the extent to which males and females become vulnerable to any event such as HIV infection, and the responses that occur. Gender inequalities are a major driving force behind the spread of the HIV/AIDS epidemic (Walsh, 2001:2). This is because the different attributes and roles societies assign to males and females profoundly affect their ability to protect themselves against HIV/AIDS and to cope with its impact. Gender based inequalities often have their roots in cultural, economic, and political roles and obligations society assigns women and men.

When HIV/AIDS emerged two decades ago, few people could predict how the epidemic would evolve, and fewer still could describe with any certainty the best ways of combating it. Now, we are past the stage of conjecture. It is known from experience that HIV/AIDS can devastate whole regions, knock decades off national development, widen the gap between rich and poor nations, and push already-stigmatised groups to the margin of society. UNAIDS estimates show that in 1999, 5.4 million people in the world were newly infected with HIV (UNAIDS, 2000), with another five million people infected in 2001.This represented 15,000 new infections a day. More than 330 million people acquired STIs each year, making such persons ten times more vulnerable to HIV infection (UNAIDS, 2002). The hardest hit countries in Africa are Botswana (35.8 per cent), South Africa and Zimbabwe (40 per cent each). The hardest hit persons among the vulnerable group are children, women, and the youth. The world prevalence rate is 1.7 per cent, while

that of Africa is 8.9 per cent. In Ghana, the prevalence rate is about 3.6 per cent (UNAIDS, 2002). According to the World Health Organization, Ghana has the 11th highest rate of reported cases of AIDS in the world and the second highest reported number of AIDS cases in West Africa. The reported AIDS cases by age and sex for Ghana from 1997 to 2001 are shown in Figure 1.

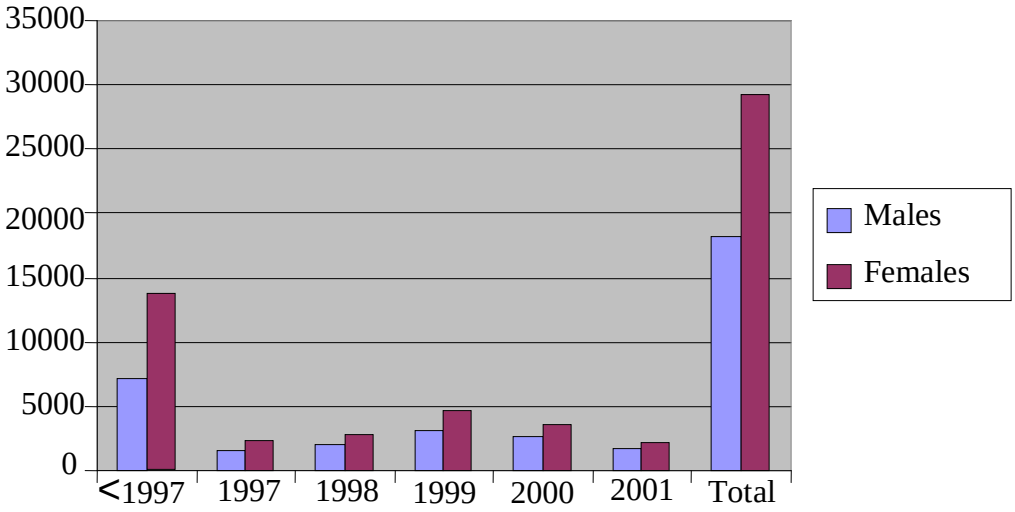

Figure 1: Reported AIDS Cases by Age and Sex – Ghana

Source: NACP, 2001

The figure shows that in almost all the age brackets, more females than males are infected with the AIDS. This is more serious for the ages 20-44. For instance, for ages 25-29 and 30-34 both sexes show wide disparities by totals. This may be attributed to reasons linked to gender roles assigned to males and females.

Statement of the Problem

From an initial infection of 42 reported cases in 1986, HIV/AIDS in Ghana had increased to 48,771 by October 2001 (National HIV/AIDS Control Programme,

2001). While the initial core area of the reported infection was the Eastern Region, the virus has now been diagnosed among people in all the ten regions of the country, with the Ashanti region reporting the highest number of infected persons and the Upper West reporting the least (Table1). This may be due to the type of information disseminated which may not have taken into account the sociocultural milieu of the people.

Table 1: Reported Cumulative Aids Cases In Ghana by Region, March 1986 October 2001

Region	Cases	Per cent
Ashanti	14,400	29.53
Greater Accra	8,208	16.83
Eastern	7,762	15.92
Western	4,146	8.50
Brong Ahafo	3,806	7.80
Central	3,139	6.44
Northern	2,372	4.86
Upper East	2,318	4.75
Volta	1,753	3.59
Upper West	781	1.60
Not stated	86	0.17
Total	**48771**	**100.0**

Source: NACP, 2001

On the other hand, the prevalence rates for 2002 in the country are different. Whilst the national prevalence rate is about 3.6 per cent, in the Southern belt it is 2.3 per cent in Accra and 6.6 per cent at Agomenya. In the middle belt, it is highest at Ashanti Mampong at 4.8 per cent and lowest in Sunyani at 1.1 per cent. In the Northern belt, the highest is 6.0 per cent at Wa, and the lowest 1.6 per cent at Bolgatanga. The rates for some selected towns and cities in the country also show some wide deviations from the national rate. For example, in the Eastern Region, Agomanya and Koforidua recorded the highest rates of 6.6% and 6.4% respectively and Bolgatanga in the Upper East Region recorded the least, 1.6% (Table 2).

Table 2: Prevalence Rate of HIV/AIDS in Some Selected Towns and Cities in Ghana (in percentages)

Town	Accra	C/Coast	Kumasi	Ta'di	Koforidua	Agomanya	Wa	Bolga
Rate	4.8	3.6	3.4	4.0	6.4	6.6	6.0	1.6

Source: NACP, 2001

At the onset of the crisis in the 1980s, AIDS was defined as a problem of the individual. Now it is widely recognized as an enormous social crisis as well. Social norms, expectations, community attitudes and policies towards roles and behaviour in relation to maleness and femaleness have been found to contribute to the spread of the epidemic (Kiragu, 1998).

Given the existing scenario, this study seeks to explore the implications of sex roles in the spread of HIV/AIDS and how behavioural traits of maleness and

femaleness contribute to the HIV/AIDS menace. Also, how ethnic differences has affected gender roles as well as sex and sexuality.

As noted by Merson (1993:1267), wherever women are culturally and economically subordinate to men, they cannot negotiate safer sex, including condom use and lifelong mutual fidelity. It is therefore important to find out the possible relationship between gender and HIV/AIDS. The study used the Krobos of the Eastern region and the Gurene of the Upper East region as test cases.

Objectives

The general objective of the study was to assess the gender roles among the Krobo and the Gurene people and their implications for HIV/AIDS infection.

The specific objectives were to:

- compare some of the sociocultural practices of the two ethnic groups which inform their sexual roles and decision making; and
- assess the relationship between these roles and HIV/AIDS infection.

Hypotheses

The hypotheses tested are that:

- there are no significant differences between residents of the two ethnic groups in the perception of risk of HIV infection.
- there are no significant differences between males and females in the two ethnic groups in terms of risk taking behaviour in sexual reproductive health.

Rationale of the Study

The HIV/AIDS pandemic continues to spread in spite of the quantum of knowledge, information, and the risk aspects, which have been availed to people. In Ghana, results from the Demographic and Health Survey (DHS) of 1998 indicated that over 95 per cent of Ghanaians have heard of HIV/AIDS (Ghana Statistical Service (GSS), 1999). Also, available evidence indicates that over 99 per cent of Ghanaians are aware of HIV/AIDS and how it is transmitted (GSS, 1999). The spread has now become a malady to the whole world in general including Ghana. This has made various governments, agencies, NGOs and others try to find a lasting solution to curb the spread considerably if not to eradicate it entirely. These include the use of peer educators, advertisements, and funding for interventions. However, it seems the issue has not been addressed from the angle of sex roles. This is particularly important in our culture where males dominate in issues concerning sex.

Our culture and traditions has ascribed a role of passive acceptance for female gender, especially in sexual relations. This state of affairs makes women more vulnerable to infection because most women do not have the power to negotiate for safe sex, so they do not have control over their own sexual relations.

Also, a form of inequality that appears to be common to nearly all societies is the greater external control over women's sexuality than over men's (Rubin 1975); men have more sexual freedom than women. Even where women enjoyed considerable sexual freedom, they are often forced to marry, and their obligation to remain sexually faithful to their husband is very strong (Preston-Whyte, 1994). It is therefore imperative to tackle the issue of HIV/AIDS from a gender perspective.

The study is very relevant to the Manya Krobo and Bolgatanga Districts as the findings would help to determine the spread of HIV/AIDS related issues. The study will also contribute to the existing literature, particularly on the sociocultural dimensions of the disease. It will provide a framework for further research, as well as contribute to knowledge, which also serves as a guideline for policies on HIV/AIDS in Ghana.

Study Areas – Manya Krobo and Bolgatanga Districts:

Location and Physical Characteristics

Manya Krobo District is one of the fifteen districts in the Eastern Region. It lies between latitude 6^0 05' S and 6^0 30' N and longitude 0^0 08' E and 0^0 20' W. It is bordered to the northeast by Afram Plains, to the northwest by Fantiakwa, to the southwest by Dangbe West, to the east and west by Asuogyaman and Yilo Krobo Districts respectively and to the southeast by North Tongu District. The District covers an area of 1476 sq. km, constituting about 8.1% of the total land area within the region (18,310 sq. km). The important towns include Odumase township (which incorporates Atua, Agomanya, and Nuaso), Akuse and Kpong in the Lower Manya area. The major towns in the Upper Manya area are Asesewa, Sekesua, Akateng and Otrokper (Plate 1).

The District has an average height of about 452m above sea level. The highest point is about 660m above sea level at the south-western part of Sekesua in the Upper Manya and the lowest area located at the Southeastern part being about 50 m. above sea level.

Several rivers such as the Volta, Ponpon, Krum, Dawado, Ayermesudo, and Anyaboni drain the District. With the exception of the Volta River, almost all these rivers are seasonal. The District has a mean annual rainfall ranging between 900mm to 11,500mm. Relative humidity is high during the wet season, between 70% and 80%, and low at about 55% to 60% in the dry season.

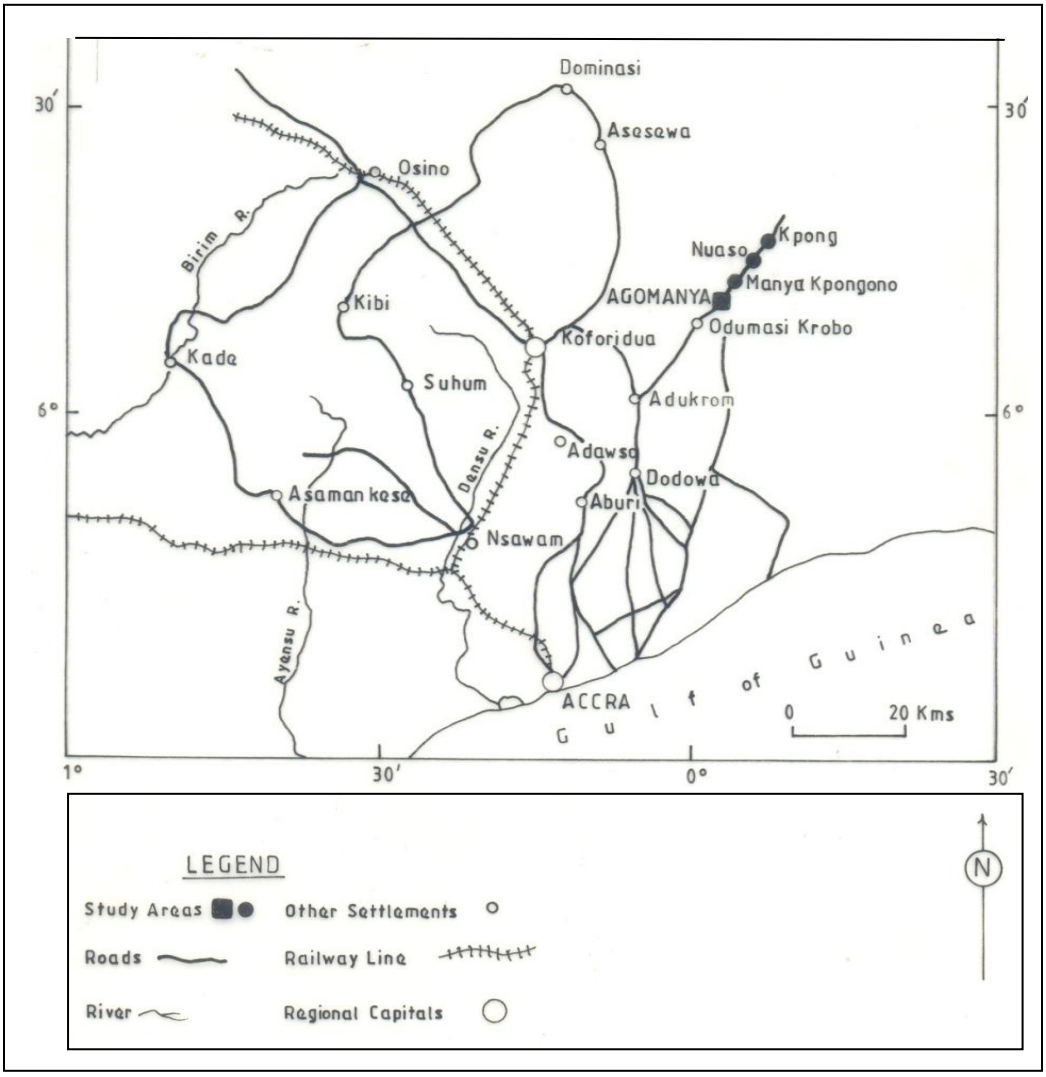

Plate 1: Map Showing The Study Area – Agomanya and Some Surrounding Settlements

Source: Cartographic Unit, University of Cape Coast, Department of Geography and Tourism, 2003

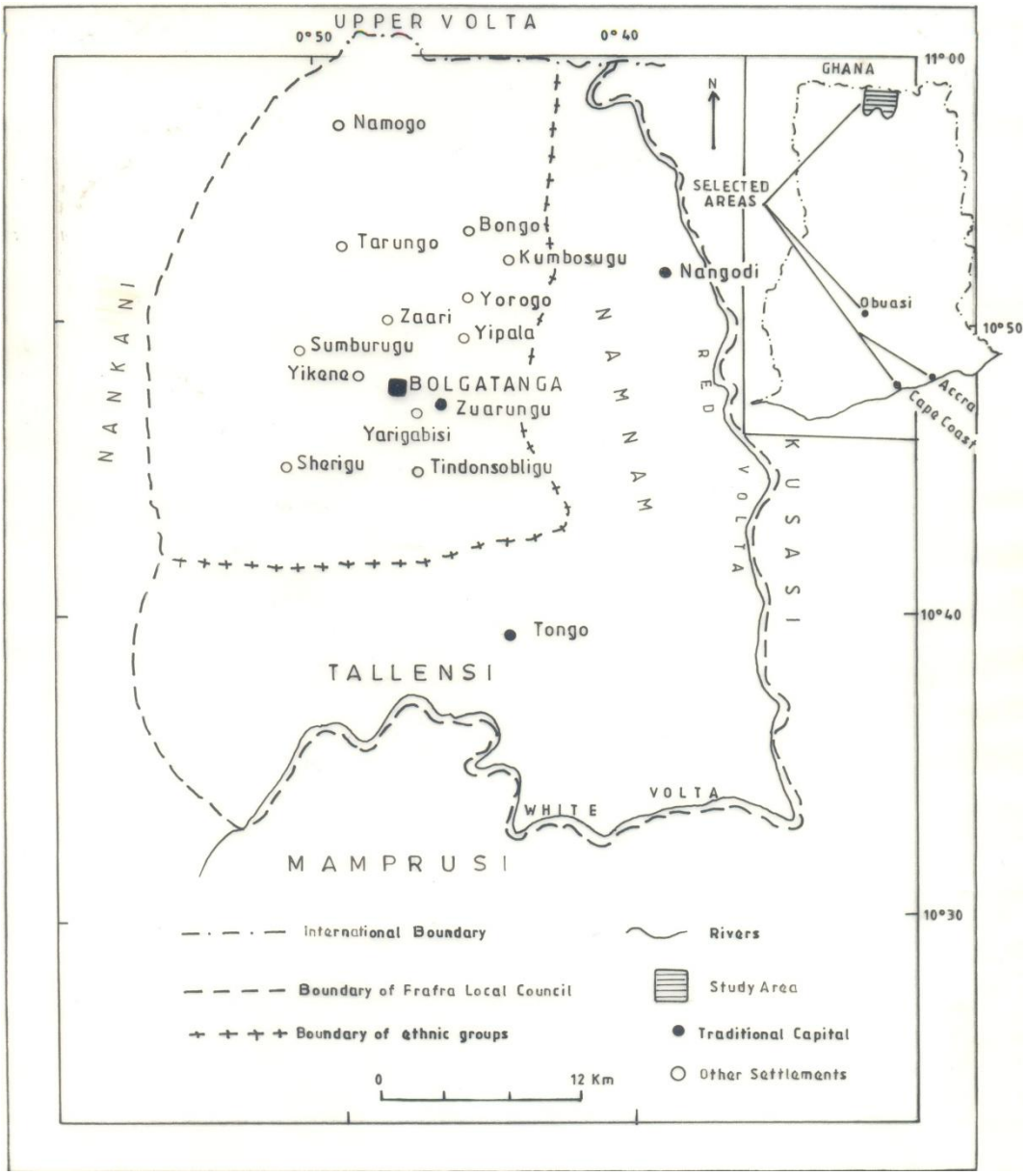

Plate 2: Map Showing The Study Area -Bolgatanga and Some Surrounding Settlements

Source: Cartographic Unit, University of Cape Coast, Department of Geography and Tourism, 2003

The District lies within the semi-deciduous forest and derived savannah zone. The semi-deciduous forest covers the lower part of the District, stretching from Yilo Krobo District to about 8,855 sq. km. Trees commonly found on such vegetation are the palm, mango, ceiba, neem and acacia.

Conversely, Bolgatanga District is centrally located in the Upper East Region and is the regional capital. It has a total land area of 1,620 sq. km and is bordered to the north by the Bongo District, south by the West and East Mamprusi District (both in the Northern Region), Kassena-Nankana District to the west and Bawku to the east (Plate 2).

The main rivers are the White and Red Volta and their tributaries which include the Atankwidi, Yaragatanga, Atamore, Kuldaga and Kulbiliga.

The District has gentle slopes on inselberg outcrops and some uplands that have fairly steep slopes. The District falls within the Birrimian and Tarkwaian and Voltarian rocks of Ghana.

The climate is classified as tropical and has two distinct seasons – a wet season that runs from May to October and a long dry season that stretches from October to April characterised by the Harmattan wind. Mean annual rainfall is 950mm while maximum temperature is 45 °C in March and April with a minimum of 12 °C in December.

The natural vegetation is that of guinea savannah woodland consisting of short deciduous trees widely spaced and a ground flora which gets burnt by fire or scorched by the sun during the long dry season. The most common economic trees

are the sheanut, dawadawa, baobab and acacia. The district has three constituted forest reserves, which primarily protect most of the rivers.

Socio – Demographic Characteristics

The total population figures for 1970, 1984 and 2000 with their corresponding inter-censual growth rates are shown in Table 3.

Table 3: Total Population & Growth Rates - 1970, 1984 & 2000 for Manya Krobo District

Census Year	Total Population	Intercensus Growth Rate
1970	113,072	–
1984	134,530	1.2%
2000	154,301	1.0%

Source: GSS: Population and Housing Census, 1970, 1984 and 2000

From the Table, it can be seen that the population of Manya Krobo District in 1970, 1984 and 2000 was 113,072, 134,530 and 154,301 respectively. The inter-census growth rates during 1970-1984 and 1984-2000 were 1.2% and 1.0% respectively. The population density for the years 1970, 1984 and 2000 for the district were 77, 91 and 114 persons per square kilometres respectively. Table 4 shows the male-female split within each age group in the year 2000 for the district as well as the region.

Table 4: Age – Sex Composition 2000 for Manya Krobo District

(in percentages)

Age Group	District			Regional		
	Male	Female	Total	Male	Female	Total
0-14	18.5	19.6	38.1	21.2	20.5	41.7
15-64	29.3	29.2	58.5	25.4	27.2	52.6
65 +	1.6	1.9	3.5	2.5	3.2	5.7
Total	**49.3**	**50.7**	**100.0**	**49.1**	**50.9**	**100.0**

Source: GSS: Population and Housing Census, 2000

As the Table shows, males constitute 49.3% of the population, slightly lower than females (50.7%). This translates into a sex ratio of 95.2 males to 100 females, which is a little below the national average of 97.9 males to 100 females. This is a cause of concern for the nation since they are as well the most vulnerable and affected population with the HIV/AIDS virus making the study more relevant.

On the other hand, Bolgatanga returned a figure of 225,684 in the 2000 Population and Housing Census giving a growth rate of 1.1% and a density of 139.3 persons per square km. The male population is 108,567 whilst the female population is 117,297 representing a sex ratio of 92.6. By age distribution, about 47.7% falls under the age of 15 years, 50.8% between 15 and 64 years and 1.5% above 64 years.

Ethnicity and Religion

The Manya Krobo District's population is made up of various ethnic groups, with different religious backgrounds as shown in Tables 5 and 6.

Table 5: Ethnicity - Manya Krobo District

Religion	Krobos	Ewes	Akans	Others	**Total**
Percentage (%)	70.5	18.2	7.7	3.6	**100.0**

Source: District Health Management Team, Manya Krobo, 2001

The people are predominantly Krobos. Ewes who constitute 18.2% are mainly fisherman and fishmongers living along the Volta Lake (Table 5).

Table 6: Religion - Manya Krobo District

Religion	Christians	Moslems	Traditionalist	Others	**Total**
Percentage (%)	76.4	17.5	6.1	0.0	**100.0**

Source: District Health Management Team, Manya Krobo, 2001

In the district there are as many as 76.4% Christians and 17.5% Moslems. The remaining 6.1% are Traditionalist (Table 6). This is relevant for the study since religious and ethnic background can influence the spread and acceptance of HIV/AIDS programmes.

Compared to this, the rural population of Bolgatanga is predominantly indigenous and the ethnic groups found in the area are the Gurenes, Talensis and

Nabdams who occupy the Nangodi-Sekoti areas. Bolgatanga Township has a more cosmopolitan outlook. The main religion of the people is Christianity but there are Moslems and Traditionalists.

Human Resource Development and Basic Services

The delivery of health in the Manya Krobo District is the primary responsibility of public sector health institutions. The private sectors, especially NGOs, assist in the delivery of health by constructing health facilities.

In addition to these facilities, there are several Traditional Birth Attendants (TBAs) and traditional healers or herbal centers in the communities. They usually offer important health services to the people.

The District has three hospitals, all of which are located in Lower Manya. The major one is the St. Martins De Porries Hospital. The majority of the people in Upper Manya depend on only one Health center at Asesewa and a few MCH/FP centers in other Upper Manya settlements. The major diseases in the study area are tabulated in Table 7.

Table 7: Major Diseases in the Manya Krobo District - 2001

Disease	% of O.P.D Attendance
Malaria	70.3
HIV	12.2
Boils	5.4
Rheumatism	4.1
Waist Pains	2.7
Stomach Aches	2.7
Hernia	1.3
Bilharzia	1.3
Total	**100.0**

Source: District Health Management Team, Manya Krobo, 2001

The Table clearly shows that malaria is the predominant disease and accounts for most deaths in the district. The calibre and number of personnel also determine to a large extent the level and quality of service provided. Table 8 shows the kind of health staff available and their number in the district.

Table 8 Health Personnel in the Manya Krobo District - 2001

Health Personnel	Number
Medical Doctor	8
Medical Assistant	3
Dentist	1
Dental Assistant	1
Pharmacist	1
Dispensary Technicians	7
Dispensing Assistants	5
Professional Nurses (General)	47
Auxiliary Nurses	54
Professional Nurses (PH)	8
Auxiliary Nurses (PH)	26
Health Inspectors	2
Health Inspecting Assistants	16
LaboratoryTechnologist/Technician	4
Total	**183**

Source: District Health Management Team, Manya Krobo, 2001

As the Table shows, the district has 8 doctors out of a population of 183 health workers for the region. The doctor population ratio is 1:26,023. There are a few of other health personnel such as physiotherapists in the district.

The case of HIV/AIDS in the Manya Krobo District is a cause of concern. The district is rated first in terms of reported cases of AIDS in the Eastern Region and in the country. Table 9 shows the number of reported cases between 1994 and September 2002.

Table 9: Reported Cases of HIV/AIDS in Manya Krobo District, 1994 – September 2002

Year	1994	1995	1996	1997	1998	1999	2000	2001	2002
Cases	141	218	241	487	321	247	241	241	367

Source: District Health Management Team, Manya Krobo, 2002

From table 9, the year with the highest number of reported cases is 1997. However, the figures began to drop after 1997 until 2001, when the increases were again recorded. Several campaigns and publications on the causes and effects of HIV/AIDS have been organized by NGOs and CBOs in the communities and in the schools all aimed at ameliorating the high prevalence rate.

The percentage enrolment of education revealed that as many as 54.0% of whom had had middle/J.S.S. education. However, only 10.3% had any secondary or senior secondary level education. The tertiary level rate is very low at 1.2% (District Directorate Manya Krobo, 2001). This has implications for assimilation of HIV/AIDS messages. This can also influence the knowledge and perception of issues relating to the AIDS pandemic, since studies have shown that the higher the literacy rate, the higher the rate of understanding and assimilation of information.

The Bolgatanga Regional Hospital and a private facility, Odoi-Agyarko's Clinic, are the only well equipped health facilities in Bolgatanga. The service providers comprise of the public and private sectors, which include Non-governmental organizations (NGOs), and traditional practitioners.

Table 10: Health Facilities: Bolgatanga District - 2001

Sub-district	Health facilities	Pop./ Catchment served
Bolgatanga North	1 Hospital; 3 Clinics	37,634
Bolgatanga South	1 Health Centre; 1 Clinic	48,538
Zuarungu	1 Health Centre	18,564
Tongo East	1 Chip Centre; 2 Clinics.	40,553
Tongo West	1 Health Centre; 1 Clinic.	24,020
Shirigu-Sumbrungu	1 Clinic, 1 Health Centre; 1 Chip Centre	27,377
Nangodi-Kongo	1 Health Centre; 2 Clinics	11,711
Zolib-Sakote	1 Clinic	16,590
Total		224,987

Source: District Health Management Team, Bolgatanga 2001

The district has only one government hospital located in Bolgatanga and a number of public and private owned clinics. There are mobile clinics run by the Catholic and Presbyterian Churches. Some newly created Community Health Integrated Planning Service (CHIPS) centres have been established at Shirigu,

Kpatia, Datuku, Zuarungu-Moshie and Gambibgo to provide community based health service. The type of health facilities, their locations and the populations they serve are presented in table 10.

The Ministry of Health has divided the district into eight sub districts. There are also 12 clinics, of which two are CHAG clinics and three are privately owned. The district also has five health centres in the eight sub-districts. The district is served by two pharmacies, which are located in the Bolgatanga township. Only eight out of the 27 licensed chemical stores are located outside the township.

Similar to the problem of inadequate equipment in rural health facilities, the distribution of medical staff is equally considered unfavourable in these areas. Apart from the one private clinic and the only hospital, medical assistants and nurses man all other health facilities. The doctor-patient ratio in the district is 1 to 28,000 while the nurse-patient ratio is 1: 5000.

Life expectancy in the district is only 50 years compared to the national average of 55 years. The prevalence of diseases such as malaria, diarrhoea, anaemia, acute respiratory infections and gynaecological disorders as well as the outbreak of epidemics such as cholera, anthrax and CSM can be traced to factors like inadequate equipments and distribution of medical staff. Other conditions such as malnutrition and micro nutrient deficiency (mostly among children) are also prevalent in the district. During the lean season that is April to August, 28% of the population is estimated to be malnourished. This phenomenon has contributed to the high morbidity and infant mortality rates. Table 11 shows the top 5 common diseases in the district.

Table 11 Top Five Common Diseases: Bolgatanga District

Disease	Number of Cases
Malaria	40,458
Diarrhoea	1,324
Anaemia	1,143
Acute Respiratory Infections	7,604
Gynaecological Disorders	2,287

Source: District Health Management Team, Bolgatanga 2001

These top five common diseases observed in the district have severe effects on the lives of the people. Malaria, diarrhoea and anaemia are said to have contributed greatly to most deaths in the district, especially among infants. Malaria alone accounts for 25% of all infant deaths in the district. The collaborators in Health Delivery in the district are the Bolgatanga District Assembly, Presbyterian Primary Health Care, Diocesan Health Care Unit, Rural Help Integrated, Red Cross and Traditional Birth Attendants (TBAs). Also, included are Community - based Disease Volunteers, District and Community Health Committees, Action Aid (Ghana), Sight savers (Ghana) and herbalists.

With regard to the HIV/AIDS menace, the district is as vulnerable as any other town in the country. It is estimated that the prevalence rate is about 1.6%. In 1999 recorded HIV positive cases stood at 85 from a figure of 22 in 1997. In December 2000, the number of reported cases was 215.

The educational institutions in the district include pre-schools, first and second cycle institutions and a polytechnic (Table 12).

Table 12: Number of Institutions in the Bolgatanga District

Level	Public	Private	Total
Nursery	50	10	60
Primary	90	5	95
J.S.S.	51	1	52
S.S.S.	5	-	5
Tech. Institute	1	-	1
Polytechnic	1	-	*
Private Institutions	-	6	6
Total	**198**	**22**	**220**

NOTE: * Polytechnic yet to be established.

Source: District Directorate, GES, Bolgatanga, 2001.

Enrolment of pupils at the basic level is quite high but is characterised by a slow rate of increase. The number of schools, both private and public, is more at the pre - secondary level than the secondary and post secondary levels as seen in Table 12.

Economic Activities

There are major and minor occupations in the Manya Krobo district. Farming which employs about 82.5% of the total workforce is the major occupation.

Other major occupations include fishing, 8.8%, teaching 3.5% as well as trading, sewing and carpentry. Trading ranks highest at 66.0% in the minor occupation. Distilling /tapping and other are included as economic activities in the area (District Health Management Team, Manya Krobo, 2002).

In the Bolgatanga District, the main type of occupation is farming which employs about 80% of the population (District Health Management Team, Bolgatanga, 2001). Some of the crops grown include cereals, legumes, vegetables and others. The second most important economic activity is livestock and poultry production. Fishing in the major rivers such as the Red and White Volta and some other 15 water bodies scattered throughout the District is also important.

Chapter Organisation

The thesis is organised into six chapters. Chapter one introduces the study. It presents the problem statement and the objectives and states the hypothesis that the study seeks to verify. It also states the rationale of the study as well as the study areas and chapter organisation.

The purpose of the second chapter is to examine the theoretical and empirical issues in HIV/AIDS and present the conceptual framework.

Chapter three discusses the methods used in the study and the justification for using these methods. It consists of a brief description of the questionnaire, its administration, and sampling. Related to these are the pre testing and issues from the field.

Chapter four discusses the findings from the research categorised under socio – demographics, gender roles, AIDS knowledge and perception.

Chapter five examines the traditions, norms, and practices, laws, and taboos on sex, which have implications for HIV/AIDS infection.

Finally, chapter six considers the implications of the findings with respect to AIDS prevention and education as well as a summary, recommendations, and conclusion.

CHAPTER TWO

THEORETICAL AND EMPIRICAL ISSUES IN HIV/AIDS

Introduction

This chapter discusses the background to the HIV/AIDS pandemic, AIDS epidemiology worldwide and narrows the focus to sub-Saharan Africa and Ghana. It further examines the sociocultural values, ethnicity, gender and sex, knowledge of HIV, as well as gender roles as they relate to HIV/AIDS infection. The purpose of the chapter is to provide an in-depth critical review of the literature. The chapter concludes with a discussion of the theoretical and conceptual framework underlying the study. In particular, the Proximate Determinant Model which has been adopted for the study is explained.

Background to HIV/AIDS Issues

HIV like herpes, is a virus. Like syphilis, it affects the whole body, can take few or many years before it can cause serious damage, and can be fatal. HIV cannot live on its own or in water or air. People can get a cold, flu, or pneumonia just being near to someone who has them. People can get hepatitis A or salmonella from contaminated food or water, and malaria from being bitten by mosquitoes. People do not get HIV from any of these ways.

In the late 1970s, doctors begun to recognize that a new pattern of illness was occurring in a growing number of people and that a new type of infection was spreading. AIDS was recognized as a syndrome of illness in 1981, and HIV, the virus that causes it 1993 (Berer et al, 1993).

HIV is a complex virus. No one knows how it evolved into its present form. Before anyone knew it existed, it was being passed from person to person and country to country and had spread worldwide (National AIDS Control Programme (NACP), 1999). The earliest cases of people who died of HIV – related illnesses were identified in the 1980s from stored samples of tissue and fluids. They included a seafarer from England, who died in 1959, a teenage boy in the USA, who died in 1969; a sailor, his wife and their youngest daughter from Norway, who begun to develop HIV disease in the mid-1960s and had all died by 1976 (Froland, et al, 1988); and in 1959, a blood donor in Zaire. Sporadic cases of AIDS in people who had contact with West Africa date as far back as the mid-1960's (Fleming, 1990). No one understood at the time why these people had become ill and died.

HIV/AIDS has become a threat to the entire globe. This threat is regardless of one's religious, social, economic, political, cultural, and environmental background. Because of this, it has caught the eyes of researchers, governments, individuals, religious leaders/bodies, countries, and other social commentators. Many research theses and papers have been presented on this pandemic. Researchers who have made considerable contribution to the subject matter include Caldwell et al (1989), Orubuloye et al (1997), Caldwell et al (1991), Anarfi (1997), and Awusabo-Asare et al (1997).

Various fora, symposia, meetings, documents, and other materials have been focussed on the issue of HIV/AIDS regardless of the arena in which one finds them. AIDS can be contracted by all manner of people; from the poor to the rich, the literate to the illiterate, woman to man, young and old, and as well having no limit in relation to color. This is a threat to socioeconomic development. Governments are doing all things possible to curb as well as eradicate the HIV/AIDS pandemic.

Despite the above attempts, the virus continues to spread in intensity and the infection rate continues to increase across all boundaries. Even though much research has been done and suggestions and recommendations made as to how the virus can be controlled and contained, the pandemic still looms on. The situation is even more scary when one considers the available figures showing the infection rate. The statistics in Ghana indicate that 125 people will die daily by the year 2009 if the rate of HIV/AIDS infection in the country continues. This situation in the country is quite alarming. Currently, 220 people get infected daily and about 3.0 per cent of the population aged 15 - 49 have already been infected with the virus (UNAIDS, AIDS Epidemic Update, December, 2002).

Since the 1970s HIV has been spreading rapidly. Everyday, around 14,000 people in the world become newly infected with HIV and these infections occur in every country. To date about 23 million people in the world have been infected with the virus (NACP, 1995).

In a “moment of common purpose”, the international community adopted a sweeping plan of action to fight the global epidemic of HIV/AIDS. At the UN Special Session on 25 - 27 June, 2001, the International Labour Organization (ILO)

launched a pioneering Code of Practice on HIV/AIDS and the World of Work. The new code provides workers, employers, and governments with global guidelines-based on international labour standards – for addressing HIV/AIDS and its impact in the workplace (Berners, L.T et al, 2001). One of the key principles of the ILO Code of practice on HIV/AIDS and the world of work is that the gender dimension of HIV/AIDS should be recognized. More equal gender relations and empowerment of women are vital to successfully preventing the spread of HIV infection and enabling women to cope with HIV/AIDS (Berners, L.T et al, 2001).

The global epidemic of HIV was seen initially as a crisis in public health and was defined as a health issue that required a health response. This is now generally seen as too simplistic. In part, this redefining of the problem has its origins in the perceived ineffectiveness of the global response to HIV and AIDS. It is unfortunately the case given that in almost all developing countries, that HIV has spread in spite of the policies and programmes designed to reduce transmission. In part it reflects a much more complex understanding to social, cultural, and economic determinants and consequences of the epidemic. It is now commonplace to argue that the epidemic is not simply about public health but is concerned with development in all of its dimensions. In societies where there is de jure equality, for example, of paid or employment or property rights, these differences nevertheless remain a significant feature of the economic and social life. To attempt to understand economic and social change without incorporating an explicit gender analysis is therefore an exercise of futility (Smith and Cohen, 2000). It is therefore imperative

to note that two basic things are important in understanding the interaction of gender, development and the HIV epidemic.

The first is that, it is impossible to make any coherent analysis and assessment of the factors driving the HIV epidemic unless it is founded on gender analysis of socially, culturally and economic determinant roles; and

The second is that, given the critical social and economic roles that women play it is essential that they are empowered. This is so since only through a restructuring of social and economic relationships will it be possible to address the multiple challenges of the HIV epidemic (Smith and Cohen, 2000).

Most women are at risk of infection by sexual transmission. Yet the prevention strategies advocated to prevent sexual transmission have offered women little or no protection from infection (Berners, L.T. et al, 2001). Prevention strategies in general and education messages [Information, Education and Communication (IE&C)] in particular have focused on the reduction of sexual partners, fidelity within relationships, safer sexual practices, and more recently the treatment of sexually transmitted diseases (STDs).

However, these measures are grounded in men's physique, lifestyle and experiences, rather than women's, and should be directed at men. As to the means by which women can protect themselves from HIV infection, they are inadequate. (Reid, 2003, Paper No. 10)

Advocating the reduction of sexual partners as a prevention strategy is irrelevant to the lives of many women who have no sexual partner other than their husband or regular partner. Where women have multiple partners, this is often a

choice forced on them by economic necessity. For as long as this situation and socio-economic system that gives women few choices for economic interdependence remain, women will not be able to adapt this strategy. Neither is the second strategy, faithfulness within relationships, enforceable by women. It is estimated that between 50 and 80 per cent of all infected women in Africa have had no sexual partners other than their husbands (Reid, 2003 Paper No. 10). Having no sexual partners other than their husbands may be under women's control but their husbands' behaviour is not.

The silence surrounding the infection of young women must be broken. Girls and young women must be able to speak out, to cease to feel silenced or powerless to change what happens to them. It is critical that parents, communities and nations realize that, unless they face this issue urgently, not only will many young women be lost but so, too, will their children and their children's children. Clans and communities will cease to exist and, with them, their ancestors.

If the silence is broken then young infected women will begin to speak out and tell their stories. This will be an effective programme to prevent their younger sisters from also becoming infected. If not, the breaking of the silence will add the agony of younger girls, since they will now know that they face a future of possible, perhaps almost certain, infection. Young girls will therefore feel powerless to avoid the fate of their mothers and older sisters (Reid, 1992).

The psychological trauma of such a situation is virtually beyond comprehension. If we do not succeed in developing an effective, timely agenda for action, the insight and analysis which demands that the silence be broken will become a curse.

The ability of young women to protect themselves from infection becomes a direct function of power relations between men and women and, in particular, of men's sexual identity. Gender is formed in families but constructed by societies (Reid, 1992).

To change accepted patterns of male behaviour and expected patterns of female behaviour, therefore, require community organizing and collective action.

Individual families and societies must change how they value women. The more women are valued, the better they will be fed and nurtured, given access to health services and education, provided with the skills required for economic autonomy and have their rights honoured (UNDP, 1997).

Families must also change what they value in men so that men will be less likely to place themselves and others at risk of infection. Men, not only women, must become the guardians of compassion, of respect for others, of healing, connectedness and of mercy.

The Global AIDS Policy Coalition projected that by the year 2000, there would be a minimum of 38 million adults living with HIV, and possibly as many as 110 million. New infections among men during 1993 were estimated at 139.73 per 100,000, compared to 99.15 new infections for every 100,000 women (The Global AIDS Policy Coalition, August 5, 1994). Sexual transmission is currently held to be responsible for 86 per cent of all HIV infections. While men with HIV tend to be older than the women infected, they are still primarily young adults at the prime of their lives.

Finally, while many men are coping with being infected with HIV, there are even more who are experiencing losses due to HIV-related illness and death among their family, friends and colleagues.

Michael Helquist, an expert in HIV communication based in San Francisco points out, that "how we think about men - and women - affects how we try to fight AIDS" (Helquist, 1994).

However, there has been no systematic examination of men's multiple roles in the epidemic, the many factors that influence them, as well as the obstacles that prevent more men from becoming involved. While many men have responded to HIV with a sense of urgency, responsibility, and compassion, they often appear to be the exceptions rather than the norm in their communities or professions.

At an individual level, there are many men who continue to engage in behaviours that place them and others at increased risk for HIV. Their actions may reflect a lack of awareness or understanding, or simply human frailty in the face of the immensely difficult task of maintaining safer sexual behaviours over time. Yet there are many others whose actions or lack of action can only be considered irresponsible, selfish and even cruel. These men do not heed the warnings, do not see themselves as responsible, or seem to simply care more about their own pleasure than the risk their actions pose to themselves and others. In the extreme, they are the men who lie to their partners about their sexual history and even their HIV status, sexually exploit those with less power, and use sex as a form of violence against women, children and other men (Carovano, 2003).

Given that nearly 90% of HIV infection is attributed to sexual transmission, conditions, norms and practices that facilitate the sexual spread of the virus must be the central focus. HIV is transmitted sexually through unprotected sexual intercourse - anal, vaginal, and oral (Carovano, 2003). Because this is known, behaviours to eliminate or reduce the likelihood of acquiring HIV infection have been fairly easy to identify. People have the options of not having sex, having unprotected sex with only one other uninfected, faithful partner, or engaging in non-penetrative or protected sex (e.g. sex with a condom, dental dam, or female condom). Individuals may choose strategies involving some combination of these behaviours, either concurrently or consecutively, to meet diverse or changing needs.

Early efforts to promote behaviour change in response to HIV focused almost exclusively on identified "high-risk groups." In recent years, the focus has broadened somewhat, including increased attention to understand and support change among women. While this expanded focus has been necessary and significant, it has still ignored the development of targeted efforts for most men (Carovano, 2003).

As men in most cultures dominate decision-making and have greater independent control over sexual relations, it is imperative that efforts to respond to the epidemic and promote behaviour change place greater emphasis on men. As a first step, a better understanding is needed of the process of HIV - related behaviour change among men and the factors that motivate their sexual behaviour, both unsafe and safe.

As noted by respondents from many cultures, norms of masculinity also encourage men to view sex as a form of conquest and expression of male prowess. According to Ernesto Guerrero of the Dominican Republic, "in some regions, men have been educated under the premise that having many girlfriends (women) is the best symbol of virility and power." At its extreme, sex can become an act of violence with domination or humiliation the apparent goals. Whenever these are primary reasons for engaging in sex, respect for one's partner can be expected to be absent. Without respect, a concern for a partner's health will have little impact on the behaviour of men.

In many cultures, societal norms (and human physiology) permit men to take little responsibility for the consequences of their sexual behaviour. Generally, women bear the burden of responsibility for pregnancy, often even where they are the result of rape (Carovano, 2003). Because a man cannot be easily linked to his offspring - including a man with HIV - it remains possible for men to deny paternity and any responsibility. A European respondent asserted that in order for behaviour change efforts to succeed, "we need to hammer in (to men) their responsibility for their dependents and themselves (Larvie, 1992)." There are many reports of women being blamed for bringing HIV into a family, generally because their HIV status is identified first, through the illness of a child. This is so in spite of the fact that the socially sanctioned behaviours of their male partners were more likely to have been the cause of the initial infection (Carovano, 2003).

Commenting on these issues, Bob Connell noted that in 'Western' culture, the most honoured form of masculinity involves being authoritative, decisive,

controlling other people and exerting power. This affects heterosexual relationships in damaging ways. Where sexual conquest is the main goal, a pattern of sexuality can be created where women are repeatedly at risk and have limited resources to resist. Until dominant forms of masculinity are challenged, and economic power shifts towards women, this is not likely to end (UNDP, 1997).

World Overview of HIV/AIDS Epidemiology

The world population is showing a rapid growth recently after registering a relatively moderate growth for a long time in the past. The world population was about 1 billion in 1850, while in 1950 it climbed to 2.5 billion and to about 5.6 billion in 2003. According to an estimate by the UN, the population will reach 8.5 billion in 2025, and is expected to exceed 10 billion by the end of the 21st century according to a long-term forecast (UNAIDS, 2002)

Over 95 per cent of the world's population growth is taking place in the developing countries, where the growth will be at a higher place in the future. The rapid population growth is regarded as a threat to the existence of all humanity and with this thought, the term 'population explosion' is being used nowadays to express this situation. The most important issues deriving from rapid population growth is the issue of poverty that is getting more severe in developing countries and its influence on global environment.

Since the first patient was found with AIDS in the early 1980's the number of people infected with the HIV/AIDS has continued to increase sharply. By the late

1980's, AIDS cases were found in many countries of the world and the reality of the spread of AIDS particularly in developing countries came to light (Berer, 1993).

At the end of 1993, the AIDS cases with over eight hundred and fifty thousand people in 180 countries and areas in the whole world were reported to the World Health Organization (WHO) and those cases reported were regarded as only part of the AIDS cases in the world then. Taking into consideration all the possible cases of infection with HIV/AIDS, WHO estimates that, as of the beginning of 1994, there must have been over three million people infected with HIV in the world, including over five hundred thousand new- born babies infected with HIV through mother-to-child transmission. Also, estimations suggest that there will be the cases of AIDS with ten million people, with the cases of infection with HIV involving thirty to forty million people at the end of this century (UNAIDS, 1994).

The number of people living with HIV/AIDS in 2002 in the world has risen to 42 million, up from 40 million at the end of 2001, according to the UNAIDS and World Health Organization (WHO) update on the global HIV epidemics. Five million people were newly infected and the disease killed 3.1 million people in 2002 (UNAIDS, 2002).

HIV/AIDS in Sub-Saharan Africa

In Sub-Saharan Africa, one of the world's most sparsely populated areas, the epidemic spread of HIV begun over 25 years ago. The region holds a cumulative total of 9 million infections in adult population (over half of the global total). It is also in the grip of a devastating disease. By early 1994, according to the WHO

estimate, more than 2 million men, women, and children in the region become ill with AIDS. By the year 2001, the cumulative total of AIDS cases exceeded five million (UNFPA, 2001).

According to the UNFPA (2001), "there are many countries outside Africa, especially in Asia and Eastern Europe, where HIV/AIDS is spreading at an alarming rate. But nowhere yet has AIDS become a threat to economic, social, and political stability on a scale that it now is in Southern and Eastern Africa. In 1999, AIDS killed about 10 times more people in Africa than did armed conflict".

In most sub-Saharan countries, adults and children are acquiring HIV at a higher rate than ever before. As the UN Secretary- General has warned, AIDS in Southern and Eastern Africa is a threat to economic, social, and political stability unparalleled in the world. HIV infection rates have stabilized in Senegal, and Uganda's extremely high rates have been reduced. However, high rates of infection in Africa mean that although the pandemic shows some signs of stabilizing in a number of countries, millions of people will continue to fall ill and die from infections acquired so many years ago. Also, million more new infections are expected as young people become sexually active in countries where a large number of people are already infected.

Such is the frightening situation in Africa. HIV/AIDS is the second leading cause of death due to high rates of poverty, illiteracy, diseases, socio – cultural norms, beliefs and practices. This has led to a situation where more than one tenth of the people aged 15 – 49 are infected with HIV in 16 countries. Invariably, 55 per cent of HIV positive adults in the sub region are young women. Conversely, more

women than men are infected in Africa than any part of the world. Young women than men continue to be infected due to our social setup (NACP, 2002).

Ghana Overview on HIV/AIDS

The first case of HIV and AIDS in Ghana was reported in March 1986 (Anarfi et al, 1993). In that year 42 cases, of which 35 were women and 7 men, were reported. At the onset, 89 per cent of the diagnosed cases were females who had histories of living outside the country, and almost all were involved in commercial sex in their countries of residence (Konotey-Ahulu, 1989). The Eastern Region was the most affected with 26 cases of which 23 were women who were thought to have contacted the infection outside Ghana.

However, the situation has changed since 1992 when the Ashanti Region reported the highest percentage of cases (34%). As at December 1993, the cumulative total number of reported cases was 12,303 with the 20-49 years age group accounting for over 80 per cent of the cases. More than 50 per cent of the reported cases today have no history of travel outside the country. Paediatric cases account for less than 2 per cent, while the ratio of male and female cases was 1:5 in 1986; today it is about 1:2.3 (WHO Ghana Newsletter, 1994 Vol.3 No. 2:3). The estimated number of adults and children living with HIV/AIDS, at the end of 2001 can be seen in Table 13.

Table 13: Ghana HIV/AIDS Estimates, 2001

Group (ages)	Estimates	Rates (%)
Adults and children	360,000	-
Children (0-15)	34,000	-
Women (15-49)	170,000	-
Adults (15-49)	330,000	3.0

Source: UNAIDS/WHO Epidemiological Fact Sheet (2001)

The estimated number of adults and children who died of AIDS during 2001 was 28,000. By 2002 more than 52,961 cases of HIV/AIDS had been reported in the country's health institutions. Women accounted for about 55 per cent of these numbers (NACP, 2002).

Like elsewhere in sub-Saharan Africa, almost 90 per cent of all cases occur in adults of age 20-49. It should also be noted that there is a gender differential in the distribution of the ages at which infection peaks. For females, it is between age 25 and 29 years and for males, 30-34. This implies that on average, females are infected at an earlier age than males. Table 14 shows the AIDS reported cases in Ghana by gender from 1997 to 2001. It is clear that, the rate of infection is higher among females than males. This may be so because many cultures, norms of masculinity encourage men to demonstrate their manhood by taking risks.

Table 14: AIDS Reported Cases by Gender (1997-2001)

Gender	<97	1997	1998	1999	2000	2001	Total
Male	7,135	1,537	2,028	3,136	2,678	1,681	18,195
Female	13,724	2,296	2,826	4,616	3,611	2,176	29,249

Source: UNAIDS/WHO Epidemiological Fact Sheet (2001)

The control and prevention of AIDS has caught the attention of both government and the international community. In 1987, the World Health Organization (WHO) provided technical, financial, and material support for the planning and implementation of a Short Term Plan. In order to combat the rapid spread of HIV, various educational activities have been undertaken by the National AIDS Control Programme, to create awareness about the disease and enhance behavioural change. In order to ensure the effective HIV/AIDS education of the public, specific groups were targeted. They include: policy makers, and politicians, health care workers, youth (in-school and out-of-school), women, teachers, workers, musicians, and artistes, long distance truck drivers and commercial sex workers (WHO Ghana Newsletter, 1994). Some of the methods used in the HIV/AIDS prevention educational campaigns are seminars, workshops, conferences, radio/TV talk shows and interviews, condom commercials, publication of feature articles, production and distribution of educational materials - posters, leaflets, comic books, flash cards, video films, T-shirts (WHO Ghana Newsletter, 1994).

From the analyses, it is possible to summarize that beyond the economic determinants, there are the socio-cultural norms that influence HIV risk taking. These are examined next.

Socio-cultural Values and Ethnicity

Beyond the economic determinant of HIV risk is the much broader and complex framework of sociocultural attitudes, practices, and norms, which shape gender roles. Around the world sociocultural practices and traditions increase people's risk for HIV/AIDS. For the most part, these practices and traditions affect women even more than men.

In many societies women are expected and thought to subordinate their own interest to those of their male partners. With such expectations, women feel powerless to protect themselves against HIV infection. Many women do not dare even to bring up issues such as condoms for protection against HIV infection for fear that they will be physically abused (Varge, 1997). This is due mainly to the status that is given to women in our societies.

Also, the marriage practices in our societies account partly for the HIV pandemic. In many cultures the premium placed on having children often leads to childhood marriage and early childbearing. Girls as young as age 10 are given to older men in marriage in order to cement friendship and economic ties between families. When girls are married to older men, they can be vulnerable to HIV infection because their husbands usually have already had a number of sexual partners. Social, political, and religious barriers often hide young girls from the

world (Zabin & Kiragu, 1998), while their husbands frequently have other sexual partners (Ankrah, 1991).

Polygyny, the practice of a man having multiple sexual wives, occurs in some countries such as Ghana. In Africa when a man seeks a new, often younger wife, he may have had sexual contact with a number of women in the process, thus possibly bringing HIV home (Ainsworth and Over, 1997; Caldwell, et al, 1998). In some cultures wife inheritance is practiced- a tradition in which a wife is given to her brother-in-law upon her husband's death. Thus, either partner can be at risk of HIV infection if the other is infected. Younger widows are at particular risk because they are more likely to seek and be sought by other sex partners (Oppong, 1985).

In some societies payment of bridal dowry is necessary when a man and woman marry. In parts of Africa the man pays the bride price to the woman's family. Once the marriage is sealed with the bride price the woman is considered "paid for" and often cannot leave her husband, should marital problems ensue. Even if her husband's behaviour places her at risk of HIV infection, the woman may not be able to protect herself (Heise, 1988).

Cultural rites of passage from childhood, although traditionally serving to unite communities, can also increase risk for HIV. For example, traditional male and female circumcisions are sometimes carried out using unsterilised equipment. In some communities, circumcision ceremonies are often accompanied by post-initiation sexual experiments, increasing the risk of HIV infection (Talle, 1995). For example, among the Massai of East Africa, the relationship among male peers is so

close that, after circumcision, the initiates are encouraged to share wives and girlfriends (Talle, 1995).

Other practices such as virginity testing of women place so much high premium on chastity that before marriage some women practice anal sex instead, putting themselves at even greater risk for HIV/AIDS than if they had vaginal sex (Stein, 2000). Also, strong cultural norms that emphasise the value of virginity limit young women's ability to seek information on sex. Young women fear that seeking information on sex or condoms will label them as sexually active regardless of the true extent of their sexual activity. To them talking about sexual matters clearly conflicts with the need to preserve the outward appearance of virginity (Mann, et al, 1996). The next section deals with gender, sex and gender roles.

Gender, Sex and Gender Role

The Urwin Hyman Dictionary of Sociology (Jary et al, 1995), defines gender in many perspectives. The common usage of gender is the distinction between males and females to anatomical sex. It is a social division frequently based on, but not necessarily coincidental with anatomical sex. Thus, sociological usage of the term gender can be at odds with the everyday usage.

Sociologists and social psychologists argue that while sex refers to the biological characteristics by which human beings are categorised as 'males', 'females', or in rare instances 'hermaphrodite' (in which the biological characteristics of both sexes are actually or apparently combined). Gender refers to the social and social-psychological attributes by which human beings are categorised

as ‘masculine’ or ‘feminine’ or ‘androgynous’ (in which the social-psychological characteristics of both genders are intentionally or unintentionally combined). Many sociologists stress that within sociological discourse gender should be used when referring to the socially created division of society into those who are masculine and those who are feminine. Whereas ‘male’ and ‘female’ are terms reserved for biological differences between man and woman and boys and girls, ‘masculine’ and ‘feminine’ are reserved for culturally imposed behavioural and temperamental traits deemed socially appropriate to the sexes. These traits are learnt via a complex and continuing process of socialization.

Anthropologists, psychologists and sociologists have stressed that gender is not biologically determined but socially and culturally defined. Gender is seen as culturally and historically relative, (that is, the meaning, interpretation, expression and experience of gender) underlining the fact that gender cannot be equated in any simplistic way with sex or sexuality. Thorne (1982), and Rubin (1975) also noted that sex and gender systems vary historically and cross-culturally, but each system includes at least three interrelated components. These are

- the social construction of gender categories on the basis of biological sex;
- sexual division of labour in which specific tasks are allocated on the basis of sex; and
- the social regulation of sexuality in which particular forms of sexual expression are positively or negatively sanctioned.

Gender refers to the different roles that men and women play in the society, and the relative power they wield. Gender roles vary from one country to another,

but almost everywhere, women face disadvantages relative to men in the social, economic, and political spheres of life. Where men are viewed as the principal decision-makers, women often hold a subordinate position in negotiation about limiting family size, contraceptives, managing family resources, protecting family health or seeking jobs (Ashford, 2001).

Inequalities between men and women are closely linked to women's health making the issue of gender pertinent for discussions on how to improve reproductive health. Gender differences affect women's health and well-being throughout the life cycle (Programme for Appropriate Technology (PATH), 2001). In this vein the following observations were made:

- Before or at birth, parents who prefer boys may put girls at risk of sex-selective abortions (where technology is available to identify the sex) or infanticide.
- Where food is scarce, girls often eat least, and usually less than boys do.
- Girls may be less likely than boys to receive health care when they are ill.
- In some countries, in Africa, including Ghana, girls may be subjected to female genital cutting.
- Adolescent girls may be pressured into having sex at an early age- within an arranged marriage, by adolescent boys proving their virility, or by older men looking for partners not infected with STI's.
- Married and unmarried women may be unable to deny sexual advances or persuade partners to use condom, thereby exposing themselves to the risk of STI's.

- In all societies, women are more likely than men to experience domestic violence. Women may sustain injuries from physical abuse by male partners or family members, and the fear of abuse can make women less willing to resist the demands of their husbands and families (Programme for Appropriate Technology (PATH), 2001).

Gender roles are the expected behaviours, attitudes, obligations, and privileges that a society assigns to sex. These roles show up quite early, in children's play. For instance, boys tend to dominate the aggressive activities in the playground while girls stand around or engage in more passive play, such as playing with dolls or jumping rope (Thorne, 1982). Gender roles are based on a set of gender stereotypes that have been challenged by both social scientists and the women's movements. Gender stereotypes help maintain gender roles by shaping ideas about tasks to which men and women are "naturally" suited (Calhoun, 1997:3). Seeing people in traditional role everyday strengthens our belief that gender roles and stereotypes reinforce each other.

In gender and development circles, women are generally identified as having a triple role- reproduction, productive, and community roles, whilst men are identified as having a dual role, productive and community roles (Moser, 1993). The issue of sexual division of labour, which forms the basis for determining gender roles, derives from the fact that some tasks are allocated solely or exclusively to women and others to men.

All societies, from the most simple to the most advanced, use gender as an organizing principle, dividing the chores and rewards of social life into men and

women's roles. "No aspect of social life - whether the gathering of crops the ritual of religion, the formal dinner party, or the organization of government- is free from the dichotomous thinking that casts the world in categories of 'males' and 'females' (Epstein, 1998:232)". From clothing styles to careers, men and women are expected to be different. While no sociologist believes that there is more cross-cultural consistency in the male and female roles that Mead indicated. Furthermore, in nearly every culture gender roles are structured so that skills and traits that are considered masculine are valued more highly than are those considered feminine (Chafetz, 1984). Eventhough these roles affect an individual, the level of knowledge on HIV and AIDS also contributes to risk taking behaviours.

Knowledge of HIV/AIDS

In order to determine knowledge, attitude, and practices connected with high risk factors pertaining to HIV/AIDS in a rural community, six senior medical students interviewed a random sample of 89 adult males in a rural community in the Dembia district of Ethiopia. About 74.4 per cent reported having heard something about AIDS. Eighty males (89.9 per cent) did not know about condoms. Among the most common sources of information were close friends, health workers, schoolteachers and the radio. The attitude observed was that as many as 60.7 per cent were afraid of getting AIDS but 7.5 per cent had practiced extra - marital sex in the past three months (Ismail et al, 1995). The information suggests that males may see sex as something they need to enjoy regardless of the circumstances of their opposite sex.

In another study Kpaiga et al (1995) interviewed 2,285 women who were at three representative family planning clinics between February 1991 and June 1992 and observed that knowledge of sexual transmission of AIDS was very high but less than half of the respondents (42.5 per cent) mentioned the use of condoms as an AIDS preventive measure. Only 4.6 per cent of the women interviewed were regular users of condoms, while 19.8 per cent were occasional users of condoms. But the 57.5 per cent who had never used a condom reported not using it because *"men did not like them"*. Other reasons given for the lack of condom use were that they *"were using other contraceptive methods"* (28.7 per cent), respondents "*don't like condom"* (5.5 per cent), they "*trusted their partners"* (5.3 per cent), and *"because condoms made sex less enjoyable"* (4.1 per cent). The better-educated and younger men were more likely to use condoms for AIDS prevention, even though the overall number of users was very small. The investigators also found that 14.8 per cent of the women reported having more than one sex partner in the last year. The behaviour was more common among unmarried women living together with their male partners. The fact that the unmarried women living together with their partners had higher condom use compared to the married women suggests that they may perceive themselves at risk since the relationship is unstable, or they may have the power to suggest condom use compared to women in permanent relationship.

In Ghana, results from the Demographic and Health Survey (DHS) of 1998 indicated that over 95 per cent of Ghanaians have heard of HIV/AIDS (Ghana, 1999). Available evidence indicates that over 99 per cent of Ghanaians are aware of HIV/AIDS and how it is transmitted (Ghana, 1999). This is exemplified by the

behavioural change model where Ghanaians have moved from the stage of knowledge to the stage where they have to express the intention to act on the information (Awusabo-Asare, 2001).

Conceptual Framework/ Model

Given the present spread of AIDS, there is a need to examine the extent to which risk of HIV/AIDS issues are reinforced by sociocultural values such as gender. There are many models and theories of human behaviour that can be adopted for this study. These include Preds Behavioural Change Model, AIDS Risk Reduction Model and the Proximate Determinant Model. The various models are described in detail the subsequent pages.

Pred's Behavioural Model

As an economic geographer, Allen Pred (1967) tried to device a model that represents the human being as a culture with imperfect knowledge. In his behavioural matrix a decision making situation is depicted as a function of the quality and quantity of perceived information available in an environmental situation, and of the individual or group's ability to use such information (Figure 2). Each facet of the matrixes is in turn a function of the environmental system, since this governs both the availability of information and the perception of its usability. It must be emphasised that Pred's matrix is intended only as a heuristic device, that is, as something that leads to the discoveries that will replace it.

The following observations may be made about this device:

1. The position of a person on this matrix represents his perceived information, and his ability to use it. This distinction must be made because, while motivation is one of the factors affecting the decision maker's ability to use information, empirical studies have shown that the decision maker's own perception of his decision-influencing motivations either may or may not accord with his actual motivation.

2. The matrix represents one point in time and space.

3. The decision-makers are boundedly rational satisficers - or, in other words, no person could fall into cell Bnn (Perfect knowledge, perfect ability to determine an optimal solution).

4. Each matrix is unique in its degree of information availability and perfection, by virtue of a particular operational milieu.

5. Roughly the lower half of the matrix (especially the lower right- hand corner) corresponds to "adaptive acts", and the upper half to "adoptive acts".

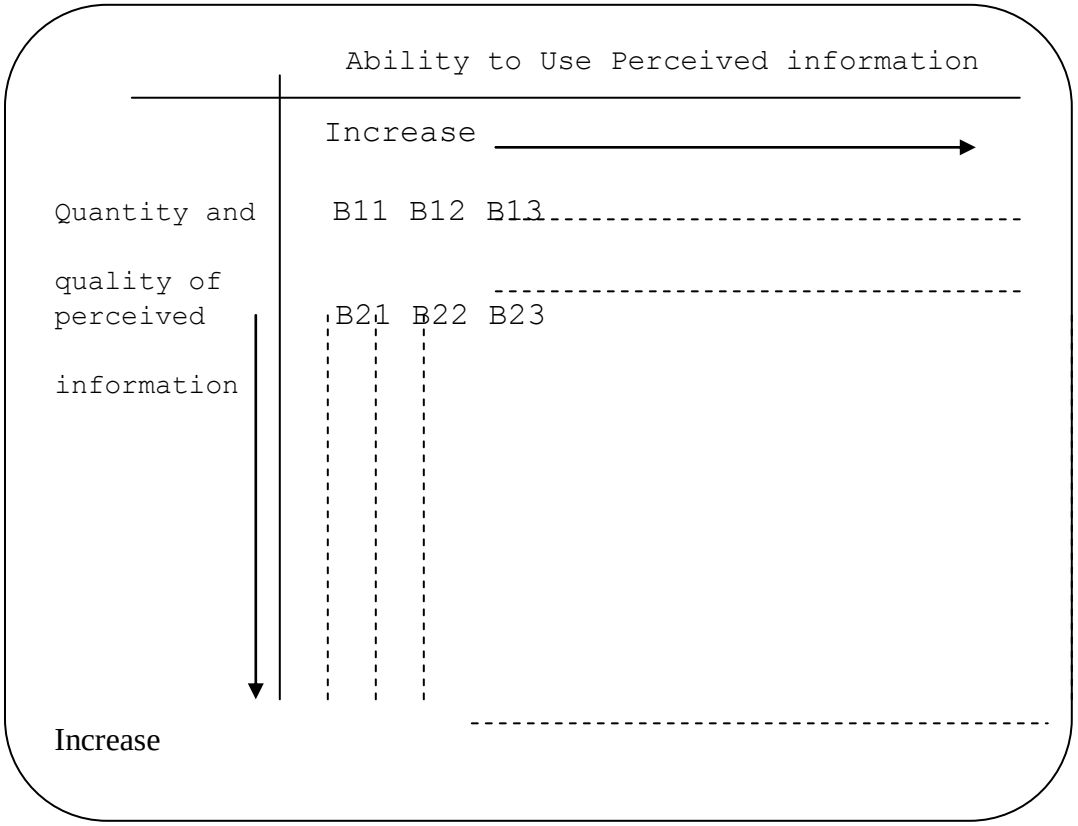

Figure 2: The Behavioural Matrix by Allen Pred

Source: Hurst, M.E.E, 1972.

Pred suggests that each decision should be interpreted in terms of information level. The matrix depicts a decision making situation which is a function of the quality and quantity of perceived information available in an environmental situation and of the individual or group's ability to use such information. Since the environmental system governs both the availability of information and the perception of its usability, each matrix is, therefore, a function of the environmental system. "*Every locational decision is viewed as occurring under conditions of varying information and ability, ranging , at least theoretically, from null to perfect*

knowledge of all alternatives, and as being governed by the varying abilities (as well as objectives) of the decision – maker(s)" (Pred, 1967:24).

The matrix (figure 2) represents one point in space and time. A position towards the bottom right of the matrix (Bnn) represents a good level of knowledge as well as good ability to use it.

B11, B12 represent low level of knowledge as well as low ability to use it;

B1n represent a low level of knowledge as well as good ability to use it; and

Bn1, Bn2 represent good level of knowledge as well as low ability to use it.

Pred's behavioural matrix has its own weaknesses. These are

1. Theoretically, each group or individual should be surrounded by a circular array of information that decreases as distance from the centre increases. But such determinants of social contact as group relationship, kinship ties, or religious affiliation can introduce irregularities into an information flow. Thus the ratio of potential information to actual information will vary from group to group.

2. The aspirations, goals, and values set by a particular culture may reduce or enhance the likelihood that people will respond to a particular stimulus or piece of information. The cultural milieu of a particular group may set very high or very low threshold levels of utility or achievement.

3. The reliability of communication channels may also vary over time and space. This is because almost any decision-making behaviour is likely to take place with incomplete information.

AIDS Risk Reduction Model (ARRM)

The AIDS Risk Reduction Model, introduced in 1990 by Catania, et al, provides a framework for explaining and predicting the behaviour change efforts of individuals specifically in relationship to the sexual transmission of HIV/AIDS. A three-stage model, the ARRM incorporates several variables from other behaviour change theories, including the Health Belief Model, "efficacy" theory, emotional influences, and interpersonal processes. The stages, as well as the hypothesized factors that influence the successful completion of each stage see figure 3 are as follows:

STAGE 1: Recognition and labeling of one's behaviour as high risk

This is where the individual realizes and appreciates the fact that one is at risk due to a person's behaviour.

The hypothesized Influences are given as:

- knowledge of sexual activities associated with HIV transmission;
- believing that one is personally susceptible to contracting HIV;
- believing that having AIDS is undesirable;
- social norms and networking.

The second stage is making a commitment to reduce high-risk sexual contacts and to increase low-risk activities

The hypothesized Influences are given as:

- cost and benefits;
- enjoyment (e.g., will the changes affect my enjoyment of sex?);

- response efficacy (e.g., will the changes successfully reduce my risk of HIV infection?);
- self-efficacy;
- knowledge of the health utility and enjoyability of a sexual practice, as well as social factors (group norms and social support), are believed to influence an individual's cost and benefit and self-efficacy beliefs.

The third stage is taking action. This stage is broken down into three phases:

- information seeking;
- obtaining remedies; and
- enacting solutions.

Depending on the individual, phases may occur concurrently or may be skipped.

The hypothesized Influences are given as:

- social networks and problem-solving choices (self-help, informal and formal help);
- prior experiences with problems and solutions;
- level of self-esteem;
- resource requirements of acquiring help;
- ability to communicate verbally with sexual partner;
- sexual partner's beliefs and behaviours.

In addition to the stages and influences listed above, the authors of the ARRM identified other internal and external factors that may motivate individual movement across stages. For instance, aversive emotional states (e.g., high levels of distress over HIV/AIDS or alcohol and drug use that blunt emotional states) may

facilitate or hinder the labeling of one's behaviours. External motivators, such as public education campaigns, an image of a person dying from AIDS, or informal support groups, may also cause people to examine and potentially change their sexual activities.

To date, ARRM studies in the United States have examined a variety of populations, including people attending HIV testing clinics, gay and bisexual men, unmarried white, black and hispanic heterosexuals, and adolescent females attending family planning centers. (These are unpublished studies conducted by the Center for AIDS Prevention as described in Catania et al., 1990.) Results from a published study revealed how difficult it was for urban and rural women in Zaire to label their behaviour as problematic: only one-third of the study participants felt personally at risk for contracting HIV/AIDS (Bertrand, Brown, Kinzonzi, Mansilu and Djunghu, 1992). Other research has expanded the ARRM to examine the behaviours of injecting drug users, as well as the protective behaviours of women who are already infected with HIV (Malow, et al, 1993; Kline and Van Landingham, 1994).

A general limitation of the ARRM model is its focus on the individual. Secondly, the ARRM does not take into greater consideration the sociocultural issues that influence and limit an individual's behaviour choices and ability to take action.

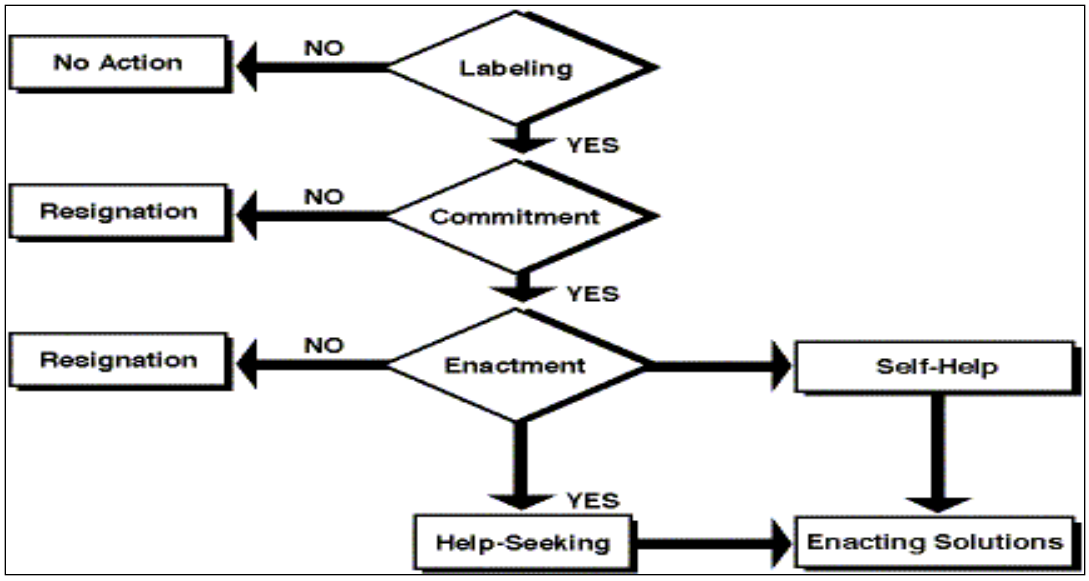

Figure 3: An AIDS Risk Reduction Model (ARRM)

Source: Catania, J.A., Kegeles, S.M., and Coates T.J. (1990).

The Proximate Determinant Model

A proximate determinant is a variable that, when changed in value, is significant to produce a change in the outcome assuming all other conditions remain unchanged (Bongaarts and Porter, 1983:1). In the general proximate framework that looks at fertility, the proximate determinants are the biological, and behavioural factors through which social, economic, psychological, and environmental variables affect fertility. The distinguishing feature of a proximate determinant is its direct influence on fertility.

According to Bongaarts (1978), conceptually, it is possible to identify a set of proximate variables through which sociocultural and economic variables operate to give rise to morbid conditions or death. There are proximal factors, which immediately link up with exposure or non exposure and risk taking or non risk-

taking behaviour, which lead to infection or non infection (Table 15). It is seen from Table 15 that there are contextual issues or factors, linking up to proximal issues to produce an outcome. These issues include the sociocultural, economic, and environmental factors.

The sociocultural factors consist of the arena at home and in the community with its associated norms, practices, beliefs and values, marriage network, network of social obligations and behavioural patterns. Issues such as gender inequality, gender roles, are also considered.

On the other hand, the pattern of socio-economic development in the community some years back and currently has created social inequalities within the communities. Access to high-income occupation and other resources have also been associated with such risk-taking behaviour as multiple partnership and early exposure to sexual intercourse.

Table 15: Proximate Determinants Model

Conceptual Factors	Background	Intermediate/ Proximal	Outcomes	
Socio-cultural	Ambiguities to premarital sex.	Behavioural :	Risk	**I**
Beliefs Practices Norms e.g. Gender roles and inequality	Age-sex interrelationship Circumcision, Initiation ceremonies & others. Decision-making	Multiple partnership- Serial / concurrent.	taking	**N F E**
Economic Pattern of Socio-economic development Inequalities of power.	Enclaves: unequal access to resources. Economic empowerment. Different power relations.	Age at first intercourse. Motives for sex.	behaviour and exposure	**C T I**
Environmental Health care and Nutrition Sanitation	Level of health care and diseases. Presence of opportunistic infection.	Feelings towards sex.	to risk	**O N**

Source: Bongaarts, 1978.

Environmental factors, which include elements of life such as sanitation, diet, and availability of health care. These may contribute to the individual vulnerability to HIV/AIDS infection whereas the background links up with the

contextual issues. These include ambiguity to premarital sex, age-sex interrelationship, decision-making, and circumcision and initiation ceremonies that are linked to the sociocultural issues.

Furthermore, issues on unequal access to resources, different power relations, and economic empowerment are vital in patterning behaviour outcomes.

The contextual issues / factors do not by themselves lead to risk-taking behaviour but rather operate through some proximate factors to either hinder or elevate the level of HIV/AIDS infection. These include genetic, biological, and behavioural factors. The study will consider behavioural factors that include multiple partnership that may be serial or concurrent, age of first intercourse, motives for sex and feeling towards sexual intercourse.

These proximate factors then lead directly to risk-taking behaviour or exposure to risk of infection. The model gives some of the implications of issues for infection, subsequent spread and exposure to risk.

Some of the merits of the proximate determinant model include the following:

1. Identifying the sociocultural, economic, and environmental issues which operate through the proximate factors to either hinder or elevate the level of HIV infection.
2. All factors are as composite.
3. The model is able to show the pathway through which factors such as gender inequalities and poverty lead to risk-taking behaviour and subsequent infection.

One of the weakness of the model that needs highlighting is the fact that it is not able to discuss or show the knowledge level of people.

Considering the three models discussed the Proximate Determinant Framework looks more plausible for the study. This is due to the fact that the merits outweigh the demerit, making it more suitable for the study. The study adapted it to analyse HIV/AIDS and gender among the Krobo and Gurene ethnic groups in Ghana.

CHAPTER THREE

METHODOLOGY

General Overview

This chapter discusses the methods used for the research and justifies their relevance. It presents the sources of data, research instrument, and the sampling procedures. The preliminary survey and finally, the problems encountered in the field are discussed.

Sources of Data

For the purposes of the study, data were collected from both primary and secondary sources. Primary data for the study were obtained through a field survey that involved the administration of questionnaires and organisation of focus group discussions (FGDs) in Bolgatanga in the Upper East region and Agomanya in the Eastern region of Ghana. The respondents were all aged above 14 years.

Secondary data were also obtained from both published and unpublished literature. Also, the Internet and other sources such as the electronic and print media served as useful sources. Other sources were relevant institutions such as the Ghana AIDS Commission and the District administrations of the two study areas.

Research Instrument

Questionnaires and focus group discussions (FGDs) were employed in the study. The questionnaire was made up of close- ended items that were categorised into four modules (Appendix A). Module A was on gender roles and included questions on decision-making in the households, economic empowerment, and job/functions, which are the preserve of males and females. This was to help the researcher know how both men and women are perceived in their communities. Module B dealt with knowledge and perception of HIV/AIDS. Some of the questions asked were the sources of information on HIV and AIDS and the knowledge on the transmission of HIV/AIDS. Also included were the risk perception, its spread, sexual behaviour, and sexual interactions. Socio-cultural issues that affect sex roles and decisions were in Module C. The issues covered included sexual taboos or restrictions, initiation ceremonies, sexual laws, feelings towards sex, and the reasons why people engage in sex before marriage. The final Module (D) was on the personal profile (socio-demographics) of the respondents that is, age, sex, marital status, highest level of education, place of residence and religion.

The focus group discussion guide was divided into two sections, namely the general and the socio-cultural issues. The general issues dealt with the main social, cultural and economic activities for men and women in the community. The socio-cultural issues relating to HIV/AIDS looked at who is considered a man or a woman as well as the taboos and laws restricting both men and women from engaging in certain activities in the community. The respondents were asked to mention some

cultural norms that prohibit sex before marriage and extra marital sex for men and women.

Method of Sampling

The target population was the total population of 154,226 (75,201 males and 79,025 females) for Manya Krobo and 222,778 (111,516 males and 117,268 females) for Bolgatanga (Ghana Statistical Service (GSS), 2000). The units of analysis were men and women aged more than 14 years in the two ethnic areas. The reason for including people below 18 years is because they are part of the most vulnerable and formed the highest proportion of the total population who were at risk of HIV/AIDS infection due to high sexuality (GSS, 1998). A sample size of 300 was purposively selected. The sample size of 300 consisted of 150 respondents each for the two study areas, that is Bolgatanga and Agomanya despite the difference in total population and prevalence rate.

Preliminary Survey

A pretest was conducted on a sample size of 20 respondents. It was carried out between the 3rd and 5th of March 2003 at Agomanya, Manya Krobo. Agomanya was purposively chosen due to the high prevalence rate of the infection among the two areas. After the pre testing some corrections were effected on the questionnaire and all ambiguous questions reworded to set the stage for the actual fieldwork.

Data Collection (Field Work) and Processing

The survey in Agomanya started from the 18th of March 2003 to 25th of March, 2003. At Manya Krobo, four (4) field assistants who were fluent in the local Krobo dialect were recruited to help the researcher administer the questionnaire as well as carry out the focus group discussions. This was mainly due to the fact that the researcher could not speak the local Krobo dialect. The field assistants received a one-day orientation from the researcher on how the questionnaire was to be administered and the focus group discussion (FGD) conducted. From the recognisance survey, it was found that the study area was serving as a destination for most of the victims. It therefore became imperative for the researcher to visit the cluster of towns around Agomanya. Some of the towns surveyed or visited included Atua, Nuaso, Manya Kpong, Abasay (Abanas), Saisi. Odumase Krobo, Aklomuase, and Mampong.

In Bolgatanga, the survey was undertaken between 31st March, and 7th April, 2003. Four field assistants who were fluent in the local dialect, that is the Gurene language, were used for the work. Among the settlements visited outside Bolgatanga were Tanzui, Soe, Zaari, Zorbisi, Doporetindongo, Gambibigo, Yikene, and Yarigabisi.

In both study areas, a respondent was randomly selected on the basis of s/he being a male or female in a household and above the age of 14. Also, the focus group discussion was organised as follows:

14 years – 35 years (youth)	10 males; 10 females;
36 years and above	10 males; 10 females;

An Assemblyman was interviewed.

The questionnaires were screened and edited. There was no case of incomplete questionnaires because the research assistants were well trained to elicit all the necessary information. Also, because the questionnaires were administered to the respondents, they could not evade some of the questions. The data was then coded and analysed using the SPSS software PC version. Proportions and percentages were used to describe the socio- demographic characteristics and other assumptions were addressed using frequencies and cross tabulations. The hypotheses were tested using the Chi square statistical technique.

The data was processed and presented in tables, graphs, and pie charts to provide a pictorial impression of the issue at stake. The response rate was 99.67%, that is 290 out of 300 respondents.

Problems Encountered on the Field

The most debilitating setback to the work was the inability of the researcher to speak and understand the local dialect of the two study areas. The researcher contacted the two District Assemblies for reliable and able people who were fluent and also understood the local dialect in the two study areas. Since in each case the Assemblies were prepared to assist with only one field assistant, other people were contracted to help. This exerted a lot of pressure on the researcher's already scarce and poor financial standing.

Also, the researcher met a degree of hostile reception in some areas, especially Agomanya where some local residents refused flatly to have anything to

do with the study. A case in point was a woman at the District Assembly who queried, "W*ho told you the publication is true? We don't know anything about it so go away".* Another person also said, "*You people are not allowing us to have our peace and privacy, at all".* This they explained was due to the Daily Graphic publication, which had caused the influx of researchers to the town. The researcher had to spare some time to explain issues to the people who were concerned. The researcher at times made some impact thereby making the people have a change of mind but in other cases they still did not budged. In respect to those who refused to respond to the survey questionnaires, other respondents who were of the same sex were sought and interviewed.

Inadequate funds was yet another hindrance to the work. The research team had to contend with continuous demands for money from participants in the exercise. This was more pronounced in the Agomanya area. One old man said "those who have been coming here give us money before we give them information so if you don't have go away". This is not surprising though given the insight provided by the Social Exchange Process Model (Feldman, 1996). People will only be willing to exchange information in anticipation of some reward (mainly money).

The recruitment and training of the research assistants constituted the single most important expenditure item causing a huge financial drain. Daunting as the difficulties were, they did not in any way affect the outcome of the study or the quality of the data collected since the difficulties were not enough to cause a significant change in the trend of the findings.

CHAPTER FOUR

SOCIO-DEMOGRAPHIC CHARACTERISTICS, GENDER ROLES AND PERCEPTION OF RISK AMONG THE KROBOS AND GURENES

Introduction

This chapter deals with the issues from the field concerning the socio – demographic characteristics of the respondents, gender roles - assignment of gender roles, gender roles in decision-making, gender roles in the household, and economic empowerment as well as knowledge and perception of HIV/AIDS and risk taking behaviours.

Socio - Demographic Characteristics of Respondents

This section provides the summary of the socio-demographic characteristics of the respondents. The information in this section has been compiled and presented in the form of tables.

Sex Distribution of Respondents

The survey covered a total of 290 respondents. This comprised 142 males and 148 females representing 49 per cent and 51 per cent respectively.

Age Distribution of Respondents

The age range of the respondents was between 14 and 60 years. The groupings are presented in the bar chart in Table 16.

Table 16: Age Distribution of Respondents

Age Groups	Frequency	Percentage (%)
14 – 19	39	13.4
20 – 29	93	32.1
30 – 39	81	28.0
40 – 49	39	13.4
50 – 59	27	9.3
60+	11	3.8
	290	100.0

Source: Field Work, 2003

It is clear that those aged 20-29 had the highest number of 93 respondents (32%), followed by respondents aged 30-39 (81) represented by 28%. The most dominant age groups were between ages 20 to 39, who coincidentally are the most vulnerable with respect to HIV/AIDS infection.

Marital Status of Respondents

The distribution of respondents by marital status shows that 127, (44 per cent), were married while 121 (42 per cent) were single. The respondents who were

divorced, or separated or widowed represented 18 (6%), 18 (6%), and 6 (2%) respectively, (Table 17).

Table 17: Marital Status of Respondents

Marital Status	Frequency	Percentage (%)
Married	127	44
Single	121	42
Divorced	18	6
Separated	18	6
Widowed	6	2
	290	100.0

Source: Field Work, 2003

Surprisingly, the divorced cases were more for ages 20-49 than other age groups. Two out of 4 were males whilst 10 out of 14 were females. Conversely, more males (14) were separated than females with ages 30-39 recording the highest as compared to the total female respondents of 4. This may be attributed to unfaithfulness on the part of married couples, which was noted by the respondents and poses a threat to the spread of HIV/AIDS.

Educational Background of Respondents

The majority of the respondents about (97) had JSS/MSLC education, followed by secondary (84), Technical/Vocational/Training College (45), and Primary (34). The University/Polytechnic reported 13 (Table 18).

Table 18: Highest Educational Level of Respondents

Education	Cumulative Frequency	Cumulative Percentage (%)
Primary	34	11.7
JSS/MSLC	131	45.1
Secondary	215	74.1
Tech/Voc/Tr. College	260	89.6
University/Poly	273	94.1
Non	290	100.0

Source: Field Work, 2003

At least some 131 (45.1 per cent) of the respondents had had education up to the basic level (primary and JSS/MSLC) whereas 84 (29 per cent) had had secondary education and 58 (20 per cent) had had Technical/Vocational/Training College and University/Polytechnic education. Only 17 (6 per cent) said they had no formal education.

A higher percentage of females 33.8 per cent (78) had basic education as compared to 18.2 per cent (53) for males. The trend was the same with regards to secondary education with 48 (16.6 per cent) out of 148 females compared to 36 (12.4 per cent) out of 142 males having secondary education. It was discovered through cross tabulation that 93 of the respondents are aged 20-29, whilst 30-39 make up 81 of the respondents. This forms more than half of the response rate of the survey. In this vain, HIV/AIDS education must be targeted at people within the ages of less than 20 to 49 since they form three quarters 252 (87 per cent) of the respondents. The 50+ form the minority of 38 (13 per cent) even though significant.

Occupation of Respondents

More than half of the respondents (152) were self employed including seamstressing (21), hairdressing (14), tailoring (2), trading, farming, and painting. The rest were students (48). Civil and public servants (32), and carpentry or painting (20), Drivers (4) constituted the least of the workers (Table 19).

Table 19: Occupation of Respondents

	Frequency			
Occupation	**Males**	**Females**	**Total**	**Percentage (%)**
Seamstress/hairdresser/tailor	2	35	37	12.8
Unemployed	24	26	50	17.2
Trading	16	36	52	17.9
Farming	27	7	34	11.7
Student	25	23	48	16.6
Teaching/formal sector	17	15	32	11.0
Painting/carpentry	13	0	13	4.5
Driving	4	0	4	1.4
Others	14	6	20	6.9
Total	142	148	290	100.0

Source: Field Work, 2003.

Not surprisingly, no female was engaged in painting or driving which are seen as preserves of males. More females were engaged in trading (36) than males (16), whilst more males (27) were engaged in farming as compared to females (7).

The unemployment rates were almost the same for females (26) and males (24). The unemployed were mainly aged less than 39.

There was a form of relationship between one's level of education and occupation. Of the 133 respondents who had had basic education, the main occupation was trading. For those with secondary education, 84 were engaged in all other occupations except painting and driving whilst for those with Technical/Vocational/Training College 45 were engaged in all other occupations like teaching and self employment.

Religion of Respondents

Up to 181 (62.4%) of the respondents were Christians. There was not marked difference between Moslems (55) and other religions like Traditional religion, and Rastafarianism (54). Generally, there was evidence that the two study areas were predominantly Christian (Table 20).

Table 20: Religion of Respondents

Religious Status	Frequency	Percentage (%)
Christians	181	62.4
Moslems	55	18.9
Traditionalist	34	11.7
Rastafarianism	20	7.0
	290	100.0

Source: Field Work, 2003

Gender Roles

Gender roles are the expected behaviours, attitudes, obligations, and privileges that a society assigns to sex. These roles show up quite early, in children's play. For instance, boys tend to dominate the aggressive activities in the playground while girls stand around or engage in more passive play, such as playing with dolls or jumping rope (Thorne, 1982). Gender roles are based on a set of gender stereotypes which help maintain gender roles by shaping ideas about tasks to which men and women are "naturally" suited (Calhoun et al, 1997:3).

In gender and development circles, women are generally identified as having a triple role- reproduction, productive, and community roles, whilst men are identified as having a dual role, productive and community roles (Moser, 1993). The issue of sexual division of labour, which forms the basis for determining gender roles, derives from the fact that some tasks are allocated solely or exclusively to women and others to men.

A variety of factors such as social norms increase the vulnerability of women to HIV. Compounding women's vulnerability is their limited access to economic opportunities and autonomy, and the multiple household and community roles they are saddled with (Walsh, 2001). The assignment of gender roles and gender roles in decision making among the Krobos and the Gurenes will be considered for the analysis.

Assignment of Gender Roles

To be able to analyse gender roles the researcher made use of questions

relating to how gender roles are assigned and who assigns gender roles in the household/community.

Table 21, gives a summary of the responses. It is clear that assignment of gender roles by society is higher in Agomanya (41 per cent) whereas by birth it is higher at Bolgatanga (46 per cent). Out of the assignment of roles by society in the case of Agomanya, 18.6 per cent were males and 22.1 per cent were females. But in contrast to that of Bolgatanga, a total of 21.4 per cent respondents out of which 13.1 per cent were males and 18.3 per cent were females said society assign roles. In contrast, 29.0 per cent of the respondents from Agomanya said roles are assigned by birth out of which were 17.2 per cent males and 11.7 per cent females. Those from Bolgatanga were 45.5 per cent, comprising 22.1 per cent and 23.4 per cent males and females respectively. There were no marked differences in the responses for both Agomanya and Bolgatanga concerning responses on economic roles. Whilst Agomanya had 29.0 per cent, Bolgatanga had 33.1 per cent.

Table 21: Assigning Gender Roles by Status

Gender Roles are assigned by	Agomanya			Bolgatanga		
	Males n=70 %	Females n=75 %	Total n=145 %	Males n=72 %	Females n=73 %	Total n=145 %
Society	18.6	22.1	40.7	13.1	8.3	21.4
Birth	17.3	11.7	29.0	22.1	23.4	45.5
Economic	11.1	17.9	29.0	14.5	18.6	33.1
Others	1.3	0.0	1.3	0.0	0.0	0.0

Source: Fieldwork, 2003.

The aspect of gender roles which deals with who assigns gender roles has been represented through cross tabulation in Table 22.

Table 22: Assigning Gender Roles by Relations

Gender Roles are assigned by	Agomanya			Bolgatanga		
	Males n=70 %	Females n=75 %	Total n=145 %	Males n=72 %	Females n=73 %	Total n=145 %
Father	25.5	31.0	56.5	31.7	35.8	67.6
Mother	6.2	9.7	15.9	5.5	4.1	9.7
Grandfather	10.3	5.5	15.9	11.7	9.0	20.7
Grandmother	2.1	0.0	2.1	0.8	1.4	2.0
Others	4.2	5.5	9.6	0.0	0.0	0.0

Source: Fieldwork, 2003

From the Table 22, more than half of the 290 respondents said men (fathers and Grandpas) assign roles in the household/community. At least some 56.6 per cent and 67.6 per cent of the respondents from Agomanya and Bolgatanga respectively said fathers assign roles as against 15.9 per cent and 20.7 per cent for Grandfathers from Agomanya and Bolgatanga respectively. There is men's dominance in the household/ community since as many as 80.3 per cent of the 290 responses show men's responsibility for assigning roles. Comparatively, 6.2 per cent males as against 9.7 per cent females from Agomanya whilst 5.5 per cent males and 4.1 per cent females from Bolgatanga said mothers assign gender roles. For both study areas 13.8 per cent responded that Grandma and others assign roles.

Gender Roles in Decision Making

Questions were asked to ascertain the influence of gender with regard to decision-making in the household. The respondents were asked questions such as who is included and/or excluded from decision-making. They were to assign reasons for their choices as well. Concerning 'who is included in decision-making and why', the responses were as expected (Table 23).

Table 23: Inclusion in Decision-Making

Decision Making By	Agomanya			Bolgatanga		
	Males n=70 %	Females n=75 %	Total n=145 %	Males n=72 %	Females n=73 %	Total n=74 %
Men	24.8	33.8	58.6	44.8	44.8	89.6
Women	2.8	0.7	3.5	0.0	1.4	1.4
Both	20.7	17.2	37.9	4.8	4.1	9.0

Source: Fieldwork, 2003.

From Table 23, it is clear that 58.6 per cent of the respondents, representing more than half from Agomanya, mentioned that 'men are included' in decision-making as against 37.9 per cent who said 'both men and women are included'. Only 3.5 per cent indicated that 'women are included' in decision-making.

The responses from Bolgatanga also showed that nearly 90 per cent felt 'men are included' in decision-making. Out of this there were 44.8 per cent each for males and females. In contrast, some 10 per cent said decision – making was done in consultation with both males and females.

From the data, it can be inferred that men are more highly recognised as decision-makers in the household/community than women. That recognition was

more pronounced in Bolgatanga than in Agomanya. Some of the reasons assigned for the assertion that men dominate in decision-making were that men are "*breadwinners or heads of the households"* (34 per cent); men "*married and brought women into the home"*, (10.3 per cent), and that generally men are "*perceived to be more important than women"* (10.0 per cent). Other perceptions were the fact that men "*have sharper brains"* (9.7 per cent) and men "*have more power"* than women (9.0 per cent).

The reasons attached to the fact that both are included in decision-making were that "*two heads are better than one"* (11.4 per cent) and that "*it is useful for good/ effective planning and running of the home"*, (5.2 per cent). "*In reality both are the same"* (2.8 per cent) and "*both raise money for the household"* 1.3 per cent were other reasons mentioned.

Also, the researcher asked questions on *'who is excluded in decision-making'* to check the authenticity of the responses in the first situation. The responses are shown in Table 24.

Table 24: Exclusion In Decision-Making:

Decision Making By	Agomanya Males n=70 %	Agomanya Females n=75 %	Agomanya Total n=145 %	Bolgatanga Males n=72 %	Bolgatanga Females n=73 %	Bolgatanga Total n=145 %
Men	3.4	2.8	6.2	1.4	0.7	2.1
Women	35.9	44.1	80.0	46.2	44.1	90.3
None	9.0	4.8	13.8	2.1	5.5	7.6

Source: Fieldwork, 2003.

Economic Empowerment

Writing on Development, Gender and the HIV epidemic, Smith and Cohen (2000), noted that given the critical social and economic roles that women play it is essential that they are empowered, since only through a restructuring of social and economic relationships will it be possible to address the multiple challenges of the HIV epidemic.

The researcher, following on this, wanted to find out how economic empowerment affects both men and women in the two ethnic groups in relation to the spread of HIV and AIDS. To accomplish this two questions were asked, firstly, "*who is economically empowered"*; and secondly, "*who is economically marginalized"*?

From table 25, it is clear that nearly 76 per cent of the total respondents in Agomanya said men are more economically empowered than women in the household. Out of this about 39 per cent and 37.2 per cent were males and females respectively. With respect to Bolgatanga, 77.2 per cent of the respondents said men are economically empowered. Within this there were about 41 per cent males and 36.5 per cent females. Some of the reasons assigned to the responses given were the fact that men are the "*heads of the household"* (45.9 per cent); men are "*breadwinners"* (20.3 per cent); and men "*work harder"* (5.9 per cent) and men have "*more job opportunities"* than women (4.5 per cent).

At Agomanya, 16.5 per cent of the respondents said both sexes are about equally economically empowered (7.6 per cent for males; 9.0 per cent for females). A total of 18 per cent respondents said the same from Bolgatanga. Out of this males

represented 5.5 per cent and females 6.9 per cent. Among the reasons given for this response included the fact that both male and females "*share ideas and help each other"* (7.6 per cent).

Table 25: Economic Empowerment in the Household

Empowered	Agomanya			Bolgatanga		
	Males n=70 %	Females n=75 %	Total n=145 %	Males n=72 %	Females n=73 %	Total n=145 %
Men	38.6	37.2	75.9	40.7	36.5	77.2
Women	2.1	5.5	7.6	3.5	6.9	10.3
Both	7.6	9.0	16.5	5.5	6.9	12.4

Source: Fieldwork, 2003

The researcher in order to verify the authenticity of the responses asked a counter question as to 'who is economically marginalized'. The responses from the field showed that women are more economically marginalized as can be seen in Table 26. In Agomanya 103 respondents, out of which 33.1 per cent were males and 37.9 per cent females, responded that women are more economically marginalized than men. The same applied to Bolgatanga where a total of 88 respondents including 47 males and 41 females also agued that females are more economically marginalized. Some reasons assigned to this assertion were that it is "*not the responsibility of the woman to provide for the household"* (25.2 per cent), "*females are not head of households"* (17.9 per cent); and "*that they are not financially sound"* (17.2 per cent).

Only a few respondents indicated that males are more economically marginalized than females in both Agomanya and Bolgatanga, being 2.8 per cent and

4.8 per cent of the total respondents respectively (Table 26).

Inferring from the framework, the pattern of socioeconomic development, which has background of economic empowerment, may contribute to multiple partnership either serially or concurrently which may elevate the risk of contracting HIV. Since women from the analyses are economically marginalized there is the tendency for them to engage in risk taking behaviour/activities to enable them cater for certain basic necessities of life. This increases the risk of their infection more than the men.

Table 26: Economic Marginalization in the Household

Marginalized	Agomanya			Bolgatanga		
	Males n=70 %	Females n=75 %	Total n=145 %	Males n=72 %	Females n=73 %	Total n=145 %
Men	0.7	2.1	2.8	0.7	4.1	4.8
Women	33.1	37.9	71.0	32.4	28.2	60.7
None	14.5	11.7	26.2	16.6	18.0	34.5

Source: Fieldwork, 2003

Gender Roles in the Household

In gender and development circles, women are generally identified as having a triple role, that is, reproductive, productive, and community roles, whilst men are identified as having a dual role- productive and community roles (Moser, 1993). The issue of the sexual division of labour, which forms the basis for determining gender roles, derives from the fact that some tasks are allocated solely or exclusively to women and others to men. The researcher wanted to find out the functions or jobs that are the preserve of men and women in the two study areas. Table 26 shows

respondents reaction on jobs or functions that are the preserve of males in the two study areas.

Table 27: Functions / Roles Performed by Males in the Household

Functions	Agomanya			Bolgatanga		
	Males n=70 %	Females n=75 %	Total n=145 %	Males n=72 %	Females n=73 %	Total n=145 %
Rc	2.7	5.5	8.2	0.7	2.1	2.7
Wd	22.1	24.8	46.9	22.1	20.7	42.8
Mm	5.5	5.5	11.0	0.7	4.1	4.8
Wu/ck	0.7	0.7	1.4	0.0	0.0	0.0
Rc/wd	0.0	0.7	0.7	0.0	0.7	0.7
Ru/mm	0.7	1.4	2.1	0.0	0.0	0.0
Wu/mm	0.0	0.0	0.0	0.7	0.0	0.7
Wd/wu	0.7	0.7	1.4	0.0	0.0	0.0
Wd/mm	10.3	9.0	19.3	20.0	16.6	36.6
Rc/wd/mm	2.7	3.4	6.2	4.8	6.2	11.0
Rc/wu/mm	0.7	0.0	0.7	0.7	0.0	0.7
Others	2.1	0.0	2.1	0.0	0.0	0.0

Source: Fieldwork, 2003

NOTE:
Rc - Rearing Children only; **Wd - Weeding only;**
Wu or Ck - Washing Utensils or Cooking only; **Mm - Money Making**

From the Table 27, it can be observed that nearly 45 per cent of the 290 respondents saw weeding only as the preserve of males. Out of this, 46.9 per cent were from Agomanya and 42.8 per cent from Bolgatanga. Weeding and money making 37 per cent placed second 19.3 per cent from Agomanya and 36.6 per cent from Bolgatanga. This confirms Moser's assertion that males perform a dual role as people in productive and community work. Other roles such as money making only, rearing children/ weeding/ money making had a few responses in both areas.

As to which roles are the preserve of females it emerged that in both Agomanya and Bolgatanga washing utensils/ cooking only had the highest score

with 32 and 22 per cent respectively. Rearing children and washing utensils or cooking had 14.4 per cent from Agomanya and 29.0 per cent were from Bolgatanga (Table 28).

Table 28: Functions / Roles Performed by Females in the Household

Functions	Agomanya			Bolgatanga		
	Males n=70 %	Females n=75 %	Total n=145 %	Males n=72 %	Females n=73 %	Total n=145 %
Rc	4.1	2.1	6.2	1.4	3.4	4.8
Mm	0.0	6.2	0.7	0.7	0.0	0.7
Wd/mm	0.7	0.0	0.7	0.0	0.0	0.0
Wd/wu	0.0	0.0	0.0	5.5	4.8	10.3
Rc/wd	0.0	0.0	0.0	0.0	0.7	0.7
Rc/mm	0.0	0.0	0.0	0.0	0.7	0.7
Wu/mm	2.8	0.0	2.8	2.1	1.4	3.4
Wu/ck	11.7	20.0	31.7	9.7	12.4	22.1
Rc/wd/wu	3.4	6.2	9.7	2.8	1.4	4.1
Rc/wd/mm	0.0	0.0	0.0	2.1	1.4	3.4
Rc/wu/mm	11.0	14.4	25.5	4.1	1.4	5.5
Rc/wu/ck	8.3	2.1	14.4	15.1	13.8	29.0
Wd/mu/mm	0.0	0.0	0.0	0.0	1.4	1.4
Rc/wd/wu/mm	4.1	0.0	6.2	6.2	7.6	13.8
Others	2.1	0.0	2.1	0.0	0.0	0.0

Source: Fieldwork, 2003

NOTE:
Rc - Rearing Children only; **Wd - Weeding only;**
Wu or Ck - Washing Utensils or Cooking only; **Mm - Money Making**

The responses buttress Moser's (1993) position that females perform a triple role- reproductive, production and community roles.

Knowledge and Perception of HIV/AIDS:

Available evidence indicates that over 98 per cent of Ghanaians are aware of

HIV/AIDS transmission (Ghana, 1999). Also, results from the Demographic and Health Survey of 1998 indicated that over 95 per cent of Ghanaians had heard of HIV/AIDS (Ghana, 1999).

To assess the knowledge level and the perception of the respondents on HIV and AIDS transmission in the two study areas, questions on whether respondents have heard of AIDS or not and how they got to know of the virus were asked. Issues on perception were also covered. For instance, people were asked to react to statements such as whether one could get AIDS by working alongside or in close proximity to someone with AIDS; by having intimate sexual contact with a person of the same sex; through being coughed or sneezed on; receiving blood transfusion; and through insect bite.

Even though the responses showed that all had ever heard of HIV/AIDS the sources of their information varied substantially (Table 29).

Table 29: Source of Information on HIV/AIDS

Variables	Agomanya			Bolgatanga		
	Males n=70 %	Females n=75 %	Total n=145 %	Males n=72 %	Females n=73 %	Total n=145 %
Tv only	9.0	6.2	15.2	6.9	8.3	15.2
Np only	2.8	1.4	4.1	2.8	0.7	3.4
Ch only	0.0	0.7	0.0	0.0	4.1	4.1
Fr only	0.0	2.1	2.1	3.4	2.8	6.2
Fm only	0.7	2.1	2.8	0.0	0.7	0.7
Tv/np	2.1	1.4	3.4	4.1	2.8	6.9
Tv/ch	0.7	2.4	3.4	2.8	4.1	6.9
Tv/fr	1.4	0.7	2.1	4.1	1.4	5.5
Tv/fm	0.0	0.0	0.0	0.7	0.0	0.7
Ch/fm	0.0	0.0	0.0	0.7	0.7	1.4
Fr/fm	0.0	0.0	0.0	0.7	0.7	1.4
Tv/np/ch	2.1	1.4	3.4	1.4	1.4	2.8
Tv/np/fr	1.4	3.4	4.8	1.4	0.7	2.1
Tv/np/fm	0.0	0.7	0.7	0.7	2.1	2.8
Tv/ch/fr	2.1	2.1	4.1	2.8	1.4	4.1
Tv/ch/fm	1.4	0.0	1.4	1.4	0.0	1.4
Tv/fr/fm	2.4	1.4	4.1	5.5	5.5	11.0
Np/fr/fm	0.0	0.7	0.7	0.7	0.0	0.7
Ch/fr/fm	0.0	0.0	0.0	2.1	2.8	4.8
Tv/np/ch/fr	2.1	0.0	2.1	3.4	2.1	5.5
Tv/np/ch/fm	0.7	0.0	0.7	0.7	0.0	0.7
Tv/ch/fr/fm	4.8	6.2	11.0	0.0	0.0	0.0
Tv/np/fr/fm	3.4	3.4	6.9	0.0	0.0	0.0
Tv/np/ch/fr/fm	6.2	13.8	20.0	2.1	6.2	8.3
Others	4.8	2.1	6.9	1.4	2.1	3.4

Source: Fieldwork, 2003

NOTE
TV only - Television only; **Np only - Newspaper only;**
Ch only - Church only; **Fm - Family member only;**

The sources of knowledge were given as television – 15.2 per cent from Agomanya and Bolgatanga respectively. The rest were from newspaper, church, friend and family member. About 11 per cent of the respondents from Agomanya had heard of the virus through the television/ church/friend/family member whilst

more than six per cent of the respondents from Bolgatanga had heard of HIV/AIDS through television/newspaper and television/church.

With the aid of Table 30, a matrix was generated to know the respondent's knowledge levels on HIV/AIDS transmission. The following percentages were used to determine knowledge

80 % and above	High knowledge
60 % - 79 %	Medium Knowledge
Below 60 %	Low Knowledge

Table 30 shows that over 92 per cent of the respondents in both Agomanya and Bolgatanga had indicated that working in close proximity does not expose someone to HIV infection. Less than 7 per cent were not able to respond correctly. From the matrix therefore, there is high knowledge on how HIV is transmitted.

On stimulation of sexual contact, there was also a high level of knowledge. The respondents were able to show that it is a way of getting HIV/AIDS. The range was 86.2 per cent at Bolgatanga and 91.7 per cent at Agomanya.

Concerning blood transfusion as a way of contracting HIV/AIDS, the responses were similar in both areas with 89.7 per cent and 87.6 per cent of the respondents from Agomanya and Bolgatanga respectively indicating that it is another mode of contracting HIV/AIDS. This showed high knowledge level.

With respect to insect bites, 90.3 per cent of the respondent from Agomanya and 80.0 per cent from Bolgatanga thought that it is not a way of getting HIV/AIDS. This continues the high knowledge level in both areas.

Table 30: Knowledge of HIV/AIDS Transmission

Variable	Agomanya n=145 %	Bolgatanga n=145 %
It is	7.6	5.5
It is not	92.4	94.5
It is	91.7	86.2
It is not	8.3	13.8
It is	72.4	84.1
It is not	27.6	15.9
It is	15.2	13.1
It is not	84.8	86.9
It is	89.7	87.6
It is not	10.3	12.4
It is	9.7	20.0
It is not	90.3	80.0

Source: Fieldwork, 2003.

Perception of Risk

The respondents were asked the following questions to ascertain their risk perception in the era of HIV/AIDS.

- Do you think you are at risk of contracting HIV/AIDS in the next one year?
- What was your reaction when you first heard of AIDS?
- Which group of people are mostly at risk of HIV/AIDS infection and why?

Table 31 gives a summary of the responses. Nobody said he/she is already infected even though they had once heard of someone who had the virus. However, even though they were relatives, friends and colleagues they were reluctant to provide details.

Table 31: Perception of Risk of Contracting HIV/AIDS

Response	Agomanya			Bolgatanga		
	Male n=70 %	Female n=75 %	Total n=145 %	Male n=72 %	Female n=73 %	Total n=145 %
Scared	40.0	44.8	84.8	13.8	8.3	22.1
Not scared	3.5	4.8	8.3	26.2	29.7	55.9
Indifferent	4.8	2.1	6.9	9.7	12.3	22.0
Men	10.3	13.8	24.1	20.0	19.3	39.3
Women	22.8	26.2	49.0	20.7	24.8	45.5
Both	15.2	11.7	26.9	9.0	6.2	15.2

Source: Fieldwork, 2003.

On respondents' reaction when they first heard of HIV/AIDS, more than three-quarters of the respondents from Agomanya, 84.8 per cent were scared compared to 22.1 per cent out of 145 respondents from Bolgatanga. Among the Krobo's of Agomanya, the female respondents who were scared on hearing of HIV/AIDS were higher than the male respondents but the reverse was the situation among the Gurenes of Bolgatanga.

Those who were not scared and indifferent were in the minority response group for the Krobo's but in the majority for the Gurene's. This view goes to buttress the *"ALL DIE BE DIE"* phrase used by a sixteen year old sex worker in an article by Awusabo-Asare et al, (1999). A total of 8.3 per cent and 55.9 per cent of the respondents from Agomanya and Bolgatanga respectively were however not scared.

On the issue of which group of people spread HIV/AIDS, the responses are seen in Table 31. In all 94.4 per cent of the respondents said women are at greater risk of HIV/AIDS infection. This represented 49.0 per cent from Agomanya including 38 females as against 45.5 per cent from Bolgatanga including 36 females. Other responses given include nature of the sexual organ, sex for pleasure or

recreation or for financial reasons, belief that men's immune systems are stronger than women and the fact that women do not have control over their decision to have sex or not. This last assertion corroborates Merson's view that 'wherever women are culturally and economically subordinate to men, they cannot control or even negotiate safer sex (Merson 1993).

A total of 31.7 per cent out of the 290 respondents said both men and women spread HIV/AIDS. From the Table 31, 26.9 per cent from Agomanya and 39.3 per cent from Bolgatanga said men are at greater risk than women. The reasons given were that men practice indiscriminate sex and unprotected sex as well as have multiple sexual partners and take decisions on when to have sex. Against this was a contrary view by 22 per cent of the 290 respondents that, *"both are at risk".* The reasons given were that both engage in indiscriminate sex and unfaithfulness and these go a long way to expose them to HIV infection.

Table 32: Risk of Contracting HIV/AIDS in the Next One Year

Study Area	Very Sure n=72 %	Sure n=70 %	Not Sure n=88 %	Will Never n=60 %	Total n=290 %
Agomanya - Males	8.6	9.3	2.1	4.1	24.1
Agomanya –Females	9.7	11.0	1.7	3.4	25.9
Bolgatanga- Males	2.4	1.7	13.1	7.6	24.8
Bolgatanga- Females	4.1	2.1	13.4	5.5	25.2

Source: Fieldwork, 2003.

The Chi-square statistic was used to test the hypothesis that there was no significant difference in the perception of risk among men and women in the two ethnic groups.

The result showed a critical value of 16.92 at 0.05 the calculated score of 105.29. Since the latter was higher, Ho was rejected, implying that there is significant difference in the perception of risk among men and women in the two ethnic groups. In other words, Gurenes and Krobos perceive the causes and effects of HIV/AIDS differently.

Risk Taking Behaviours

To ascertain whether the prevalence rates of HIV and AIDS in the two study areas have influenced sexual behaviour by decreasing the propensity to take risk, the following questions were asked:

- How many sexual partners have you had in the last 6 months?
- In the past 3 months have you had sexual intercourse with a casual partner without using a condom?
- Do you think you are the only sexual partner of your regular sex partner?
- Do you use condoms when you have sex with your regular sex partner?
- Has knowledge in HIV made you more cautious in your sexual life?

Table 33: Risk Taking Behaviours - Use and Non Use of Condom

Response	Agomanya			Bolgatanga		
	Male n=70 %	Female n=75 %	Total n=145 %	Male n=72 %	Female n=73 %	Total n=145 %
Yes	17.9	20.0	37.9	14.5	19.3	33.8
No	28.3	30.3	58.6	32.4	28.9	61.3
Not stated	2.1	1.4	3.5	2.8	2.1	4.9
Yes	33.1	30.3	63.4	33.8	35.9	69.7
No	13.1	20.0	33.1	15.9	14.4	30.3
Not stated	2.1	1.4	3.5	0.0	0.0	0.0

Source: Fieldwork, 2003

Table 33 shows the responses in both areas on whether in the *past 3 months respondents have had sexual intercourse with a casual partner without using a condom*. The responses show that in Agomanya (Krobo) 37.9 per cent including 20.0 per cent females respectively had done so, whilst 33.8 per cent including 19.3 per cent females had done so in Bolgatanga. The majority however said 'No' in both areas.

On the question as to whether respondents had used condom when they had sex with their regular sex partners, a higher percentage said 'Yes" in both areas. Among the Krobos 33.1 per cent males and 30.3 per cent females said they regularly used condom compared to 33.8 per cent and 35.9 per cent of the males and females respectively among the Gurenes.

Also, respondents were to tick either "Yes" or "No" to the question *'Do you think you are the only sexual partner of your regular sex partner'*. From Table 34 it is clear that 26.9 per cent females as against 30.3 per cent males and 41.4 per cent females compared to 33.1 per cent of males among the Krobos and Gurenes of Agomanya and Bolgatanga respectively answered in the affirmative.

Table 33: Risk Taking Behaviours – Sexual Life

Response	Agomanya			Bolgatanga		
	Male n=70 %	Female n=75 %	Total n=145 %	Male n=72 %	Female n=73 %	Total n=145 %
Yes	30.3	26.9	57.2	33.1	41.4	74.5
No	17.3	22.7	40.0	13.1	8.3	21.4
Not stated	0.7	2.1	2.8	3.4	0.7	4.1
Yes	35.2	31.7	66.9	41.4	43.4	84.8
No	13.1	20.0	33.1	8.3	6.9	15.2

Source: Fieldwork, 2003

About 2.8 per cent of Krobos and 4.1 per cent Gurenes, however, did not respond to the question.

Finally, to whether knowledge in HIV had made them more cautious in their sexual life, a total of 66.9 per cent as against 33.1 per cent said 'Yes' and 'No' respectively among the Krobos whereas 84.8 per cent and 15.2 per cent said 'Yes' and 'No' respectively among the Gurenes (Table 35)

Table 35: Sex Behaviour in the Last 6 Months by Sexual Partners

District / Sex	0 n=13 %	1-2 n=244 %	3+ n=33 %	Total n=290 %
Agomanya- Males	0.3	20.7	3.1	24.1
Agomanya -Females	1.4	18.3	6.2	25.9
Bolgatanga- Males	1.0	21.7	2.1	24.8
Bolgatanga- Females	1.7	23.5	0.0	25.2

Source: Fieldwork, 2003.

The Chi-square statistic was used to test the hypothesis that there was no significant difference in risk taking among males and females in the two ethnic groups. The calculated value (25.47) was found to be greater than the critical value

(12.59) at 0.05, and the null hypothesis (Ho) was therefore rejected in favour of the alternative. Since our initial hypothesis was that the presence of HIV and AIDS in a given area might influence sexual behaviour by decreasing the propensity to take risks, the results failed to confirm this, at least, among the Gurenes and Krobos of Bolgatanga and Agomanya respectively.

It was also thought that residents (respondents) of Agomanya (high prevalence HIV Area) might engage in less risk taking behaviour than Bolgatanga (low prevalence HIV area) residents/respondents, but this did not seem to be the case. Thus, the high prevalence in Agomanya may be attributed to the possibility that the inhabitants are high-risk takers than Bolgatanga as can be seen in Table 34.

Summary

Even though both men and women in the two ethnic groups have high knowledge of the transmission of HIV and AIDS, women are at a higher risk of infection by the virus due to gender inequalities in almost all spheres of social endeavours. This is corroborates the conclusion in a document (UNDP, 1997), that until dominant forms of masculinity are challenged, and economic power shifts towards women, HIV and AIDS pandemic is not likely to end.

CHAPTER FIVE

SOCIO-CULTURAL PRACTICES THAT INFORM SEXUAL ROLES AND DECISION-MAKING

Introduction

Beyond the economic determinants of HIV risk is the much broader and complex framework of socio-cultural attitudes, practices, and norms, which shape gender roles. Around the world socio-cultural practices and traditions increase people's risk of HIV infection. For the most part, these practices and traditions affect women even more than men.

In many societies women are expected and thought to subordinate their own interest to those of their male partners. With such expectations, women feel powerless to protect themselves against HIV infection. Many women do not dare even bring up issues or the topic of condoms for protection against HIV infection for fear that they will be physically abused (Varge, 1997).

This chapter, which deals with a comparism of the socio-cultural practices and issues that affect sex roles and decisions in the two ethnic groups, will be divided into two sections. Section A will deal with socio-cultural practices and Section B socio-cultural issues.

Some questions on practices and issues were posed, these included whether:

- sexual taboos/restrictions exist;
- sexual initiation ceremonies exist;
- laws on sexual practice exist;
- sexual relations before marriage are allowed in the two communities; and
- sexual relations outside marriage are permitted in their communities.

Group discussions were also conducted to elicit respondents views on general and socio-cultural issues and these have been used to support the data from the questionnaire.

Socio-Cultural Practices

Some of the socio-cultural practices covered are sexual initiation, sexual relations before marriage, and sexual relation outside marriage. The focus group discussions provided answers to these issues. Generally, Agomanya has a matrilineal type of inheritance whilst the patrilineal types of inheritance exist in Bolgatanga. The main dialect spoken at Agomanya is Krobo whilst Gurene is the dominant dialect in Bolgatanga.

Culturally and linguistically, the Gurene belong to the Mole-Dagbani speaking group. As Fortes, (1943) pointed out, there is a cultural uniformity in the voltaic region of Northern Ghana. The social and economic arrangements, customs, beliefs, and material culture of the people are related. It is therefore difficult to have rigid boundaries between the various ethnic groups. Thus, though the homeland of some Gurene is found in the surrounding district, which was taken as the homeland of the Gurene in this study. This also applies to the Krobos who are culturally and

linguistically part of the Manya and Yilo Krobo land speaking the Krobo dialect.

From the focus group discussions, the two ethnic groups see men and women in almost the same perspective with slight deviations. On the question 'who a man is', both agreed that a man should provide money, food for the home from the farm; he should go to the farm as well as be the head of the home. But among the Krobos in Agomanya a male must be circumcised before he is regarded as a man, which is not the case among the Gurene in Bolgatanga.

A woman in both study areas is a female who sweeps, washes, looks for fuelwood, is fertile (reproduction), and goes to the market. Among the Krobos a woman is a female who has gone through the Dipo rites (puberty rites) successfully which is not so among the Gurenes.

With respect to cultural norms such as sexual initiation, among the Krobos, Dipo is for women and somehow male circumcision is for the men. But among the Gurenes some cultural norms have outlived their usefulness. For instance, tribal marks, which were for identification and differentiation and male circumcision have all been abandoned. One respondent said, "I *have not been circumcised but I have given birth to all these children here"*. In the case of people from Agomanya, the responses showed that 73.1 per cent of men as against 79.3 per cent of women thought sexual initiation ceremonies are appropriate. For the Gurene, the proportions were 72.4 per cent for men and 88.3 per cent for women.

Some of the taboos in the two study areas are summarised in below (Table 36). Among the Krobos in Agomanya some of the taboos include:

Table 36: Taboos Among the Two Ethnic Groups

Agomanya	
Men	Women
Being uncircumcised and engaging in sex	Having sex without performing Dipo rites
Responsibility for pregnancy	Taking over someone's marriage.
Encouraging abortion, sanctions include banishment	Cooking for husband/father during menstruation.
Not taking care of children (a person must be responsible)	Causing abortion
Gurene	
Going after someone's wife or having sexual intercourse with someone's wife	Having sex with any man before marriage
Entering the kitchen	Engaging in extra marital affairs. The consequence is sickness such as bloating of stomach and death
Encouraging abortion	Having two husbands

Source: Fieldwork, 2003

In both study areas the implications were the control of teenage pregnancy and faithfulness in marriage to avoid diseases as well as control of women's sexuality.

Despite these taboos/restrictions, HIV and AIDS are higher among the Krobos in Agomanya than among the Gurenes in Bolgatanga. This may be due to the

serious spiritual connotations attached to these taboos in Bolgatanga deterring the people from engaging in the practices. But this is not the case at Agomanya where the taboos are relaxed allowing people to abuse them with impunity.

It came out during the discussion that the age for the Dipo rites was too low. One female respondent, remarked: *"How can a 12-13 year old girl go through the Dipo and expect her to stay? She will definitely go in for sex since she has been 'licensed' to do it"*

On the question of whether sexual relations before marriage is permissible, the responses were generally in the affirmative in both areas. This can be seen in Table 37.

Table 37: Socio-Cultural Norms that are Practiced (in percentages)

	Agomanya		Bolgatanga	
Response	**Men n=145**	**Women n=145**	**Men n=145**	**Women n=145**
Yes	73.1	79.3	72.4	88.3
No	20.7	15.2	21.4	9.0
Unknown	6.2	5.5	6.2	2.7
Yes	40.6	31.0	20.7	14.5
No	58.0	67.6	77.2	83.4
Unknown	1.4	1.4	2.1	2.1
Yes	21.4	16.5	11.1	6.9
No	77.2	82.1	86.2	91.0
Unknown	1.4	1.4	2.7	2.1

Source: Fieldwork, 2003 ***Multiple Responses**

It is clear from the Table that about 41 per cent of the men and 31.0 per cent of the women from Agomanya agreed that sexual relations before marriage are

allowed. Comparatively, only 21 per cent of men and 15 per cent of women also from Bolgatanga agreed to the statement.

Although relatively lower than the "no" proportion, it is still the case that sex before marriage is more likely to occur among the Krobo of Agomanya than the Gurene of Bolgatanga.

On the question of sexual relations outside marriage, 21.4 per cent of women in Agomanya as against nearly 17 per cent thought it is being practiced. These should be compared with 11 per cent of men and about seven per cent for women in Bolgatanga. Generally, the people believe sexual relation outside marriage is not allowed in both communities, but the proportions were fairly higher for those in Bolgatanga.

From the focus group discussion, there seems to be a strong spiritual connotation attached to taboos in Bolgatanga as compared to that of Agomanya. This makes the people afraid of illicit sex for fear of the consequences that might befall them.

Questions were asked to find out the frequency of sex, age and reasons for sexual intercourse affect gender. This can be seen on Tables 38, 39 and 40.

Table 38: Frequency of Sex Life Among the Two Ethnic Groups

Response	Agomanya			Bolgatanga		
	Male n=70 %	Female n=75 %	Total n=145 %	Male n=72 %	Female n=73 %	Total n=145 %
Daily	8.3	4.1	12.4	3.5	4.8	8.3
Once a week	13.8	11.7	25.5	10.3	8.3	18.6
2-3times a week	18.6	23.5	42.1	23.4	22.1	45.5
1-2times a month	4.8	8.3	13.1	8.3	11.0	19.3
Not stated	2.8	4.1	6.9	4.2	4.1	8.3

Source: Fieldwork, 2003.

From Table 38, about 2.8 per cent of males as against 4.1 per cent females from Agomanya and 4.2 per cent of males as well as 4.1 per cent females from Bolgatanga did not respond to *'how often they have sex'*. Perhaps, they felt it was too personal but this did not affect the analysis since alternate questions were asked. For instance, 8.3 per cent males as against 4.1 per cent females from Agomanya thought sexual contact should be a daily affair whilst 3.5 per cent males and 4.8 per cent female respondents from Bolgatanga felt similarly so.

Conversely, 13.8 per cent and 11.7 per cent males and females respectively from Agomanya said sexual contact was once a week, but a lower proportion of 10.3 per cent males and 8.3 per cent females responded as such in Bolgatanga. The response peaked at 2-3 times a week where 18.6 per cent males and 23.5 per cent females from Agomanya and 23.4 per cent males and 22.1 per cent females said it should be so. About 4.8 per cent versus 8.3 per cent males and females from Agomanya said sexual contact was 1-2 times a month, whilst 8.3 per cent males against 11.0 per cent females from Bolgatanga also said the same. This shows that there is frequent sexual contact in both study areas judging from the fact that it peaked at 2-3 times a week and once a week. This might increase their risk of HIV

and AIDS.

Table 39: Sexuality: Practice

Response	Agomanya			Bolgatanga		
	Male n=70 %	Female n=75 %	Total n=145 %	Male n=72 %	Female n=73 %	Total n=145 %
15-19	28.3	28.3	56.6	39.3	32.4	71.7
20+	4.1	10.3	14.4	2.8	5.5	8.3
Not yet	0.0	0.7	0.7	0.0	0.0	0.0
11-14	13.8	15.9	29.7	15.9	9.0	24.9
15-19	27.6	33.0	60.6	24.8	24.1	48.9
20+	6.9	2.8	9.7	9.0	17.2	26.2
For money	5.5	26.2	31.7	2.7	20.7	23.4
Friends do it	17.2	14.5	31.7	26.9	18.6	45.5
For pleasure	19.3	6.2	25.5	14.5	4.8	19.3
No reason	2.1	1.3	3.4	2.8	2.0	4.8
Want a child	2.8	2.8	5.6	1.4	2.8	4.2
Not stated	1.4	0.7	2.1	1.4	1.4	2.8

Source: Fieldwork, 2003.

Helitzer-Allen and Makhambera (1993) noted that "a girl is not supposed to have sex before menstruation or before initiation, according to social norms", yet seven of every 10 girls had sex before one of these occurred. The average age of first intercourse is 13.6 years (Table 39). On the question as to the "age the respondent become sexually active" there were divergent views. About 15.9 per cent of males and to 12.4 per cent of females from Agomanya compared to 7.6 per cent of the males and 12.4 per cent of females from Bolgatanga had become sexually active by ages 11 – 14. This gives a mean age of 12.5.

At ages 15-19, 28.3 per cent males and 28.3 per cent of females had become sexually active at Agomanya whereas in Bolgatanga 39.3 percent males and 32.4 per cent females reported on the same issue. Less than one per cent of the females at

Agomanya and none in Bolgatanga had not yet become sexually active at age 20 or more.

There was a drastic difference between the ideal and reality. This was because an alternative question ‘’what age do your people generally begin to be sexually active” shows discrepancies as can be seen from the Table 39. This may be due to personalisation of the question or that respondents felt shy to delve into such issues. The responses showed that nearly 13.8 per cent and 15.9 per cent of the males and females respectively at Agomanya generally become sexually active at ages 11-14 compared to about 15.9 per cent of males and to 9.0 per cent of females in Bolgatanga. In other words, six out of every 10 girls at Agomanya and about three out of every 10 girls in Bolgatanga become sexually active at a mean age of 12.5. The result at Agomanya reinforces the assertion by Helitzer-Allen and Makhambera (1993), that early sex may have accounted for the high HIV and AIDS prevalence rates in the area compared to Bolgatanga. Another issue expressed during the focus group discussion was that due to early age of Dipo at Agomanya, girls engage in sexual intercourse earlier than boys. But in Bolgatanga due to fear of death and diseases, males rather engage in early sexuality than females.

Anarfi (1990) noted that "Ghana provides an example of a country in which first the majority of HIV diagnosed cases were female migrants returning from neighbouring African countries who were believed to be involved in sex trade". On "what drives people to having sex before marriage", the responses showed that majority of the females from both study areas engage in sex before marriage for money. Indeed, some 26.2 and 20.7 per cent of the respondents in Agomanya and

Bolgatanga respectively said females engage in sex for money. For them sex was for survival. This is against 5.5 and 2.7 per cent of the males in the two areas – Agomanya and Bolgatanga respectively. This shows that the tendency for females to engage in sex for money may be because they are marginalized economically and yet have to take care of the home and keep it going. To address the HIV/AIDS issue, therefore, women must be empowered economically (Smith and Cohen, 2000).

For most males in both areas they engage in sex because friends do it and for pleasure. Among the Krobos 17.2 per cent males as against 14.5 per cent females compared to 26.9 per cent males and 18.6 per cent females among the Gurenes engage in sex because friends do it. Similarly, 19.3 per cent versus 6.2 per cent males and females respectively among the Krobos compared to 14.5 and 4.8 per cent males and females respectively among the Gurenes all said pleasure drives them into having sex before marriage.

It also emerged that more females engage in sex before marriage because they want a child, although the proportions here are relatively lower than those doing it for pleasure and money.

From the Proximate Determinant Model, conceptual factors such as gender inequalities, through some background to ambiguity to premarital sex, sex-age-sex interrelationship goes through certain intermediate factors like age at first intercourse, motives for sex and frequency of sex can affect risk taking behaviour as well as exposure to risk leading to infection. From the analysis, the motives for sex are varied for both women and men. Whilst most women engage in sex for survival, men do so for pleasure and as part of peer pressure. Among the Krobo's there is an

earlier age of sex experience than among the Gurenes, making the former a high-risk area. In all the cases women are the most affected.

Finally, on sexual interaction and reproductive decision-making the responses showed that men initiate, dominate and control. This was so for the ethnic groups. This confirms the earlier analysis of decision-making in the household. From Table 40, for example, 60.0 per cent as against 76.6 per cent among the Krobos and Gurenes said men initiate sexual interaction and decision-making whilst 22.8 per cent versus 12.4 per cent among the Krobos and Gurenes said women take charge of these decisions. On who dominates, 46.2 per cent among the Krobos said men, whilst 47.6 per cent among the Gurenes also declared for men.

Table 40: Decision-Making in Relation to Sexuality

Response	Agomanya			Bolgatanga		
	Male n=70 %	Female n=75 %	Total n=145 %	Male n=72 %	Female n=73 %	Total n=145 %
Men	33.1	26.9	60.0	37.3	39.3	76.6
Women	9.0	13.8	22.8	5.5	6.9	12.4
Both	6.2	11.0	17.2	6.9	4.1	11.0
Men	24.2	22.0	46.2	24.8	22.8	47.6
Women	17.2	20.7	37.9	22.8	20.0	42.8
Both	6.9	9.0	15.9	2.1	7.5	9.6
Men	15.9	18.6	34.5	12.4	11.7	24.1
Women	22.1	26.9	48.9	29.7	24.1	53.8
Both	10.3	6.2	16.6	7.6	14.5	22.1

Source: Fieldwork, 2003.

Socio-Cultural Issues

Some of the socio-cultural issues covered in the study include taboos/restrictions and sexual laws. From both the questionnaire and the group

discussions it became clear that the youth were abreast with the socio-cultural issues in their respective areas. Table 41 shows some of the socio-cultural issues that emerged.

Table 41: Issues Relating to Socio-Cultural Norms (in percentages)

Response	Agomanya		Bolgatanga	
	Men n=145	Women n=145	Men n=145	Women n=145
Yes	55.2	70.4	78.6	87.6
No	38.6	24.1	16.6	7.6
Unknown	6.2	5.5	4.8	4.8
Yes	48.3	69.7	79.3	89.7
No	43.4	22.7	14.5	8.2
Unknown	8.3	7.6	6.2	2.1

Source: Fieldwork, 2003. ***Multiple Responses**

As to whether sexual taboos/restrictions exist in their areas, 55.2 per cent of the females and 70.4 per cent of males from the Krobos answered in the affirmative. This should be compared to 78.6 and 87.6 per cent of the males and females respectively among the Gurenes.

Some respondents said they did not know about sexual taboos /restrictions, but these were in the minority with only 6.2 per cent men and 5.5 per cent women among the Krobos in Agomanya and 4.8 per cent each for both men and women among the Gurenes in Bolgatanga.

With respect to the existence of sexual laws, the trend was almost the same as for the taboos/restrictions. The most striking feature is, however, the high (43.4 per cent). 'No' response rate for men among the Krobos. This may give rise to men giving high credence to their masculinity, which will let them engage in extra marital

sexual activities. This puts women at a higher risk despite the laws they have to follow or adhere to since they do not have control over their sexuality.

Summary

Generally, the Gurene ethnic group in Bolgatanga appear to attach greater value to their cultural practices than the Krobo ethnic group even though the Krobo seem to have more socio-cultural practices for both men and women. This can be attributed to the fact that among the Gurene ethnic group there are effective spiritual implications to these practices than among the Krobos.

Also, the Gurene experienced a late penetration of western culture which affected education than the Krobos. This has given a leeway to speculate that the high prevalence rate of HIV and AIDS among the Krobos in Agomanya has some socio – cultural underpinnings.

CHAPTER SIX

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Introduction

The purpose of this study was to explore gender roles among the Krobo and Gurene ethnic groups that have implications for HIV and AIDS infection. This is because the two ethnic groups have different prevalence rates of HIV/AIDS, which generally affect growth, and development of the various areas (Agomanya and Bolgatanga). The study was therefore specifically aimed at

- Assessing gender roles among the two groups that have implications for HIV and AIDS;
- Identifying some of the socio-cultural practices of the two ethnic groups which inform their sexual roles and decision-making; and
- Assessing the implications of these roles for HIV and AIDS

Bongaarts Proximate Determinant model guided the study. Data from the fields of study was collected by random sampling of males and females above 14 years and by focus group discussion to achieve the stated objectives of the study. A sample of 300 respondents was targeted but the response rate of 290 was attained. This was made up of 145 respondents constituting males and females from the two areas. In analysing the data, both descriptive and quantitative statistics were

employed. The Chi-square statistic was used to test the stated hypotheses.

Summary of Findings

Advocating the reduction of sexual partners as a prevention strategy is irrelevant to the lives of many women who have no sexual partner other than their husbands or regular partners. Where women have multiple partners, this is often a choice forced on them by economic necessity. For as long as this situation and the socioeconomic system that gives women few choices for economic interdependence remain, women will not be able to abandon this strategy. The study has revealed that contrary to the assertion that "all are at risk" of HIV and AIDS infection, women are at a higher risk than men. This is so because of the fact that women are marginalised economically and in decision-making. This has been proven by other studies that it is essential for women to be empowered, since only through a restructuring of social and economic relationships will it be possible to address the multiple challenges of the HIV epidemic.

Women engage in sex before marriage due to economic hardships, that is the 'survival theory'. Also, they engage in sexual intercourse at an early age of between 11-16 years (mean 15 years) due to the same reasons. This rightly fits into the proposition that unfavourable socioeconomic conditions literally push people to get involved in sex for financial rewards and survival.

It was seen that even though people had perfect knowledge of the presence or have heard of HIV through one or more modes of information and, as well have high knowledge of the mode of transmission, the virus continues to spread in intensity

more especially among the Krobos in Agomanya. This was seen to be mainly due to relaxed cultural norms. Also, in the two areas unemployment rates are high making the people, more especially the females, to look for other means of surviving.

The study as well explored the possible linkage between gender roles and HIV and AIDS. Where women are assigned a triple role- reproductive, productive, and community without being part of decision – making at the household level and men a dual role - production and community it has made women generally submissive to the whims and caprices of men no matter the cost or consequences. The implication of this is the high-risk exposure to HIV.

It was also found that people know the identity of AIDS victims but were not ready to own them up due to the element of stigmatization. This goes a long way to hinder ways of finding effective and lasting solution to the virus infection rates in the two areas.

The high rates of illiteracy, unemployment and single marital status have contributed to the spread of the disease in the areas under study.

There were also strict socio-cultural norms, practices, and beliefs among the two groups but these were stronger among the Gurene than Krobos. This is due to the strong and effective spiritual connotation attached to them by the Gurenes.

Conclusions

The main objective was to assess gender roles among the two ethnic groups in Ghana, Krobo and Gurene that have implications for HIV/AIDS. The two ethnic groups were chosen because Agomanya which is linguistically Krobo dominated and

Bolgatanga which is also linguistically Gurene dominated have the highest and lowest prevalence rates respectively of HIV and AIDS in Ghana.

The study was rationalised on the premises that gender has implications on HIV and AIDS, which also has inbuilt socio-cultural implications. The main findings of the study are that:

- The main reason for women engaging in sex before marriage was mainly economic, whilst men engaged in pre – marital sex for pleasure;
- There are differences in the risk taking behaviour (motives) among men and women;
- Women are mostly marginalised in both decision-making and economic empowerment making them more vulnerable to HIV infection;
- Women's triple roles – reproduction, production and community impose a bigger burden on them than men's dual roles - production and community;
- Both men and women have heard of HIV and AIDS through more than one source and they know someone who has or has had AIDS. Also they have high knowledge of how the virus is transmitted;
- Also, both men and women in the two study areas have good knowledge of the socio-cultural practices that affect sex roles and decisions in their respective areas;
- Socio-cultural norms/practices are more effective tools among the Gurenes than the Krobos in curbing certain situations, for instance, engaging in pre - marital sex;
- The presence of reverse causation when AIDS is in the community does not

by itself reduce sexual risk taking behaviour. Therefore, for one to assume or presume that people will change their behaviour when there is a high prevalence of AIDS and/or know someone with AIDS is wrong; and

- Generally, people of Agomanya become sexually active at an earlier age than people from Bolgatanga.

Recommendations

It was found that women in the two ethnic groups (Krobo and Gurene) have been marginalised in many, if not all aspects of social life. Even though the level of education of the respondents in the two study areas was low, that of women leaves much to be desired. Because of this, girl child sensitization programmes must be spread across the whole length and breadth of the country. Most respondents see the women in a different context / perspective. For instance, they saw a woman to be always fond of performing domestic chores. It is in this vein that the two District Assemblies - Manya Krobo (Agomanya) and Bolgatanga must team up with other Non - Governmental Organizations (NGOs), religious and traditional leaders to embark on a programme aimed at sensitising more especially men in both communities on the need for female education.

Women were found to contribute immensely to the domestic upkeep but were neglected when it came to decision-making in the household and community. To some of the respondents, women do not form an integral part of the household/ family. This must be changed to enable women to be part of the household/family and as well have access to productive assets and property. This will go a long way to

improve women's economic position at home and, therefore, reduce their overdependence on their men counterparts.

To attempt to understand economic and social change without incorporating an explicit gender analysis is an exercise of futility. It is therefore imperative to note that two basic things are important in understanding the interaction of gender, development and the HIV epidemic. That

- it is impossible to make any coherent analysis and assessment of the factors driving the HIV epidemic unless it is founded on gender analysis of socially, culturally and economic determinant roles; and
- Given the critical social and economic roles that women play it is essential that they are empowered, since only through a restructuring of social and economic relationships will it be possible to address the multiple challenges of the HIV epidemic.

Community- based education must be organised in the two Districts by their respective District Assemblies in collaboration with religious and traditional leaders to educate men especially to appreciate the value of women as co-pilots in development. Individual families and societies must change how they value women. The more women are valued, the better they will be fed and nurtured, given access to health services and education, provided with the skills required for economic autonomy and have their rights honoured in particular to land and property, especially through inheritance. This can help reduce the situation where men almost always impose everything on women. In this light, women must be included always in decision-making in both the household and the community in both areas. This is

even more serious when it comes to the fact that women cannot even negotiate for safer sex. The programme must also target the youth and educate them the more on how and the relevance for them to postpone pre marital sexual activities.

Our cultural heritage must not be seen as a fetish since there is some good in them which when tapped or harnessed will help achieve the common good of curbing the HIV pandemic in the societies. By this religious and traditional leaders must team up or collaborate to modify these socio-cultural practices and norms. This is because over 80 per cent of the responses from the two areas show that the area is predominantly a Christian community. This is because even though Dipo is practiced in the Krobo land, for instance, the prevalence rate of the virus is still high since may be the Christians see it as fetish. Modification to the practices can be made so as to bring out the very good motives such as preventing early pregnancies and being faithful in marriage. This will help resolve the conflict between religion and culture as well as culture and laws.

In designing advocacy tools to change behaviour and promote reproductive health and protect human development, it is absolutely necessary to understand the cultural, social, economic, and political as well as biological and demographic factors shaping gender roles and sexual behaviour. This is because gender is formed in females but constructed by societies. To change accepted patterns of male's behaviour and expected patterns of female behaviour, therefore, requires community organisation and collective action.

Unequal development in the country must also be bridged. This will go a long to curb the incidence of HIV and AIDS in the two Districts. Cottage or small-

scale industries must be set up and agriculture productivity encouraged serving as employment avenues for the people in both areas. This aspect of economic deprivation and marginalisation is a contributory factor to the rate of infection in both areas. These are one of the backgrounds through which proximal factors act to bring about risk or exposure to risk.

The concept of stigmatization must be critically accessed since people were not ready to disclose the identity of AIDS victims. They were only prepared to mention their relation but not owing the up fellow.

Advertisements and education on HIV and AIDS must be culture centred and gender based to help address the menace. There is the need for preventive messages that stress religious and moral values and abstinence might be successful and should continue to target the youth, thereby reinforcing their decision not to get sexually active.

The following areas can be considered for further research.

- Socio-cultural practices and their implications on HIV/AIDS: The case of Dipo among the Krobos;
- Bolgatanga, a border town but not a high risk HIV infection.
- The role of traditional and religious leaders in the era of HIV/AIDS.
- Combating HIV/AIDS, the perspective of religion and culture.

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APPENDICES

APPENDIX A

This questionnaire seeks to gather information on HIV/AIDS and gender: A case study of the Krobo's and Gurene ethnic groups in Ghana. The study is purely for academic purpose and respondents are assured of the respect and confidentiality they deserve.

Justice O.D. Fenteng

Module A: Gender Roles

Please tick where appropriate.

1. Who is included in the decision-making in your household?

a) Men b) Women c) Both

Give reason for your choice…….

……..

2. Who is usually excluded from decision-making in your household?

a) Men b) Women c) None

Give reason for your choice…….

……..

3. Who is economically empowered in this community?

a) Men b) Women c) Both

Give reason(s) for your choice……

……

4. Who is economically marginalized in this community?

a) Men b) Women c) None

Give reason(s) for your choice ……

……..

5a. How are gender roles assigned?

a) Social b) Biological c) Economical d) others (specify)…

5b. Who assigns gender roles?

a) Father b) Mother c) Grandpa d) Grandma e) Others (specify)……

6) What jobs/functions are the preserves of males? (Tick those that apply)

a) Rearing children b) Weeding c) Washing of utensils/ Cooking

d) Making money e) Others (specify)…….

7. What jobs/functions are the preserve of females? (Tick those that apply)

a) Rearing children b) Weeding c) Washing of utensils/ Cooking

d) Making money e) others (specify)…

8. Do any of the groups have a say in the roles that assigned to them?

a) Yes b) No

Give reason(s) for your choice……

……

Module B: Knowledge and Perception of HIV/AIDS

Please tick where appropriate.

9. Have you ever heard of HIV/AIDS? A) Yes b) No (If NO go to 11)

10. How did you get to know of HIV/AIDS? (Pls. Tick those that apply)

a) TV/Radio b) Newspaper c) Church/Mosque

d) Friend e) Family member f) others (specify)

11. Do you think you are at risk of contracting HIV/AIDS in the next one year?

a) Very sure b) Sure c) Not sure

d) Will never catch HIV/AIDS e) Already infected

12. Do you know of anybody who has/has had AIDS? a) Yes b) No (If No go to Q14)

13. If Yes (to 12) what is/was the relationship with that person?

a) Relative b) Friend c) Colleague d) Spouse

e) Sexual relation f) No relation

14. What was your reaction when you first heard of AIDS?

a) Scared b) Not scared, just any death c) Indifferent

15. Has your knowledge of HIV/AIDS made you more cautious in your sexual life?

a) Yes b) No

16a.Which group of people do you think spread HIV/AIDS?

a) Men b) Women c) Both

16b. Give reason for your answer to 16a.

……

……

17a. In a relationship most men are not faithful (i.e. have other partners)

a) Agree b) Disagree c) Don't know.

17b. Give reasons for your answer to 17a.

……

……

18a. In a relationship most women are not faithful (i.e. have other partners)

a) Agree b) Disagree c) Don't know.

18b. Give reasons for your answer to 18a.

……

……

19a. Which groups of people are mostly at risk of HIV/AIDS infection?

a) Men b) Women c) Both

19b. Give reasons for your answer to 19a.

……

……

20a. Fear of HIV/AIDS has greatly changed the sexual behaviour of males in this area.

a) Agree b) Disagree c) Don't know

20b. Fear of HIV/AIDS has greatly changed the sexual behaviour of females in this area.

a) Agree b) Disagree c) Don't know

Tick to show how people contract AIDS from someone who has it

VARIABLES	Is a way to get AIDS	Is Not
21. Working alongside or in close proximity to someone with AIDS?		
22. Stimulate sexual contact with a person of the opposite sex?		
23. Intimate sexual contact with a person of the same sex.		
24. Being coughed or sneezed on		
25. Receiving blood transfusion		
26. Insect bite		

27. Who initiates sexual interactions and reproductive decision-making?

a) Men [ ] b) Women [ ] c) Both [ ]

28. Who dominates sexual interactions and reproductive decision-making?

a) Men [ ] b) Women [ ] c) Both [ ]

29. Who controls sexual interactions and reproductive decision-making?

a) Men [ ] b) Women [ ] c) Both [ ]

Module C: Sociocultural issues that Affect Sex Roles and Decisions.

Please tick where appropriate.

	MEN		WOMEN		UNKNOWN	
	Yes	No	Yes	No	Men	Women
30. Do sexual taboos/restriction exist?						
31. Do sexual initiation ceremonies exist?						
32. Do sexual laws exist?						
33. Is sexual relations before marriage allowed in your community?						
34. Is sexual relations outside marriage allowed in your community?						

35. How often do you have sex?

a) Hourly b) Daily c) Weekly

d) Monthly e) None f) Others (specify)……..

36. What are your feelings towards sex?

a) For recreation/ pleasure b) For Reproduction c) For sharing love

d) None e) Others (specify)……

37. At what age did you become sexually active?

a) Less than 10 [ ] b) 11-14 [ ] c) 15 - 19 [ ]

d) 20+ [ ] e) Not yet

38. At what age do your people generally begin to be sexually active?

a) Less than 10 [ ] b) 11-14 [ ] c) 15 - 19 [ ]

d) 20+ [ ] e) Not yet [ ]

39. What drives people to start having sex before marriage?

a) Financial difficulties b) Peer pressure

c) Norms/practices d) others (specify)……

Module D: Personal Profile

Please tick where appropriate.

40. Age

a) Less than 20 [ ] b) 20-29 [ ] c) 30 -39 [ ]

d) 40-49 [ ] e) 50-59 [ ] f) 60+ [ ]

41. Sex a) Male [ ] b) Female [ ]

42. Marital status

a) Married [ ] b) Single [ ] c) Divorced [ ]

d) Separated [ ] f) Widowed [ ]

43. Highest level of education

a) Primary [ ] b) JSS/MSLC [ ] c) Secondary [ ]

d) Technical/Vocational/Training College [ ] e) University/Polytechnic [ ] f) Others

44. Occupation (specify)……..

45. Place of residence……..

46. Religion

a) Christian [ ] b) Moslem [ ] c) Others (specify)…….

APPENDIX B

GROUP DISCUSSION GUIDE

A. General Issues

1. What do you consider to be the main social, cultural, and economic activities for men and women in this community? (PROBE)

2. Has there been any changes in these activities in the last ten or so years?

3. If YES (let them discuss and give reasons)

B. HIV/AIDS (Socio-cultural issues)

4. Who is considered a man or woman? Discuss.

5. What are the taboos restricting men /women from doing certain activities in your locality? Why?

6. What are the laws restricting men /women from doing certain activities in your locality? Why?

7. Mention some cultural norms that prohibit sex before marriage and extra marital sex for men and women. Discuss?

8. What are the reasons or motives for these restrictions/prohibitions? Discuss.

9. Do these cultural norms have implication on HIV/AIDS?

If YES or NO (let them discuss).