GETTING TO THE HEART OF THE MATTER: AN ASSESSMENT OF SEXUAL EXPERIENCES, KNOWLEDGE AND ATTITUDES OF STUDENTS ON STI AND HIV/AIDS IN SOME COMMUNITIES OF NORTHERN GHANA.

A. O. Agu, P. Apoya, B. Konlan and A. B. T. Zacharia*

Abstract

This study through a participatory action research tried to understand the sexual experiences of children, adolescents and youths (10-24 years) of some communities in the northern part of Ghana. It also examined some of the social and cultural practices that could be influencing sexual practices and promoting the spread of sexually transmitted infections (STI) and HIV/AIDS. Bawku district, which has one of the highest HIV/AIDS prevalence in the country was studied. The study found that school children engage in sexual activity and understand the causes of STI and HIV/AIDS. About 20 percent of the respondents (251) have ever had sex before. Most of those who have had sex are within the 15-19 year age group. A good proportion has contracted various forms of STIs such as herpes, syphilis, and gonorrhoea, with some of the infections lasting up to one year. Only about 40 percent who got infected sought care from health facilities and some others went to traditional healers. While pre-existing deep-seated social practices play some roles in the promotion of STI and HIV/AIDS, unprotected sexual experiences by children seem to be the immediate cause.

Introduction

This study looks at the sexual experiences, knowledge and attitudes of children, adolescents and youths (10-24 years) from some communities in northern Ghana on sexually transmitted infections (STI) and HIV/AIDS. It also examines some local practices that could be impacting on STI and HIV/AIDS transmission.

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Sexual transmission of HIV-1 continues unabated throughout Africa, Asia and Eastern Europe. Increasing evidence demonstrates a substantial link between the epidemics of sexually transmitted HIV-1 and other sexually transmitted diseases, especially the herpes simplex virus (HSV)-2 infection (Corey, Wald, Celum, and Qinn 2004; Ahmed, Mbwana, and Gunnarsson 2003; Korenromp, Bakker, de Vlas, 2002; Kamali, Nunn and Mulder 1999).

In Ghana, routine data available to the Ministry of Health indicates that STIs represent a significant cause of morbidity, especially among women (MOH 2000). Research on sexual networking in some selected areas of Ghana found that despite the stigma attached to sexually transmitted diseases, 21 percent of the respondents (360) reported that they had ever contracted a sexually transmitted disease (Anarti and Awusabo-Asare 1993). In the same study, about 46 and 34 percent of the males and 8 and 4 percent of females in the rural and urban areas respectively had reportedly contracted a sexually transmitted disease.

The critical nature of STI is increasingly being compounded by its link to HIV/AIDS. A person infected with an STI is between two to five times more likely to contract HIV if exposed to the disease (Wasserheit 1992). This link was confirmed in Mwanza, Tanzania where a community randomization trial of strengthened syndromic management of STD was associated with a 42 percent reduction in HIV incidence over a two-year period (Grosskurth, Gray, and Hayes, 2000). While the HIV prevalence in Ghana stood at 3.1 percent, the rate for the Bawku Municipality was 3.6 percent in 2004 (GHS 2005). School-based AIDS education activities for children, adolescents and youths have been singled out as priority areas for national response. The experiences of persons between 10-24 years are influenced by particular geographical, historical, political and social factors (Aggleton 1991). In the same way, sexual behaviour is socially constituted, and the meanings of and values ascribed to sexual expression differ according to context (Standing 1992). If HIV and AIDS prevention promotion is to be effective, it must be based on a sound and holistic understanding of adolescents' sexual experiences and sexual health needs within their specific context. This understanding needs to go into the hidden (never talked of) social practices (sexual and non-sexual) that are likely to facilitate STI, including HIV/AIDS infection. This requires getting to the heart of the matter through participatory action research.

In Ghana and elsewhere in Africa, some traditional and cultural practices are not only outmoded but constitute an impediment to these countries' development efforts. Such practices are also hazardous to the health of the people. According to the UNAIDS (2000), some of the cultural and traditional practices that increase the
individual's vulnerability to contracting HIV/AIDS include:

(i) mandatory wife inheritance;
(ii) "cleansing" of virgins on reaching puberty through having forced sex with disguised males;
(iii) the minority status of women under customary laws and unequal educational opportunities for girl-child;
(iv) the practice of female genital mutilation (FGM).

These and other traditional and cultural practices put the people in most parts of Africa at a high risk of HIV/AIDS infection. Our argument is that, for HIV/AIDS education strategies to be effective, they should address and mitigate the social practices that tend to facilitate the spread of the virus.

The main objectives of this inquiry are to:

(i) understand the sexual experiences of children, adolescents and youths (10-24 years) of some communities in Ghana;
(ii) and also assess the socio-cultural practices, knowledge and rule behaviours among the people that impact on HIV/AIDS transmission.

Method

The study is a participatory action research on and with community members in the Bawku East District of the Upper East Region of Ghana. The choice of the Bawku Municipality was not only informed by the high HIV prevalence rates of 3.6 percent; 3.8 percent; 3.2 percent; and 3.6 percent recorded in 2001, 2002, 2003, 2004 respectively (GHS 2005), but also by the fact that it is inhabited by a variety of ethnic groups who settle along well-defined ethnic and religious lines. The major ethnic groups are the Kusasis, Mamprusis, Bimobas, Busangas and Mossi. Others, in significant numbers, include Akans, Frafras and Dagombas. The people predominantly engage in agriculture and trading. A significant part of the trading involves crossing the borders to neighbouring countries such as Burkina Faso and Togo. The items traded in include textiles, electrical goods, food crops, animals, and cola nuts.

Four sources used for the data collection were:

(i) interviews with staff of the Bawku District Ghana Education Service (GES), including Heads of Schools;
(ii) Focus Group Discussion (FGD) with teachers, school children, and community members;
(iii) interviews through the use of structured questionnaire on teachers and students of Senior and Junior Secondary Schools;
(iv) and review of relevant books, journals and brochures, and
from relevant school reports. The survey instrument was administered to 317 students and 25 teachers of 12 Junior Secondary Schools in three zones of Bawku, Pusiga and Garu. Six focus group discussions - three each for men and women - were held in six communities with two from each of the three zones.

The research was conducted in ways that respected the dignity of the participants. One is that it was very participatory and participants were assured of confidentiality. We have ensured that the names of the participants are not used and the schools studied would also not be made public. Furthermore, the initial results of the study were shared with the district and some of the participants. The results and lessons from the study are now currently being used to develop a community based school HIV/AIDS programme.

Sexual Experiences, Knowledge and Practices on STI and HIV/AIDS.

Sexual Experiences of Students
All students consider copulation involving the penetration of the male organ into that of the female as sex. However, 70 percent of students do not consider oral sex as sex and over 90 percent do not consider kissing and masturbation as sex. In their opinion, safe sex is non-penetration (77.5 percent), use of condoms (45.6 percent) and maintaining one sexual partner (55 percent). Half of the respondents (50.8 percent) said they knew of their colleagues who engage in sex. Overall, 20 percent out of the 251 persons who responded to the questions have ever had sex before; 10.8 percent have had sex once in their life whilst 9.2 percent have had sex more than once.

Senior Secondary School (SSS) students lead in sexual experience (56 percent), compared to only 11 percent of the Junior Secondary School (JSS) students who indicated they ever had sex. Of the SSS-students who have experienced sex, 20 percent have had it only once, and the rest had sex twice or more. An important finding is that for both the Junior and Senior Secondary Schools, most of those who have had sex are within the 15-19 year age bracket, though 6.1% of children between 0-14 have had one sexual experience and 1 percent of them have had sex twice. This finding is consistent with the general view that most young people go in for sex as a form of "experiment" during the latter period of adolescence, and just before they become adults.

On the whole, the finding that 56 percent have ever engaged in sex in the SSS is a source of concern, though some of them indicated they practiced safe sex through the use of condoms. Among boys, 22.1 percent have had one sexual experience, and 9.7 percent have experienced sex more than once, whilst 15.8 percent of girls have ever
TABLE I
Sexual Experience among Students by Sex

<table>
<thead>
<tr>
<th>Sex</th>
<th>Frequency</th>
<th>None</th>
<th>Once</th>
<th>More than Once</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>145</td>
<td>77.9</td>
<td>12.4</td>
<td>9.7</td>
</tr>
<tr>
<td>Female</td>
<td>133</td>
<td>84.2</td>
<td>7.5</td>
<td>8.3</td>
</tr>
<tr>
<td>Total</td>
<td>278</td>
<td>80.9</td>
<td>10.1</td>
<td>9.0</td>
</tr>
</tbody>
</table>

Source: Field Survey, June 2002

had sex, with only 8.3 percent having had sex more than once as illustrated in Table I.

The number of times students have had sex according to class has also been increasing from the lower to the upper classes. The frequency ranged from 7.8 percent for year one to 15 percent for year three with respect to those who have had sex once. The pattern is the same for those who have had sex more than once. This implies that students in basic and second cycle schools are sexually active; hence ensuring that they practice it safely must be of a top priority. Others (80 percent) have never engaged in sex and this is a strength that needs to be exploited to protect this group from contracting STIs. (See Table 2). An effective school based HIV/AIDS strategies should be addressing these two groups.

The proportion of school children that engage in sex was found also to be increasing. The frequency for students who have had sex only once ranged from 6.1 percent (10-14 years) to 23.5 percent (20-24 years). A high proportion of students do not perceive kissing and oral sex as sex. Expressed in another form, 77.7 percent of students consider all non-penetrative forms of sexual practices as not being sex. These opinions constitute a risk, as they represent misconceptions that can mislead students into such acts that do in fact transmit infection. More worrying is the observation that only 57.1 percent of the group studied mentioned the use of condom as a form of safe sex, whilst 42.2 percent perceived safe sex to be maintaining one faithful partner.

Generally, 15.8 percent of respondents currently have sexual partners. The mean and median ages of students with sexual partners are 17.4 and 18 years respectively, whilst the minimum and maximum ages are 12 and 22 years respectively. More male students (16.1 percent) than females (15.4 percent) have sexual partners.
TABLE 2
Sexual Experiences of Students by Class

<table>
<thead>
<tr>
<th>Class</th>
<th>Frequency</th>
<th>None</th>
<th>Once</th>
<th>More than Once</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year One</td>
<td>102.0</td>
<td>85.3</td>
<td>7.8</td>
<td>6.9</td>
</tr>
<tr>
<td>Year Two</td>
<td>115.0</td>
<td>80.0</td>
<td>9.6</td>
<td>10.4</td>
</tr>
<tr>
<td>Year Three</td>
<td>60.0</td>
<td>75.0</td>
<td>15.0</td>
<td>10.0</td>
</tr>
<tr>
<td>Total</td>
<td>277.0</td>
<td>80.9</td>
<td>10.1</td>
<td>9.0</td>
</tr>
</tbody>
</table>

Source: Field Survey, June 2002

Students in upper classes were more likely to have partners than those in lower classes. Nearly half (46.2 percent) of the students who engage in sex, practice it among themselves, representing the highest group of sexual partners. These are likely to be driven by peer pressure and the desire to experiment with sex. A substantial proportion of students' sexual partners come from the community (40 percent) whilst others are represented only in marginal proportions, including teachers (6.2 percent), visitors (5.6 percent) and, very strangely, their own brothers (6.2 percent). This finding underscores an approach that builds on children, teachers and the community to control the spread of HIV/AIDS.

Sexually Transmitted Infections (STIs)

Knowledge about sexually transmitted infections (STIs) was measured in terms of technical definition, knowledge of specific examples of STIs, and effects and prevention of STIs. Out of 192 students, 76.6 percent provided correct and accurate definition of a sexually transmitted infection (STI) and a high knowledge of specific examples, effects of STIs and how to prevent them. However, as high as 24.4 percent could not define an STI accurately, though they had general understanding of what STI meant. Examples of STIs cited by students included: Gonorrhea (75.8 percent); HIV/AIDS (77.9 percent); Syphilis (49.8 percent); Herpes (34.0 percent); Candiditis (20.3 percent). Some of the students (7.3 percent) have experienced some STIs within the past 12 months. Death, infertility, sores around sexual organs, and loss of weight were some of the effects that students identified with STIs.

Adequate knowledge about STIs varied according to class of student, sexual experience, age, sex, parental status and whom they currently stay with, as shown in Table 3. Knowledge among the various classes on STI was fairly good, even though, in most cases, this has not translated into behavioural...
practices as the high knowledge levels among different groups also go with increasing STI infection. This has implications for HIV/AIDS control in schools.

A much lower proportion of students who currently have sexual partners had adequate knowledge about STIs (59 percent) as compared to those who currently have none (77.4 percent). Significant variations in knowledge about STIs are observed among students in different age groups. Students within the 25+ years age group, all of whom are in the Senior Secondary School, exhibited the highest understanding and knowledge about STIs (100 percent), followed by those in the 10-14 years age-group (77.8 percent), and the 15-19 years age-group (76.2 percent). The low rate observed within the 20-24 years group (46.2 percent) is a source of concern. Knowledge about STIs among males (76.8 percent) and females (74.1 percent) differ only slightly.

Students currently staying with their brothers or sisters recorded the lowest levels of knowledge about STIs, whilst those staying with other relatives exhibited the highest levels of understanding. Knowledge trends do not appear to be related to the proportion of guardians who discuss HIV/AIDS issues with their children. Discussions on HIV/AIDS issues were observed to be highest among children who stay with only their mothers (86 percent), followed by those who stay with both parents (85.3 percent). Children with whom HIV/AIDS were least discussed with them were those who stay with only their fathers (58.8 percent) and other relatives.

Prevalence of STIs among school children was assessed based on symptoms that children had experienced during the past 12 months preceding this survey. The prevalence rates were determined based strictly on symptoms and not laboratory screening. The results thus, to a large extent, are dependent upon the extent of symptoms that students experienced, and in turn, on how truly and accurately students are able to relate the symptoms to a specific STI. An average of 7.8

<table>
<thead>
<tr>
<th>Class</th>
<th>Knowledge on STIs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
</tr>
<tr>
<td>Form one</td>
<td>68</td>
</tr>
<tr>
<td>Form two</td>
<td>93</td>
</tr>
<tr>
<td>Form three</td>
<td>40</td>
</tr>
<tr>
<td>Total</td>
<td>203</td>
</tr>
</tbody>
</table>

Source: Field Survey, June 2002
percent of the sample population had experienced an STI during the past 12 months, 16.4 percent have ever contracted an STI, and 17.3 percent knew at least one student who was harboring an infection.

Prevalence levels also varied according to sex, age, class, school, parental status and person that students currently stay with. In most cases, infection trends did not correspond with knowledge trends, though in general a relationship is observed between knowledge levels and infection rates. As indicated in Table 4, the prevalence rates were higher for males at 9.6 percent than females at 6.8 percent. The age group 20-24 years was found to have higher prevalence rate (14.3 percent) than the 10-14 years group (4.9 percent) as shown in Figure 1. Furthermore, the prevalence rate for form three was higher (14.5 percent) than form one group (3.7 percent).

The specific STIs contracted by respondents were herpes (16.0 percent), syphilis (11.1 percent) gonorrhea (6.7 percent), candiditis (2.7 percent). A total of 10.3 percent had contracted these diseases more than one year prior to this survey, 66.7 percent contracted the disease a year to this survey, whilst 24.1 percent contracted the disease in the survey year. All infections lasted different durations, some lasting up to one year (21.4 percent), up to two months (10.7 percent,) or more than two months (17 percent), whilst 25 percent lasted two weeks and 17.9 percent lasted one week. Only 40% of students who got an infection sought care from either a health facility (17.4 percent) or a drugs store (15.8 percent) and 21.4 percent sought care from traditional healers.

Infection levels are highest among single-parent children and orphans. One out of 10 children with only father or mother alive has ever experienced an STI, whilst 9.1 percent of orphans have ever experienced STIs. In general, orphans were found to be 1.7 times more likely to contract STI than non-

<table>
<thead>
<tr>
<th>Sex</th>
<th>STI Infection</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td></td>
<td>146</td>
<td>9.6</td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td>146</td>
<td>6.8</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>292</td>
<td>8.2</td>
</tr>
</tbody>
</table>

Source: Field Survey, June 2002
Figure 1

STI Infection Among School Children in Bawku East District, by Age.

<table>
<thead>
<tr>
<th>Age</th>
<th>STI Infection</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
</tr>
<tr>
<td>10-14 years</td>
<td>103</td>
</tr>
<tr>
<td>15-19 years</td>
<td>171</td>
</tr>
<tr>
<td>20-24 years</td>
<td>14</td>
</tr>
<tr>
<td>25+ years</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>292</td>
</tr>
</tbody>
</table>

Source: Field Survey June 2002

It is worth noting that even though knowledge about STIs was high, especially among children with only father alive, the effect of single parenthood resulting in the lack of adequate control/care for these children might have contributed to the high rates of STI infection observed in these groups. STI infection was more prevalent among the males than the females. This finding, however, is a divergence from the anticipated trend of STI infection, as females are believed to be more vulnerable. This
situation, however, can be attributed to the fact that a higher proportion of boys had multiple partners than girls. Also, males recognize symptoms of most STIs more easily than females; therefore it is possible that some girls may be harbouring infections without knowing that they are indeed infected. This could be one of the underlying causes of high infection rate of HIV/AIDS of females than males giving credence to the untreated STI hypothesis. The comparatively lower levels of STI awareness among females than males may compound this.

The highest proportion was recorded within the 20-24-age cohort where 15.3 percent of them said they had been infected, followed by the 15-19 years age group (9.9 percent) and the “window of hope” (10-14 years) age group (5.9 percent). An observation of the trend as indicated in Figure 1 reveals an increasing infection rate from the “window of hope” (10-14 years) upwards. It is therefore significant to note that, the “window of hope” is threatened by STIs, which could increase their exposure to the HIV virus.

The pattern of STI infection according to class of students also shows an increasing trend from the lower to the upper classes. From 4.1 percent in form one, it increased to 9.4 percent in form two to 14.5 percent in form three.

Knowledge on HIV/AIDS
97.3 percent of students in the study area have ever heard about HIV/AIDS. They had a good knowledge of the mode of transmission. Most students knew that HIV/AIDS could be transmitted through sex (89 percent), blood transfusion (77.7 percent), sharing of sharp objects with infected persons (60.7 percent) and from mother-to-child (57 percent). Some demonstrated a fairly good knowledge on safe sexual methods. They mentioned abstinence from sex (75.6 percent), use of condoms (56.5 percent) and avoidance of sharp objects (45.5 percent), as the main methods of avoiding HIV/AIDS.

The students seem to know the symptoms of HIV/AIDS. They mentioned:

(i) consistent and long bouts of diarrhoea (87.3 percent);
(ii) consistent weight loss (81.2 percent);
(iii) persistent bouts of cough (70.5 percent);
(iv) loss of appetite (59.6 percent);
(v) shingles (55.1 percent) and;
(vi) other symptoms (26.1 percent).

They knew that there is currently no cure for the disease. To emphasize the absence of a cure for this disease, one participant remarked: “there is a cure for AIDS, and that cure is “pick-axe and shovel”, actually referring to the act of using these tools for burial.

Most students indicated that HIV/AIDS patients could not be easily identified. Only 14.7 percent of the participants claimed that they could identify an HIV/AIDS victim just by looking at the person. They explained that when a person has full-blown
AIDS, it might be possible to know this, but not when the person has HIV. But with full-blown AIDS, about 37.7 percent of respondents were of the view that a victim could be identified without laboratory testing.

One positive finding is that most students (92.2 percent) were aware that a person would not necessarily contract HIV/AIDS if he/she lives in the same house or vicinity with a victim. They knew that HIV/AIDS is not spread through physical contact such as touching, hugging and shaking hands. They also mentioned that eating from the same plate or bowl and drinking from the same cup with an infected person does not put a person at risk. Despite this knowledge, 25.2 percent of Senior Secondary School and 50.6 percent of Junior Secondary School students do not feel free interacting...
with victims. In terms of gender, 40.6 percent of males and 52.9 percent of females would not interact freely with infected persons for various reasons bordering on fear of infection. On this, there is a dichotomy between espoused knowledge and action/behaviour. Overcoming this is one obvious challenge.

Radio was found to be the major source through which 56.5 percent of the respondents obtained information on HIV/AIDS. Other sources mentioned include: television (37.5 percent), teachers (17.4 percent), newspapers (12.3 percent), parents (10.7 percent), leaflets (9.5 percent), friends (6.6 percent), and other sources (5.4 percent) as those from which they received information most on HIV/AIDS.

Majority of the students (96.5 percent) claimed to have received information on HIV/AIDS in schools. Teachers delivered most of such information (71.9 percent), whilst 34.3 percent received information from persons outside the school and 16.1 percent from friends in school. Other sources include leaflets, brochures and handouts (17.4 percent). In 74.2 percent of cases, talks on HIV/AIDS are often organized for them in the school. Those who gave talks on HIV/AIDS in the schools were teachers (35.2 percent), doctors (12.6 percent), students from the University (6 percent), health personnel (2.8 percent), anti-AIDS clubs (6 percent) and past students (1.9 percent). An important issue from the data is that teachers (34.2 percent), more than any other group, gave the talks to the students in the schools. This shows that the potential role of teachers is now being practicalized. Most of the active teachers were found to have, themselves, received information on HIV/AIDS through workshops and seminars offered by NGOs and other agencies.

Posters, brochures and handbooks were found not to be used as expected. Only 10 percent of the students were aware of any posters on HIV/AIDS in their schools. Of this 10 percent, 39.8 percent and 25.9 percent indicated that there was only one type and two types respectively of posters in their schools. Messages carried by posters, as students understood, were mostly on abstinence, use of condoms, and the avoidance of sexual promiscuity. Posters carried read as follows: “AIDS is a killer”, “AIDS has no cure”, “AIDS is real”, and “Avoid infection from quack doctors”.

An important finding is the fact that 85.5 percent of the respondents discussed issues of HIV/AIDS with their colleagues. The discussions cover a wide range of issues including practice of safe sex (27.4 percent), effects of the disease, (40.1 percent), treatment (9.8 percent), and counseling and testing (15.8 percent). This reinforces the potential of peer education or child to child preventive interventions.
Underlying Economic and Social Practices Promoting Transmission

Economic
The key issue is poverty. Poverty is a major problem in most parts of Northern Ghana. It is estimated by the Ghana Living Standards Survey that over 80 percent of the people of northern Ghana are poor (GSS 2000). In the Bawku East District, pressure on land, poor soils and unfavourable weather conditions (particularly scanty and unreliable rainfall), reduces the household income of the predominantly agricultural population of the rural areas. The poverty situation, with the associated ills - ignorance, diseases, illiteracy etc. - makes the people more vulnerable to contracting HIV/AIDS. Lack of information and lack of skills and education render the youth more prone to behaviours and economic survival instincts that may include migration, petty trading, smuggling and casual sex for the sake of money and survival.

One of the key societal legacies of poverty in Africa is the existence of undiagnosed and untreated sexually transmitted diseases among many Africans (Poku 2002). It is estimated that Africa has the highest incidence of curable STDs at 284 cases per 1,000 people aged 15-49 years, compared to the second highest of 160 cases per 1,000 people in South and South-East Asia (UNAIDS 2000). It is being increasingly recognized that the public health implications of curable STI (especially those causing genital ulcers), when present could facilitate the transmission of HIV (Corey et al 2004; Ahmed et al 2003; Korenromp et al 2002). The point is that the presence of an untreated STI can enhance both the acquisition and transmission of HIV tremendously.

The issue of untreated STD could be relevant for communities in Bawku. A good proportion of school children have ever contracted one type of STI such as herpes (16.0 percent), syphilis (11.1 percent), gonorrhea (6.7 percent) as found by the study. What is important to note is that some of the infections (21.4 percent) have lasted up to one year and that only 40 percent of students who got an infection sought care from either a health facility or drug store and about 21.4 percent sought care from traditional healers. The extent to which these students have been fully treated needs to be investigated.

Aside from STDs, there are many other ways in which poverty exposes the poor to a higher risk of contracting HIV/AIDS. There is the perennial issue of population mobility in search of work. There is a high rate of migration among the youth in the Bawku Municipality. This migration stems from the absence of employment opportunities in the area during the dry season. The seasonal nature of farming, with several months of dry season, forces the youth to move to other areas for short periods (often six months) and for long periods lasting for several years. Both in and out-migration put the people in situations that facilitate casual sex, and consequently, the prevalence rate of HIV/AIDS in the
district. A substantial proportion of people are engaged in businesses, including smuggling, that would most often call for several days of travelling outside the district to other parts of the country (long-distance trading), thus exposing these traders and their partners to casual sex with other partners. For these groups (in motion), being mobile is not the risk factor for HIV/AIDS, it is the situations they encounter and the behaviours in which they may engage while they are traveling around that lead to and increase vulnerability to HIV/AIDS.

**Socio-Cultural Practices**

The point that ‘the microbe is nothing, the terrain is everything’ (Jakab, 2000) has great credence. The environment in which any infection is transmitted is strongly influenced by the prevailing socio-cultural practices. That is to say, pre-existing deep-seated social practices play a key role in people’s susceptibility to any disease. In the Bawku District, as in many African societies, these include: female genital mutilation; male circumcision; sacrificial or tribal marks; gender issues and mandatory wife inheritance; funerals, polygamy and some sexual practices.

The practice of female genital mutilation (FGM) is probably making it difficult to combat and control HIV/AIDS in the district. This needs to be investigated further. The practice is carried out seasonally, usually in groups of several girls at a time. In most cases, one razor is used on more than one girl without sterilization. Mostly the Kusasis, Busangas, Frafra and Bimobas practice FGM. Public outcry and legislation against FGM in Ghana appears to have forced the practice of FGM underground. FGM continues to be widely practiced among the ethnic groups concerned. This is, however, often done secretly. This complicates the risk further as all opportunities to educate the 'Wanzams' (traditional healers) on hygiene methods are lost. It is also done across the borders of Burkina Faso and Togo to avoid the rigours of the law in Ghana. It is not known to what extent governments of neighbouring Togo and Burkina Faso have taken steps to curtail the practice in their countries, but focus group discussion participants were of the view that FGM is still practiced freely in these areas. Thus people in the Bawku East district frequently walked a few kilometres across the border to practice it openly.

Another practice that also needs to be investigated is male circumcision. All ethnic groups in the study area practice male circumcision except the Kusasi, Bimoba and the Frafra. Most of the literature suggests that uncircumcised males are at a higher risk of contracting HIV/AIDS than circumcised males (UNAIDS 2000). Apparently, uncircumcised males are more likely to get chancroid, a sexually transmitted infection characterized by soft sores on the genitals, thus an elevated risk of contracting HIV/AIDS. Notwithstanding this, the risk of circumcised males contracting HIV/AIDS is higher during the time of circumcision if it is not done safely. It is
only an estimated 25 percent of circumcisions that are done by medical personnel or in health facilities among all the ethnic groups who practice it (Mamprusi, Busanga, Dagomba and Moshie). The rest are executed by local “wanzams”, who do not maintain adequate hygiene standards, thus increasing the risk of cross infection with bloodstained razors.

The giving of tribal marks is also a factor. As a matter of tradition in Ghana, most ethnic groups give tribal marks on the faces or bodies of children in a fashion unique to each ethnic group. More commonly and importantly, incisions are made on the body or face of children in a belief that they would be protected from evil spirits, witches and certain diseases, such as convulsion. In some instances, children within the same vicinity can be grouped and scarified one after the other with the same instrument, thus the possibility of contaminating one person with another’s blood is very high. Even though the practice of tribal marking is slowly dying out, scarification still persists prominently among all ethnic groups in the area.

A number of other sexual practices prevail among the various groups in the district and beyond. Herbs and special creams are available for use to achieve high sexual pleasure and satisfaction. Most of these herbs and creams are applied in the female sexual organ to improve firmness, vaginal contractions and friction, thus enhancing pleasure. These creams and herbs are available in the market for sale. Most male partners insist on their use to derive maximum satisfaction, and most females see it as a way of maintaining the love of their partners. Unfortunately, however, these creams have been found to drastically reduce vaginal lubrication, thereby increasing the chances of abrasions on sexual organs as a result of increased friction, hence increasing the risk of HIV infection. Some of the herbs patronized by women in the area include:

- **Etwe-tight**: Literally means “tight vagina”, derived from the Akan name for the female sexual organ. It is a mixture of ground herbs, moulded into small pellets and dried. It is inserted in the female organ hours before an anticipated sexual encounter. The practice originated from the Akan ethnic groups in the middle and southern parts of the country, but is now popular among women in the urban areas of the Bawku Municipal, but less so in the more rural areas.

- **Ginger**: Ordinary ginger is also believed to enhance vaginal firmness, and is increasingly being used to enhance sexual pleasure. According to one woman who conceded to using ginger, its use can be addictive, as she applies it on a daily basis and no longer feels the usual pain associated with ginger.

- **Mosoro**: This is made from a mixture of local spices obtained from different plants. It is very similar to Etwe-tight.

- **Alum**: This is a chemical popularly used for the purification of turbid water through coagulation. Some women report similar effects as those described for the use of Mosoro when they use it.
to wash their sexual organs.

Special Creams: Also imported from several Arabic countries are a number of creams that are applied directly at the female sexual organ just before intercourse. Most of these creams appear to be blended in honey.

A local practice that significantly increases the risk of Mother-to-Child transmission of HIV/AIDS, especially amongst the Dagomba, is the use of Kalguttim by women during pregnancy, a practice that is nearly universal among this ethnic group. Kalguttim is a local herb taken orally by pregnant women during pregnancy and birth. It has been linked to a high incidence of ruptured uterus among users who most often die when medical intervention is not immediately available. Even where victims are able to access health facilities for surgery, the risk of infecting the child with HIV (in the case of HIV-positive mothers) would have happened already with a ruptured uterus before the surgery is performed.

Post-partum sexual abstinence was found to be a facilitator for infection. In some of the ethnic groups in the area (Dagomba and Mamprusi, especially) most men do not have sexual access to their wives for up to 50 percent of their married lives, as a result of traditions regarding childbirth and sex. Pregnancy during the period of breastfeeding is socially and culturally scorned at. Amongst the Dagomba and Mamprusi, the duration of post-partum abstinence is particularly long, prompting men to resort to sex outside marriage.

Conclusion

It is now well known that HIV is largely sexually transmitted in many African countries. The immediate cause of transmission is the high rate of sexual partner change. Changes in our sexual behaviours will go a long way in preventing the spread of HIV. It is also true that there are hidden socio-cultural practices that have tended to facilitate transmission in communities; these are the underlying causes which need to be brought to the surface and tackled. But the basic predisposing factor remains the high levels of poverty in the area.

There is a complex relationship between poverty and vulnerability to HIV. Poverty is associated with weak endowments of human and financial resources, such as low levels of education with associated low levels of literacy and few marketable skills, generally poor health status and high population mobility. These were all observed in the Bawku Municipality and could explain the high levels of HIV/AIDS and other STIs in the area.

An aspect of the poor health status of the poor is the existence amongst many Ghanaians (and Africans) of undiagnosed and untreated STIs which is recognized as a very significant co-factor in the transmission of HIV. Low levels of education and literacy increase the problems of reaching these populations with programmes aimed at changing sexual and other behaviours.

Even more fundamental to the condition of poverty is the social context of complete vulnerability and social inequality which creates an
environment that increases the mobile population's vulnerability to HIV and other STI's infections. In the Bawku municipality, poverty and limited access to sustainable livelihoods are factors in labour mobility which itself contributes to the conditions in which HIV transmission occurs. Mobile populations, which often consists of large numbers of young men and women, are isolated from traditional cultural and social networks and in the new conditions, they will often engage in risky sexual behaviours, with obvious consequences in terms of HIV infection.

The HIV epidemic has its origins in the African poverty and unless poverty is reduced, there will be little progress in reducing transmission. Human sexuality is not isolated from the economic and social context. Rather it acquires meaning within the set of processes that are part of human social existence. An effective HIV/AIDS strategy in Africa should include a mass treatment of the lingering effects of untreated STIs and the development and implementation of contextually-relevant AIDS education in the schools.

References


