

Reflections and dilemmas on HIV/AIDS and condom use among young adults in Akuse, Ghana



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Master of Philosophy in Indigenous Studies
Faculty of Humanities, Social Sciences and Education
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DEDICATION

This thesis is dedicated to my mother (Rose Amanor), my sisters (Sandra Amanor and Gifty Korkor Amanor), and Mr John Teye Humphrey Otu.

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I give all the praise and Glory to God for seeing me through my master's education at the University of Tromsø, Norway. Indeed in God I live, move and have my being. For, I am who I am because of His immeasurable grace and blessings. Thank you God and unto you alone be all the glory.

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ACRONYMS

AIDS:	Acquired Immunodeficiency Syndrome
GDHS:	Ghana Demographic and Health Survey
HIV:	Human Immunodeficiency Virus
HMB:	Health Belief Model
KAP:	Knowledge Attitude Practice
NACP:	National AIDS Control Programme
NGO:	Non-Governmental Organization
OPD:	Out Patient Department
STI:	Sexually Transmitted Infections
UN:	United Nations
UNAIDS:	Joint United Nations Programme on HIV/AIDS
UNDP:	United Nations Development Programme
VRA:	Volta River Authority

ABSTRACT

This study examined reflections and dilemmas on HIV/AIDS and condom use among young adults living at Akuse in the Eastern region of Ghana. The main objectives of this study were to find out the factors that hinder condom use in the study area, examine the awareness of young adult of HIV/AIDS and condom use as well as explore religious affiliation and gender views in relation to condom use. The study focused on the young adult in Akuse in the Lower Manya district. The analysis of the data was done based on the theoretical perspectives of risk, diffusion, structuration, and gender relations. Semi structured interviews were used as a qualitative tool to conduct this study on a sample of 20 young adults.

The study indicated that condom and HIV/AIDS awareness among the young adults were high while the common avenues from which they receive information on condom use and HIV/AIDS were through; the radio, followed by television, mobile van, religious leaders and newspapers. The study also examine these factors as hindering the use of condom: lack of fear for HIV/AIDS, societal norm and perceptions about sex issues, lack of power for women to negotiate for condom use, religion and beliefs of the society, practical factors, cultural factors, poverty and institutional factors. The study indicated that both men and women advocate the use of condom for HIV/AIDS prevention. However men were more unwilling to use condom as compared to women whiles Christian and Muslim affiliate advocated for condom use in this era of HIV/AIDS.

CHAPTER ONE

INTRODUCTION

1.1. BACKGROUND

At the beginning of this twenty-first century, many political leaders and governments especially the developing countries and particularly Ghana is still battling with economic and political problems and at the same time trying to prevent the spread of Human Immunodeficiency Virus or Acquired Immunodeficiency Syndrome (HIV/AIDS) in her countries. The HIV/AIDS epidemic is a major menace to the government of Ghana as it is showing no sign of leveling off with report of people being infected daily (Ghana News, 2009). One would have thought that since Ghana is a developing country, then, disease such as HIV/AIDS that hinder development would have spared the country to allow the country focus on development projects. Unfortunately, that has not been the case; the epidemic has not spared it ravage on the country. Since the 1980s, the HIV/AIDS epidemic and the challenges in promoting condom use worldwide among young people have brought about much research on religious and gender roles in family planning and adult sexuality in the country. In view of this, the sexual behaviours of young adults towards condom use are thought to be one of the highest priorities in young adult reproductive programs (Magnani et al., 2000).

In Africa, the effects of HIV/AIDS have been overwhelming. Of the 65 million people worldwide estimated to be infected with HIV/AIDS from the beginning of the epidemic until 2005, Sub-Saharan Africa accounted for 64% as compared to 30% of South and Central America and the Caribbean. Furthermore, of the 25 million people believed to have died of HIV/AIDS relates causes over the same period, Sub-Saharan Africa has been disproportionately affect with a continuous increase AIDS death, while 17% of the estimated number of persons in need of antiretroviral therapy received it in 2005 (Global HIV/AIDS Pandemic, 2006). It is noteworthy that a special panel of international experts assembled in 1994 by the United States National Research Council to advise on data and research priorities for arresting HIV/AIDS in sub-Saharan Africa observed that it is within the Africa region that HIV/AIDS will clearly have its greatest impact on morbidity and mortality, in addition to profound economic, demographic and social consequences (Cohen and Trusell, 1996).

While the epidemic has remained dynamic throughout the continent, available epidemiologic evidence suggest that HIV/AIDS prevalence is not uniformly distributed among all Sub-Saharan African countries and that Eastern and Southern Africa are more disproportionately affected than West Africa (ibid). The World Health Organization estimated the adults (15-49years) HIV prevalence rate in 2003 to be 2.3% and 2.0% for urban and rural adult respectively in Ghana as compared to 10.1% and 5.7% respectively of East Africa country like Uganda (World Health Organization, 2008)

The HIV/AIDS epidemic continues to be a major challenge to health and socioeconomic development of Ghana which had a median prevalence rate of 3.1% in 2003. This translates into 350,000 HIV/AIDS infected persons as at the end of 2003. (Ghana AIDS commission, 2005). However it is important to note that Akuse the study area is one of the local communities in the Lower Manya district which has recorded high cases of HIV/AIDS in the region as compared to other district. This was the reason for the choice of the study site. This district is located in the Eastern Region of Ghana which has the highest HIV prevalence rate in the country (ibid). Sentinel surveillance survey data shows that where as HIV prevalence rate in Ghana as a whole is less than 4%, that for the Lower Manya area as of the year 2000 was 7.8 % (National AIDS/STDS Control programme of Ghana, 2001) and as such, controlling the spread of HIV is one of the major objectives in the fight against HIV infection in this district by the Ghana Aids Commission and National AIDS Control programme respectively. The challenge is to substantially reduce new HIV infections among the sexually active population and other vulnerable groups who are often the disadvantaged and poor in the society. This is done through the promotion of safer sexual behaviour including abstinence, condom use, and promoting sex with a single uninfected partner.

There have been debates about condom use and as such, much effort has been spent on promoting the prophylactic use of condoms as part of HIV/AIDS prevention. Over the years, the condom use has become more popular among adults partly due to its promotion among the adult population. The Ghana Demographic and Health survey 2003, indicate that, knowledge of condom use has increased to 93.3% for women respondents and 98.0% for men respondents. Despite this increase in awareness, condom use has increased disproportionately from 0.3% in 1988 to 3.1% in 2003 but the HIV prevalence remained high among the age groups of 25 to 39. The 25 to 29 age groups have the highest prevalence of 4.5% (Ghana

statistical services, 2004), It is therefore imperative to find out the reasons for low use of condoms among this age group; and this I believe should be an issue of concern as it may indicate very little impact has been made by the campaigns to increase condom use among the young adult.

Experts have argued the importance of condom use in the fight against HIV/AIDS infections. To tackle this huge problem might require changes in individual behaviour towards condom use as decision to use condom might depend largely on each partner and the kind of information they have received on condom use. Akuse like most local communities is faced with the problem of illiteracy. According to UNAIDS 2004 report, one problem to the fight against HIV/AIDS infections is illiteracy and ignorance. It is difficult reaching illiterates particularly in promoting the use of condoms in such Local community as the problem could be compounded by the fact that the large majority of the young adults who are sexually active are not likely to resort to condom use due to ignorance and lack of education.

Among the people of Akuse, there is urgent need for behavioural change to the use of condom as a means to HIV/AIDS prevention. It will be imperative to understand people's reflections and dilemmas on HIV/AIDS and condom use so as to examine the factors which hinder condom use in the study area.

1.2. STATEMENT OF PROBLEM

The paces at which sexually transmitted diseases are spreading in Lower Manya district among the young adults are very worrying to the communities. More so, with increasing rate at which especially HIV/AIDS are being passed on from person to person has been of a national concern. Despite the HIV/AIDS awareness programmes by NGOs and education on condom use, the HIV infection continues to be high in the young adult. This has attracted health workers into the district to promote condom use. Since the acceptance and use of condoms could be related to sexual habits, religious belief, gender and cultural orientation, it is important that policy makers address problems relating to condom use among the young adults. The thesis therefore seeks to examine the reflections and dilemmas on HIV/AIDS and condom use among the young adults in Akuse, Ghana.

1.3. AIMS OF THE STUDY

The study will have the following aims:

1. To examine the young adults awareness of HIV/AIDS and condom use
2. To understand the factors which hinder the use of condom among people living at Akuse
3. To explore the gender difference in condom use
4. To explore the religious difference in condom use

1.4. RESEARCH QUESTIONS

Based on the aims of the study, the research will address the following questions:

1. Are young adults in Akuse aware of condom use and HIV/AIDS?
2. What are the factors that hinder condom use among people living in the study area?
3. In what ways do the views of men differ from women in relation to condom use?
4. What are the views that Muslim and Christian affiliates hold towards condom use?

1.5. RATIONALE OF THE STUDY

The study draws attention to the relevance of behavioural change towards condom use as a major factor in the fight against the spread of the HIV/AIDS which has been a major challenge to the people of Akuse and the country as a whole. Hence to design and implement effective HIV/AIDS control programmes, it is very important to get a sound knowledge on the reasons why people refuse to use condom. In addition, the study will be innovative in a number of ways such as adding to the existing knowledge about condom use in the preventive campaign of STDs and HIV/AIDS infection among the young adults. It would also be of immense benefit to the Ghana Aids Commission and the National AIDS Control Programme who are deeply involved in the preventive campaign against new cases of HIV infections in the country. It is also hoped that the study will assist community leaders, policy makers and non-governmental organizations to apply appropriate interventions with the promotion of

condom use within this study area and in the development of strategies for HIV/AIDS prevention by providing empirical data on condom use in Akuse.

1.6. TERMINOLOGIES

1.6.1. Young Adult

Young adult has come to be known as a person in the early years of adulthood. However, according to Erikson (1950:273) young adult is a stage of human development of a person which is generally between the ages of 19 to 40. He explains that it is a stage which precedes middle adulthood. However, Young Adult in this study refers to any person whose age ranges from twenty (20) to thirty – five (35). This age group is chosen because the majority of the populations within this age group in the community are either married or in relationships and are perceived to be sexually active and thus could be expected to be aware of condom use.

1.6.2. Condom

In this study a condom refers to **male condom** which is a device made of latex, or more recently polyurethane, that is used during sexual intercourse. It is used for the purpose of preventing pregnancy and/or the transmission of sexually transmitted infections (STIs) such as gonorrhoea, syphilis and HIV.

1.7. ORGANIZATION OF THE THESIS

This thesis is organized into five chapters. Chapter one is the introduction to the whole thesis. It focuses on the background of the study, statement of the research problem, objectives of the study and the research questions. Other components of the chapter include terminologies and the rationale of the study as well as the organization of the thesis.

Chapter two is made up of two sections. The first section of the chapter namely the literature review presents empirical evidence of how different researchers have discussed the issue of condom use. The second section is the theoretical perspectives. This section is devoted to the

discussion of theories that are deemed to be important to our understanding of the reflections and dilemmas on HIV/AIDS and condom use.

Chapter three is the research methodology. It presents a brief profile of Ghana as well as the study area. An attempt is made to describe the country in terms of location and size. It focuses on the study area with a discussion on the physical, socio-economic and demographic characteristics of the study area as well as religious organization. The chapter also discusses the methods used in the collection and analysis of data, the field challenges, validity and reliability of the data as well as ethical consideration.

Chapter four analyses and discusses condom use in Akuse and the factors which hinder condom use in relation to HIV/AIDS prevention among the study population. Certain comparisons have also been made with the information in the literature review and other secondary data. The theories discussed have also been used as an interpretative framework. Chapter Five, which is the last chapter, begins with an overview on gender and religious differences in condom use. It also contains a summary and conclusion of the research findings and suggestion for further studies.

CHAPTER TWO

LITERATURE REVIEW AND THEORETICAL PERSPECTIVES

2.1. INTRODUCTION

The first section focuses on Literature reviews which show how different researchers have discussed the issue on condom use. These are mainly research findings from different parts of the world with a major focus on Africa. The second section also focuses on the theoretical perspectives and discusses some theories that are relevant for the analysis in this study.

2.2. LITERATURE REVIEW

2.2.1. Religion, beliefs and ethnicity

Some researchers have presented the idea that a person's religion or beliefs may inhibit and affect condom use. Aryee (1989) contends that Africans religious conception about the universe makes religion a very powerful motivator of sex behaviour and for that matter condom use. Catholics and Anglicans for example approve only the use of natural family planning methods like abstinence. Muslims too may limit their families according to Islamic Shariah, where birth control can only be accepted either where a mother has to space her birth to keep a breast feeding baby in good condition or where a spouse has a chronic or hereditary disease. In all cases, highly educated people are more likely to use condom regardless of their religious affiliations.

Religion exerts a reasonable influence on the use of condom. The findings from Takyi (2003) indicate that religious affiliation has a significant effect on knowledge of AIDS and condom use. However, in relation to his study, he did not find religious affiliation to be associated with changes in specific protective behaviour, particularly condom use. Again, Takyi has discovered that Christian women are more likely to report high or low levels of perceived HIV risks and high levels of knowledge about HIV transmission than non-Christians (Muslims and traditional) counterparts. Takyi noted that there is little evidence to suggest that the evaluated HIV awareness among Christian for that matter the Catholic and Protestants

compared to Muslims translated into differences in behaviour towards condom use. However it is important to note that, personal knowledge of the effects of AIDS is likely to have a large impact on condom use because it indicates knowledge of the effects of AIDS and may act to verify information given in other forms and thus lead to behaviour change towards condom use to avoid contracting HIV (Gray et al., 2001).

Many researches have been conducted into condom use and HIV/AIDS in most countries especially in sub-Saharan African countries. In most of these researches, the aims were to find out about people perception, knowledge, attitudes and intention for condom use. In one of such studies, Kinsman et al. (2001), examined children in Ugandan schools and found out that Catholics as compared to non-Catholics lack adequate knowledge about condom use and did not demonstrate positive intentions about condom use in relation to HIV/AIDS prevention. However in comparing boys and girls; their study indicated that the boys had adequate information than the girls on condom use, whereas their attitudes towards condom use were similar since they intend to use condom if it was made available. It is important to note that boys and girls may be aware of the dangers involved in non-use of condom, but religion is likely to affect their attitude towards its use.

In a similar publication by Pius (2008) in Kenya about Islam, Condom and AIDS; he indicated that Muslim clergy and other religious authorities in North East Kenya decided to campaign against the promotion of condoms as a means of preventing HIV and pregnancy. According to the Muslim clergy, the Ministry of Health's method of preventing HIV/AIDS was not acceptable to the Muslim traditions and generally believed that the use of condoms led to HIV infection because the condoms had been laced with the HIV. The religious authorities also said that huge amount of money were used to buy condom which in their view was promoting immorality. However, Pius believes that the debate about condom use only turned out to be a manifestation of ignorance among most religious leaders and cultures.

Like religious beliefs, ethnicity and culture also influence condom use (Zenebe 2006). Caldwell (1982) argued that in Nigeria and other parts of Africa some ethnic groups place more value on higher number of children and as such the use of condom in such societies is usually low. Tawiah (1997), however, noted that the ethnicity-condom use relationship may not be so significant in many societies in Ghana.

2.2.2. Government Policies

Factors such as government policies and the availability and accessibility of condom may also serve as promoting or inhibiting factors in condom use. In many developing countries like Ghana, the location of health facilities depends on central governments decisions. As the studies by Eschen and Whittaker (1993) shows, government policies in making condom available and affordable are also an influential factor in condom practice. Media messages have also been found to have some influence on condom knowledge and use (Gabe, 1995). However, some researchers have argued that due to cultural and religious hindrances, media campaigns may not always promote a behavioural change (Valent et al., 1994).

2.2.3. Condom use in relation to HIV/AIDS prevention

In his article entitled “Rethinking the African AIDS Epidemic” Caldwell (2000) outlined a number of reasons why programmes aimed at reducing the HIV/AIDS prevalence rate in Africa are not achieving desired goals. Some of the reasons include; the fact that most Africans believe that males are biologically programmed to require sex with more than one woman, women limited control over their sexual life because of norms, low fear of HIV/AIDS because of the high death rates in general in Africa, low level of commitments on the part of African governments towards HIV/AIDS control programmes and low level of condom use even in commercial sex. Caldwell further argued that any program designed to reduce the HIV/AIDS prevalence by merely encouraging people to abstain from casual sex is doomed to fail. He suggested that the surest way to curb the further spread of the disease is to massively encourage the use of condoms.

This point has been supported by most other researchers. For instance, Dowsett (1999) reported that early control of the disease in Australia was achieved mainly through a high level of compliance with condom use. The success story of Thailand in halting the spread of HIV/AIDS has also been attributed to condom use. Health inspectors in Thailand achieved a very high level of condom use by threatening brothel owners that the police would close the premises if it was shown that prostitution was taking place without condom use (Hanenberg et al., 1994 as quoted by Caldwell, 2000). Similarly, Feleyimu (1999) reported that in the villages of the Niger Delta in Nigeria from which the oil companies draw their workers, the

prevalence of sexually transmitted diseases including AIDS fell by 40% when free condoms were made available to the people.

If condom use has achieved such remarkable results elsewhere, why is it not achieving the same result in many Sub-Saharan Africa countries? Some scholars have examined the factors hindering condom use in Africa in details. Caldwell (2000) argued that most prostitutes' clients do not like using condoms because the condoms rob them of a feeling of intimacy but research in South Africa has shown that this reduction in intimacy is a major reason why some prostitutes prefer the use of condoms and may as well cooperate in their use being made almost mandatory. They want to feel less intimate with their customers than with their husbands or regular partners (Varga, 1997). The veracity of Varga's argument can be contested as it seems to suggest that prostitutes in general do not seek any enjoyment from their customers. This may be wrong as there are studies that show that some people engage in prostitution not only for economic gains but also for fun (Ankomah, 1998).

Caldwell blames the low usage of condoms in Africa on institutional factors such as activities of NGOs, and especially on government policies that do not make the use of condoms in commercial sex mandatory. He also identified religion as a hindrance to condom use since most Christian religious groups in Africa are against the campaign for condom use with the explanation that such campaigns will promote sexual immorality among the youth. Caldwell's argument has also been supported by Foreman (1999). Some researchers have also linked the low usage of condom in Africa to women limited control over their sexual life and their little power in such sexual relationships. Research elsewhere in Africa has indicated that the transactions involving gifts and cash characterize a large proportion of sexual encounters among unmarried young people. For instance, Nzuyuko et al. (1997) reported that in Kenya 78% of adolescent girls, who did not consider themselves as sex workers, exchanged sex for gifts or cash. In Malawi, 66% of a sample of 500 adolescent girls reported having accepted money or gifts in exchange for sex (Helitzer-Allen and Makhambera, 1993).

Indeed for most girls in Africa, the economic rewards override the perceived emotional gains from sexual relationship. Meekers and Ahmed (1997) found that female sexual activity is often primarily motivated by economic gains. Similarly, in one study in Mali, Castle and Konate (2000) reported that 13% of urban girls cited financial reasons as the main contributing factor for their first sexual encounter. A similar but stronger picture is painted by

Dodoo et al. 1994 (quoted by Caldwell and Caldwell, 2001) in the slums of Nairobi where sex is a survival strategy. Girls may be sent out by their parents to go and bring back money. These girls could be termed as desperate sexual workers. Perhaps even more disturbing is the fact that condoms are rarely used in such situations. There are even reports that in most parts of Africa some men pay extra money for non protected sex (Kalipeni et al., 2004). Thus sex becomes yet commodified for women whose survival strategies include seeking multiple boyfriends, pursuing serial monogamy or going into commercial sex (Teye, 2005).

In Ghana women in premarital relationships expect the partner to contribute money for food or help pay rent. Others use what they are given as a start-up capital for small businesses (Ankomah, 1998). Other girls may rely on gifts from partners much older than themselves to pay school fees and for clothes (Aryee, 1997). Ankomah argued that this situation where many sexual relationships are contracted with material gains in mind is a situation quite different from prostitution, as it is understood in Europe or the United states. He argued that a woman may face the risk of losing material benefits if the man is unwilling to use condom. From this argument, then it can be said that the immediate gains, in the eyes of the women outweighs the more distant cost of HIV infection and hence they may comply if their partners do not want to use the condoms.

Associating condom use with prostitution has also been identified as a factor hindering the use of the method and similarly, it has also been established that most people do not have the necessary communication skills to inform their spouses that they want to use condoms and this may be a factor also (Mehryar et al., 2003). In one study in Ghana, Mills and Anarfi (2002) concluded that with limited education and few vocational skills, many of the women took boyfriends to assist them with the purchase of food, clothing and shelter, as a strategy for survival. They argue further that for most women, the use of condoms with sexual partners was restricted by the high value placed on sex, the negative association of condoms with prostitution, and the women's limited ability to influence decision making in this area. Takyi (2000) also agreed that the prevailing cultural practices and norms in Africa encourage large families and discourage the use of condom and that explain why the use of condom for the prevention of HIV/ AIDS is low. Similarly, it has been demonstrated elsewhere that there are numerous social and cultural constraints surrounding the use of condoms in Africa and this include trust, gender relations and desire for more children (Kalipeni et al., 2004; Zenebe, 2006).

2.2.4. Gender difference in condom use

Researches that have been done on condom use have generally indicated an important gender difference in condom use. In a study conducted by Abraham et al. (1992) among Scottish teenagers to investigate the spread of HIV, they found out that the teenagers were willing to use condom with their sexual partners. The study also revealed that women have more positive attitude and behaviour towards using condoms than men have. They explained that men have fewer difficulties in buying and carrying a condom as compared to their female counterparts.

Another similar research was carried out by Koniak- Griffin et al. (1994). Using a qualitative focus-group methodology, the study investigated risk-taking behaviours and AIDS knowledge among minority pregnant and parenting adolescents at risk for heterosexual and prenatal transmission of HIV. Seven focus groups were conducted with a total of 48 young women recruited from alternative schools and residential facilities for pregnant adolescents and young mothers in Southern California. Participants also completed a background questionnaire soliciting socio-demographic information and an AIDS knowledge test. The sample included 33 Latinas and 15 African-Americans, ranging in age from 12 to 19 years. The study reveals that the majority of the participants were having unprotected sex. The result further reveals that lack of power and male dominance influenced women's use of condoms. As a result of this, they explain that women were embarrassed to buy condoms. Aside from this, women were also afraid that their partner might think they were promiscuous when they either negotiate for condom use or buy them.

A growing body of research has examined the behaviours and psychological factors associated with condom use and found significant gender difference towards condom use by both sexes (Atuobi, 1988). Despite the advantages of using condoms, there are number of factors that work against them. For example, Herbert et al. (1989) identified the following factors; neglecting personal risks, using alcohol or drugs, low self confidence, sexual fears and reliance on other contraceptive methods have been the most common reasons for non use of condoms.

2.3. SUMMARY OF LITERATURE REVIEWS

The low trend of condom use in most African countries including Ghana has been of national concern because it defeated the Ghana government's aim. Besides, with the emergence and rapid spread of HIV/AIDS in the country since 1980s the government and indeed many development thinkers are even more worried about how to increase the use of condoms in order to curb a further spread of the disease which has devastating effects on socio economic development of the country. What baffle the minds of many people are the reasons for the low usage of condom despite public campaigns to promote its use. The literature review indicated factors such as ethnicity, culture, religion, government policies and gender relations among others as the factor that hinder condom use. The literature reviews therefore provide evidences of how different researchers have discussed the influence of some of these factors on condom use and how religious affiliation and gender relation influence condom use. The study therefore is commissioned to focus on the study area to examine among other objectives such as factors that hinder condom use, in order to provide light for specific programme implementation on condom use.

2.4. THEORETICAL PERSPECTIVES

In the Social Sciences, different concepts and theories are used for choosing a methodological approach as well as for developing analytical tools for the research. Many social science researches has been set forth to either confirm or contest pre-existing theories either through logical argumentation or collection of empirical facts and that reality is multi-faceted, multi-layered and hence no single social science theory is thus capable of fully capturing the complexity of reality (Noth, 1990). In this study, theories are used as an interpretative guide.

This thesis adopts some theoretical perspectives deemed to be useful in explaining people's knowledge about condom and HIV/AIDS. Specifically, risk theories, structuration, and theory of gender relations as well as diffusion are used.

2.4.1. The theories of Risk

One major theory that has been very useful in explaining issues relating to condom use and HIV/AIDS is the risk theory. This theory has been given many definitions by different

Experts. Risk has been described as a multidimensional concept that refers to the prospect of loss (Yates, 1992). However in Carter (1995) opinion, the fact that risk assessment and measurement will rely on probabilistic reasoning means that the whole issue of risk will also lead to some possibility of gain and not merely being restricted to loss. Risk according to Kronick (1997), is a social construct which involve a person's thought and actions. To this end Lupton (1999) believes that risk is not a static and objective phenomenon but rather it is constantly constructed and negotiated as part of the network of social and the formation of meaning. However in Johnson et al. (2000) opinion risk can generally be perceived of as the likelihood of series of possible outcome from a decision or cause of action. In another way, Moller (2000) also explains that risk is a normal part of everyday life of a person. Ewald has put it, that: 'nothing is a risk in itself; there is no risk in reality. But on the other hand, anything can be a risk; it all depends on how one analyzes the danger and considers the event' (1991: 199 cited in Lupton, 1999:28). There is nothing in this world that could mean a lifestyle without any risk. So in as much as some habits and decision of action will certainly be more dangerous than other, there could be no behaviours without any element of risk. The choice therefore is to optimize or to take some level of risk rather than avoiding it completely.

Risk theory has been used in many fields. Most importantly in the field of Public health, where there are two approaches to risk. The first approach considers the risks to particular populations by environmental hazards such as pollution whilst the second constructs risk as a consequence of the "lifestyles" choices made by individuals, and emphasizes self control. To this end, health persuasion strategies are designed and transmitted through appropriate media to warn people about health risks on the assumption that knowledge about the dangers of certain lifestyles will result in their avoidance. This second approach is clearly the case of HIV/AIDS where certain sexual habits such as unprotected sex are perceived as risky (Lupton, 1993 cited by Gabe, 1995). The success of such persuasions aimed at discouraging people from such risk behaviours, however depends on the risk perceptions and risk tolerance levels of the people involved.

Within the camp of the risk theories, there are different perspectives on the factors that shape individual risk perception. These perspectives include the psychological risk theories, the cultural risk theories and the social risk theories. Psychologists were probably the first people to analyze the factors which influence risk perceptions in the 1960s. In these early ages, the first thesis was that lay perceptions about risk behaviour are different from expert perceptions.

It was argued, that a lay person's fear of a "dread factor" tend to be higher if the risk was involuntary, unfamiliar and uncertain where as experts perceptions was rather highly correlated with annual mortality rates. This perspective has been criticized for assuming that risks have an independent existence, separate from the more complex social, cultural and institutional contexts in which people experience them (Turner and Wynne, 1992). Later on, some social psychologists argued that risk perception does not only depend neither on the nature of the risk nor individuals' characteristics but also depends on the values and beliefs of the larger society. Following this perspective, certain models were design and among them was the *Health Belief Model*. The model argues that readiness to embark on risky behaviour is based on one's perceived susceptibility to health treat and upon the perceived seriousness of the treat (Scambler and Scambler, 1984).

Another related model was designed and that has been relied upon in many AIDS awareness campaigns is the *Knowledge - Attitudes - Practice (KAP) Model* which claims that individual's knowledge and attitudes determines one's health-related behaviour. Hence if an individual is aware of the deadly nature of AIDS and know that condom use will prevent them from being infected with the disease, they will be more willing to resort to condom use. Within this framework, Campbell (1997) argues that information-based education programs seek to change people's behaviours through providing them with information or knowledge about the dangers of particular behaviours such as having unprotected sex.

This model has been criticized for treating individuals as free agents in terms of their response to risk and ignoring social factors which has the possibilities of influencing and constraining the choices they make (Campbell and Williams, 1996). Bloor et al. (1992) argue against the attribution of risk behaviour to a volitional and individual act. He rather explains that risk behaviour involving sex has to do with two parties, not one person will be able, and that engagement in such practice may face constraints and challenges. Sexual relationships involve at least two people and sexual risk behaviour is a social rather than an individual activity. He believes that it's the client volition to refuse to use condom in sexual intercourse and that this cannot be attributed to prostitute volition. This explain why Holland et al. (1991), argues that in many heterosexual relationships, non use of condom arises out of the strategic power relationship between the two sexual partner.

Whilst psychologists have treated risk as an objective phenomenon, anthropologists have argued that risk perception can best be understood as a social construct. They introduced the cultural perspective of the risk theory. This approach is therefore concerned with groups and institutions rather than individuals as individual perceptions are shaped by the cultural contexts within which they find themselves. The approach has also been criticized for failing to explain how groups and individuals may change their risk perceptions over time. Human geographers and sociologists who like anthropologists argue that risk perception is socially constructed developed the social risk theories. This perspective also argues that material constraints and social interests as well as cultural factors are important in shaping risk perceptions as well as their management. Further, it is explained that lay men and experts perception about risk activities differs but what is more important is that lay men scrutinize what they hear from experts and may reject them if there are inconsistencies. This perspective also emphasizes the role of social institutions and structures in the framing of risk. Here it is said that; how the media reports the risk behaviour for instance can influence peoples risk perception.

In order to explain risk as a social construct, it is said that factors influencing HIV/AIDS risk perception may be grouped into three. First risk perception depends on knowing the ways by which the disease spreads. It is against this background that health officials try to give correct information about ways by which people get the virus and advise them on safety ways of preventing oneself. Secondary, individuals risk perception depends on the degree of control they feel they have on their own and their partners' behaviour. According to Bernardi (2002) if the ways of protecting oneself are not available their knowledge alone will not in any way help eliminate danger of being at risk such as HIV/AIDS infection. Finally social networks are very important in shaping people's risk perception. This is because the social environment allows information exchange, facilitates common evaluation of information and its validity. False beliefs about HIV infection may originate and spread in informal networks sometimes even more rapidly than correct belief as Zenebe (2006) also argued in Ethiopia. In the same way, informal exchanges sometimes transform the content of messages coming from health officials promoting preventive behaviour.

In relation to gender, many researchers have argued that members of social groups that are less powerful tend to be more concern about risk than members of a powerful group. For example, Lupton (1999) argues that women compared with men tend to rate their concern for

specific risks more higher than men and thus power, social status and political orientation influence people's views on risk. Religion could also possibly have an influence risk. One classical perspective in social scientific studies of religion that is consistent with risk taking principle was developed by Malinowski (1925). Religious beliefs are desirable because one has nothing to lose by believing in God but potentially much to gain (Alan et al., 1995). Malinowski claimed that religiosity is related to a desire to control those things that cannot be controlled given the level of technological sophistication of a society (e.g., diseases), and is also a way of dealing with the fear of death. Thus people focus on a supreme being in an attempt to solve a problem that is beyond their control such as HIV/AIDS and also attempt to follow religious explanation, moral guidance so as to gain emotional support from fear of death that results from a situation that is beyond the control of man. Many researchers have applied risk theories to explain HIV and condom use. These researchers have revealed several new perspectives of risk, three of which are discussed below.

The first is the Situational rational approach. This approach claims that an individual desire to undertake a risk is largely influence by how he/she perceives and evaluates situations which to others may be meaningless. The choice of people to practice unsafe sex may be emblematic of intimacy or trust (Gabe, 1995; Wilde, 1994 & 2002). Thus the situated rationality approach stress on the immediate benefits of risk behaviour. The explanation here is that sometimes the immediate incentives of risk-taking may outweigh the more distant benefits of safety precautions. Some studies on why some women prostitute themselves in this era of HIV/AIDS or why people still practice unsafe sex has given much credence to this approach. That's why in some countries in Africa where there is poverty, women often practice sex without condom since it become meaningful under such situation. Thus several constraints, challenges and difficulties put people in some situations that they have no alternative than to have sex without condom. They may be aware of the risk involved but may not have control over the situation.

The second perspective which has been advanced by researchers is the Risk optimization (homeostasis). Within this perspective an individual desires to optimize the risk he/she faces in everyday life instead of trying to eliminate the risk. Hence, it is argued that human beings are known to be strategists, and at the same time planners, who will attempts to optimize the level of risk (Wilde, 2002). Whatever kind of things people do, they take a certain level of risk to their wellbeing. Irrespective of the benefits and the advantages people gain from a

particular action, they are still exposed to a certain degree of risk. The argument put forth is that some choices may lead to a loss but it is how a person sees the loss that is of concern. In this case if a person see the loss to be less in comparisms to the gains, then the tendency of engaging in that behaviour is high (Bernardi, 2002). Alternatively it can be said that the risk tolerance level will be high if people perceive the benefits to outweigh the losses.

Wilde (1994) identifies different variety of factors that determine the optimal or target level of risk that different people are willing to take at any period of time or that an individual is willing to take at different time periods. These factors are:

1. The expected benefits of risky (comparatively dangerous) behaviour options.
2. The expected costs of comparatively cautious behaviour options.
3. The expected benefits of comparatively cautious behaviour options.
4. The expected costs of risky behaviour alternatives.

These factors imply that when the expected benefits of a risky behaviour are high and the expected costs are perceived to be relatively low, then the target level of risk will be high and the individual involved is likely to take a high risk activity. However if the expected costs are perceived to be higher than the benefits, then the target level of risk will be low and the individual is cautious. Wilde further argued that there are variations in optimal risk with respect to time, wherein people are willing to take risk today when they see gains to be great and side effect to be very far away with respect to time. To this end, women may only be concerned with the current financial rewards but may perceive the effects HIV infection due to non use of condoms to be very far from today.

The third perspective is the Stage Model. This stage model is similar to the situated rationality approach discussed above, but these models try to explain why people may engage in high-risk sexual behaviours (Perloff, 2001). There are several versions of the model but the AIDS risk reduction model and the trans-theoretical models have been selected for discussion here.

AIDS risk reduction model identifies three stages that individuals may pass to reduce risk sexual behaviour:

Stage one: Identifying and labelling activities as risky

Perloff (2001) explained that during this first stage individuals must recognize that their sexual activities place them at a high risk of contracting HIV, thus labelling their behaviours

as risky. Three factors have been identified as important here. The first one is the knowledge of how HIV is transmitted is a necessary condition for the identification of high risk activities but this condition alone is insufficient. The second factor is perceived vulnerability to HIV infection. Thus before one can identify his or her sexual behaviours as being risky, he or she must first feel personally vulnerable or have some element of fear to contracting HIV/AIDS. The final contributory factor includes social context and norms. The argument here is that what an individual's reference group considers as risky sexual behaviour influences what he/she also identifies as risky.

Stage two: Commitment to engaging in low-risk activities

This is the stage in which the individual makes a decision to change his or her sexual behaviours. The model posits that after an individual has labelled his or her sexual behaviours as risky, two factors will determine the probability that he or she will commit to engaging in low-risk behaviours. The first factor is his or her analysis of the costs and benefits of continuing or changing that risky behaviour. As discussed already, the benefits must outweigh the costs to warrant a behavioural change. The second factor is that the individual needs to feel capable of engaging in activities that will prevent HIV infection. For instance, people must feel free to acquire condoms and using them without any restriction.

Stage three: Changing behaviour

This is the stage in which people start taking appropriate steps necessary to change behaviour. It is argued that two variables determine the likelihood that a person will act on his decision to change sexual behaviour. The first is the person's sexual communication abilities. According to the model, to engage in low risk behaviours, people need to communicate their intentions to their sexual partners. Individuals may decide to use condoms but if they lack the social skills necessary to communicate this to their partners, they will not be able to act on their intentions. Secondly, people who want to change their sexual behaviours may seek the informal help and social support from friends and relatives. In some cases too they may seek the support from an expert or a "significant other". This support can help the individual to effect a behavioural change.

The three stages discussed above are neither unidirectional nor irreversible. It is argued, for example, that some people on reaching the final stage may encounter an obstacle in changing their sexual behaviour and come to re-label their activities as non-problematic or reduce their

commitment to change. One thing that is clear is that sexual behavioural change does not occur in vacuum for as Cutter (1993) cogently argues, it is important to place individual's assessment of risk in the context with a host of competing social issues and concerns. The argument here is that people may see the dangers associated with unsafe sex but compared with the other socio economic problems they face in their daily lives, the risk associated with unsafe sexual behaviours does not matter than the problems they face today such as the need for survival. Unprotected sex may be seen as a survival strategy. As Awusabo Asare et al. (1993) noted most people thus in Ghana believes that one could as well die from any suffering apart from AIDS. Caldwell (2000) also pointed the role of widespread belief that at least some role is played by predestination. This fatalistic view of death may thus be a strong hindrance to condom use.

The trans-theoretical model assumes that people progress through five stages of sexual behavioural change (Perloff, 2001):

- **Pre-contemplation:** At this stage individuals do not have any desire to change their sexual behaviours. This is mainly because they cannot see the problem. Applying the model to HIV infection, it can be said that people in this stage may not see unsafe sexual practices as a problem at all.
- **Contemplation:** It is at this stage that people recognize that they have a problem and are considering making a change within the next six months.
- **Preparation:** At this stage individuals are actively planning to change and have even taken steps toward reducing the problematic behaviours.
- **Action:** At this stage people actually modify risky behaviours.
- **Maintenance:** At this final stage people sustain behavioural changes over a long period of time.

The model also explain that the journey through these stages is not a smooth one as people relapse, regress to earlier stages and recycle through stages before maintaining a long term behavioural change. It is therefore recommended that persuasive communications and campaigns must be tailored to the needs of people at a particular stage. For instance messages targeted at pre-contemplators must aim at convincing them that their behaviours (say non use of condoms) put them at a particular risk whereas contemplators must be encouraged to consider substituting a new behaviour for the current risky activity. Similarly people who are

in the stage of preparation must be helped both socially and economically so that they can take the action needed for full behavioural change.

All the theoretical perspectives on risk perception discussed above are very important for understanding the use of condom. They must be seen therefore as complementary. It will be interesting to find out how beliefs and values of the larger society influences the risk perception of individuals and how the beliefs and values of the study population in general has shaped their risk perception about the HIV/AIDS and how this perception in turn influences their behaviour towards condom use in relation to HIV/AIDS.

The social and the cultural versions of the theory have explained that it will be important to look at how the social context affects condoms use. As the situated rationality and the risk homeostasis demonstrates engagement in unsafe sex (non use of condoms) may result from a constraint; it will thus be important to look at how certain aspects of the socio-cultural organization of the people constrain them from practicing safe sex despite their knowledge. Finally, in consonance with the position of the social risk theories that social institutions can have an influence on how people perceive risk, it will be important to examine how church leaders and non-governmental organizations are influencing the people's behaviour towards condom use and whether interventions are being tailored towards individual needs.

2.4.2. Structuration theory

There are several versions of this theory but it is Giddens work that is most relevant to this study. Giddens (1984), structuration theory, which is largely ontological in orientation (Holt-Jensen, 2000) argues that individuals are born into societies that entrap them within social structures, which both constrains and enable them. He argued that people are influenced by actions of others as well as structures. Structuration theory thus takes account of both the acting subject and the structures around him or her. Individuals are formed by society and its institutions but they are also skilled agents who direct their own lives through actions. This is what has been termed as the duality of structure. The implication here is that structures influence behaviour, but behaviour can eventually influence and reconstitute structure (Cloke et al., 1991, cited by Holt-Jensen, 2000)

Giddens (1984) maintains that social actions occur within a framework and that social systems are not only structured by rules and resources. Though this theory has been criticized by many scholars for not giving any direct guidance on how to proceed with scientific investigations, however it has some relevance for my study. Knowledge about condom and use in the area may be influenced not only by individual characteristics but also by structures such as government policies and other factors which need examination.

2.4.3. Diffusion theory

The diffusion theory is perhaps one of the best theories which can help to explain how the knowledge and use of condom spreads among a population. This model was popularized by Hagerstrand (1967). Simply put, the diffusion model explains how individuals embrace new ideas or technologies by either accepting or rejecting them at varying levels within specific environments. As such, there emerge different groups of people in the society. First, there are the innovators who start the whole phenomena. Next are the early adopters who catch on fastest. The third groups are the early majority who are also easily influenced. After this group, it becomes extremely difficult to influence people as one gets to the late majority and then the last group who will not be influenced at all. These are, theoretically, known as the laggards who are not interested in what is going on at all.

The diffusion theory recognizes that there are several factors that influence the levels of acceptance and rejection. The diffusion process also does not work in a vacuum and this is one major criticism levelled against the original version of the model which fails to adequately explain how structural factors such as income, access to education and the presence of basic amenities can affect the ideas of individuals at every particular time and within different spatial contexts. In the literature on diffusion, factors which hinder the spread of new ideas such as condom use are called 'blockheads'. Examples of 'blockheads' that inhibit condom use are institutional factors like government policies. In one study in Southern Ghana, Agyeman and Casterline (2001) have shown that several aspects of social organization such as gender relations and the prominence of voluntary organizations have strong influence the diffusion of reproductive behaviours information.

The importance of this model for my studies is that it can be used to explain the spread of condom knowledge and use. Most of the other theories discussed above can also be linked to

this diffusion theory. For instance, in the theory of structuration, Giddens talked about how both structural factors as well as human social relations are important in understanding human actions. Thus, unavailability of such structures such as family planning programmes and effective government policies can be blockheads that will inhibit the spread and use of condom. The risk theories discussed for condom use can also be linked to the diffusion model. Here, it can be argued that low risk assessment, certain beliefs and values as well as resource constraints can serve as a blockhead to the spread of condom use.

Several factors have been identified to influence the diffusion of condom use. These factors include place of residence, gender, religion, government policies among others. But it must be stated that the influence of this factors in the diffusion of condom knowledge and use differs from place to place. This means that there cannot be any simple generalization on the factors which serve as blockheads to prevent the use of condom. It is therefore after this study, that one can explain the factors that are influencing condom use in the study area.

2.4.4. Gender Relations

Yvonne Hirdman said that “gender can be understood as a variability of ideas of “men” and “women” (ideas that always use biological differences between bodies) which give rise to notions and social actions which also have influence on biology...”(Yvonne Hirdman 1988:51 cited in Norlander, 2003:2). However Scott (1988:42) gave an alternative definition of gender by defining it as “a constitutive element of social relationships based on perceived differences between sexes, and gender is a primary way of signifying relationships of power.” Scott point out that gender as a relation is built on difference and power. Norlander (2003) argues that the debates about gender around 1980s focused on oppression of women and the main issue was how to relate oppression of women by men which according to him is now named gender power relations. According to Agarwal (1997), gender relations are the relation of power between women and men. These relations impinge on economic outcomes in many ways. He pointed out that gender relations like all social relations embodies the material and the ideological, which are revealed not only in the division of labour and resources between women and men, but also in ideas and representation. That is, the ascribing to women and men of different abilities, attitudes, desires and personality traits, behaviour patterns and so on.

Research on gender has examined the role of women in condom use and gender-specific factor has been found to exert considerable influence on women's sexual decisions (Wingood and DiClemente, 1998). Several studies have also shown that condom use may not depend only on the individual characteristics of the man or woman but may also depend on whether the partner approves of it or not. Many researchers seem to agree that greater sharing in decision making between couples results in stronger desire to use condom (Mehryar et al., 2003). Indeed there is enough evidence that despite the importance of women's individual characteristics in determining their behaviour towards condom use, their husband's preferences could be brought to bear on them to influence their decision to use condom. Ezer (1993) explained that wives of men who want no additional children are more likely to approve of family planning than wives of men who want more children. He argued, further, that in Ghana, a woman's own characteristic does not affect her husband's family planning behaviour or use of condom. He concluded that spousal influence, rather than being mutual and reciprocal is an exclusive right exercised only by the husband.

In their capacity as the head of the household, men play an important role in deciding whether a woman should adopt a family planning method or not. In a study of male influence on condom use in Nigeria, Isiugo-Abranihe (1991) demonstrates that the husband's influence with respect to decisions concerning family planning is profound among major ethnic groups and this may be accentuated by policies that forbid women from obtaining family planning services without their husbands' consent. Indeed enough evidence attests to the fact that gender power relations in Africa skew reproductive decision making power in men's favour, and against women. Fapohunda and Todaro (1988) in their study of Lagos data set discovered that sex or family planning decision making is determined by who controls and allocates financial resources within the family and this is usually the man's duty. In a similar study, Dow et al. (1986) concluded that men's attitudes towards condom use are a major facilitating or inhibiting factor. Similar findings in Indonesia point to the effect of husbands influence on their wives sex behaviour. Joesoef et al. (1988) found out that husband's approval was a key influence on their wives condom use. Among women who desire to have more children, 17.4% of non use of condom in Medan and 27.8% in Jakarta were attributed to husbands' disapproval.

2.5. THEORETICAL SUMMARY

The theoretical perspective section has present perspectives on risk, structuration, diffusion and gender relations. These theories are deemed useful in the study of HIV/AIDS and condom use. The risk theories, for instance, identify how the social context and beliefs influence risk perception or fear of AIDS as well as the adoption of HIV prevention measures. The theory of structuration recognizes the importance of individual characteristics as well as socio cultural and structural factors. The theory of gender relations also discusses how male dominance influence condom use. Finally, the diffusion theory mentions some factors that may serve as 'Blockheads' to influence how people will accept or reject condom use. It's important to note that these theories are use collectively as an interpretative guide in this study.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1. INTRODUCTION

This chapter presents brief background information about the socioeconomic conditions of Ghana and Akuse, the study area. The chapter also focuses on the choice of methods used in the data collection. An attempt is made to discuss the reliability and validity of the data as well as ethical consideration.

3.2. GHANA MY MOTHERLAND – A BRIEF BACKGROUND

Ghana formally called the Gold Coast is located on the West Africa's Gulf of Guinea. It covers a total area of about 238,540 square kilometers (approximately 92,098 square miles) of which the land area constitutes 230020 square kilometers with a coastline of 550 kilometers (Ghana HomePage, 2009). The country is surrounded by Togo on the East, Burkina Faso on the North, Ivory Coast on the West and the Atlantic Ocean (Gulf of Guinea) on the South (see appendix C). In economic terms, Ghana is predominantly an agricultural economy, with about 70% of its workforce employed in the agriculture sector constituting about 45% to Gross Domestic Product (ibid). By sub-components, the agriculture sector comprises of fishing; agriculture and livestock; forestry and logging; and cocoa production and marketing. The health delivery system in Ghana is characterized by both traditional and western medicine. There is no formal integration and a less developed referral system between the two systems and individuals choose different systems depending on their health needs and the availability of a particular system. Poor people living in rural areas mostly use the traditional system. This is partly due to the fact that hospitals and clinics are mostly located in urban areas.

Ghana's population has been growing rapidly in recent years. With a population of just over 2 million in 1921, the population quadrupled to 8.6 million in 1970 and 12.2 million by 1984. Currently the country has a total population of about 18.4 million (Ghana Statistic Service, 2000). Poverty in Ghana stands at 28%, down from 52% in 1992, with real GDP growth of 6% per annum since 2005, inflation and interest rates almost entering into single digits; Ghana

is perceived as one of the best performing economies on the African continent (World Bank, 2008). However, about 70% of the poor live in rural communities. Such communities are normally characterized by low earnings and limited social amenities. In the light of extreme poverty in some parts of Ghana, the country has not been spared of the scourge of HIV/AIDS. The epidemic appeared in Ghana in 1980's and by 1994 it had hit 118,000 people. Ten years after, the epidemic had gained momentum and infected about 404,000 individuals (Ghana news Agency, 2008).

3.2.1. The study area – Akuse

Akuse is located in the eastern region of Ghana, between Somanya and Asutsuare in the Lower Manya district and is about one kilometer from the bank of Lake Volta which is the largest man-made lake in the world. Irrigation canal passes through the outskirts of the town which is used for rice farming. People have little money. Their houses are basic: bricks and blocks walls with a roof made of iron sheets. The community has a very high breed of mosquitoes leading to high cases of malaria in the community. This might be due to the irrigation canal that passes through the outskirts of the town used for rice farming in both Akuse and Asutsuare. The town has a population of about 3000 people (Hodgson, 2000). It has a tropical climate. The vegetation in the area is predominantly low savannah interspersed with shrubs and short trees with monthly average rainfall ranging from 13.7 millimetres to 195.9 millimetres with a mean of 95.7 millimetres. The monthly average temperatures are between 25.9 degrees celsius and 29.1 degrees celsius with a mean of 27.5 degrees celsius, while the monthly average evaporation is between 4.9 and 6.6 millimetres with a mean of 5.1 millimetres (ibid).



Source: Fieldwork 2009: Irrigation canal for rice farming in Akuse

A dam has been constructed on the Volta Lake nearer Akuse owned by the Volta River Authority (VRA) for purpose of generating hydro-electricity for the country. This has attracted employees from different part of the country into the community making Akuse a very renowned town in Ghana. However, it important to note that the employees of VRA are living in a separate environment of their own with good housing facilities and are economically better off than the inhabitant of Akuse. The community has Public institutions such as Police service, Prison service, Fire service and Metrological Service Department. The community can also boast of a Hospital, named; The Akuse Government Hospital which serves the district and other towns surrounding the district. However it is important to emphasize that since its inception, the hospital has not gone through any major refurbishment. The Chief of Akuse did expressed worry over the neglect of the Akuse government hospital, which was constructed about 99 years ago, during the reign of the late King Nene Azumatey Koley.



Source: Fieldwork 2009: Akuse Government Hospital, OPD.

A big concern to the people of Akuse is the mass unemployment of the youth in the community. This is attributed to lack of industries and other employable avenues in the town. It's reported that during the early 19th centuries, the Germans had a trading post in Akuse wherein they built warehouses and factories in which they employed people in Akuse and its environs. They also engaged in trading of cotton, salt dried fish, yam, cassava, maize, maize beer, maize flour, and various fruits. Akuse, Amedeca and Kpong located in the Lower Manya District then became the most important trading village along the Volta Lake at that time. After their departure, many of the employees were left unemployed and that has been the situation till date in Akuse. Most of the warehouses had been converted into church auditoriums and shops by individuals.

The major economic activity of the community is rice farming, followed by maize farming and trading. Their engagement into rice farming can be attributed to the nature of the soil. The soil has a clayey nature which makes it muddy during the raining season and hard during the dry season. As a result of this, the crops that do well on the land are predominantly rice and Maize and majority of people are found in these agricultural activities.



Source: Fieldwork 2009: Rice farm at its early stages

The community is served with 4 primary schools and 3 junior secondary schools. It also has one senior secondary school but despite the availability of these schools, literacy rate in the area is quite low. The community is largely a Dangme -speaking patrilineal settlement with major distinctive dialects such as *Ningo*, *Osu*, and *Krobo*, hence do not have a distinct festival that identify and unify this community since the community is a composition of people with different ethnic background. Religiously, the people are mostly Christian with a few section of the population being Muslims and some Traditional. Today even though the majority of the people claim to be Christians, traditional rituals and practices as well as beliefs especially those associated with the ancestors are still strong and widespread as it is believed that failure to observe these things may attract punishment from the ancestors. Local administrations are in the hands of the chief, the council of elders and the assembly men. The chief also sometimes serves as a spiritual head and besides settles disputes, arguments and conflicts that are brought to him.

This community was chosen for the study due to the fact that it is located in the district which has high cases of HIV/AIDS in the country. Sentinel surveillance survey report shows that HIV prevalence in the area is 7.8% as compared to other Districts that has very low percentages (National AIDS/STDS Control programme of Ghana, 2001). The district has

attracted the attention of many health workers and nongovernmental organizations that are working in the country to promote condom use.

3.3. CHOICE OF RESEARCH METHOD

Methodologies define how one will go about studying a phenomenon while methods are specific research techniques (Silverman, 2006). In this study I employed a qualitative method for data collection and analysis. The reasons being that I wanted to explore people's reflections and dilemmas on HIV/AIDS and condom use, why they refuse to use them or factors that affect condom use, their behaviours towards it and the meanings they give to it. Furthermore this method has the ability to find sequence in which informant's meaning are deployed (ibid) and generate deep understanding of issues relating to the topics under studied (Silverman, 2005). Above all it has the distinctive advantage of "producing discursive descriptions and exploring social actors' meanings and interpretations" (Blaikie, 2000:232) and is believed to be useful to probe deep into issues of religion, gender, HIV/AIDS and condom use (Zenebe, 2006).

3.4. PRIMARY DATA SOURCES

The primary data used in this research was collected from a field work conducted in the months of June and July 2009. Semi structured interviews were the main method for collecting qualitative primary data.

The informants for this study were all young adults of Akuse both male and female of Christian and Muslim backgrounds. Out of this a sample size of 20 young adults were interviewed. 10 were Christians; 5 males and 5 females and 10 were Muslims; 5 males and 5 females (See Appendix B). All informants were between the ages of twenty (20) to thirty-five (35) years.

The purposive sampling method was used as it helped choose a case with features of interest such as gender, age and religious affiliation (Silverman, 2005). The sample was not representative but purposive in order to ensure diversity.

3.4.1. Interviews

The interviews were to get detail information about condom use from the sampled informants. The interviews contain lists of interview questions (see appendix A) ranging from knowledge of HIV/AIDS to condom use. Opinions about factors that affect condom use, opinions of religious affiliation and gender on condom use were also collected from the interviews. Muslims and Christians of both sexes were thus interviewed to find out about their opinions and views towards condom use.

The interviews were held on one-on-one basis in the selected young adult's resident. The order of interview questions for informants was different and follow-up questions were also different. The interviews were very flexible, informal and relaxed and this led to the obtaining of more detailed information as it allow informant to talk more comfortably. During the interviews special effort was made to ensure confidentiality and privacy. Hence, each informant was interviewed separately so they could express their views freely without inhibition and to reduce the tendency of the informants being influenced by others.

After obtaining permission from the assembly men of the town, it was quite difficult to start each interview as the interview question were very personal and some questions very sensitive which relates to informant's sexual life and knowledge about condom. These questions were 'no go area' for most informants. At each interview, there were therefore very long introductions and this was time consuming but the detailed information obtained from these people were worth the difficulties involved in conducting the interviews. Having realizes the shyness of informant to speak due to the sensitivity of the questions, voice recording was withheld and instead, detailed hand written notes were kept.

Over the period of two months, I conducted 20 interviews; this was one of my difficult tasks. When it came to selecting and gathering informants for the interviews, I had assistance from one of the community teachers who has been teaching in the community for the past twenty years and had a good social relationship with the members of the community. Due to these, it was easier for the community members to trust the teacher when he encouraged them to participate in the research. That was how I recruited the entire twenty informants. The presence of the teacher might have affected the outcome of the interviews as he might have selected people that were loyal to him for the interview and thus the informants might respond to question to win the admiration of the teacher. They may have withheld information that they thought the teacher might dislike or be shocked by. Nevertheless, the information gotten

from these interviews were detail and relevant to understanding condom use which might be difficult to get using other research method. The 20 interviews were evenly spitted between Christian and Muslim affiliates, Male and female as stated earlier so as to have a balanced review and assessment of the cases (See appendix B). The informants were mostly traders and farmers who had little education. The majority of them were also in relationships while some were married. Others were not into any relationship but were conversant with relationship issues.

3.5. SECONDARY DATA

In order to improve the quality of explanation as well as to allow for comparisms, secondary data was widely used in addition to the primary data since a number of studies had gone on about condom use and HIV/AIDS by scholars and authorities. At fieldwork, I visited the University of Ghana Libraries; especially the sociology department library which gave me the opportunity to collect documents. The secondary data were collected from both published and unpublished sources including journals, articles, books, and the internet sources. This data focused on the views of condom use by earlier researchers. Most of these types of data were used during the literature review and theoretical perspective chapter as well as during the analyses and discussion chapter.

3.6. DATA ANALYSIS

The steps I took to analyze the data were to read the interview script and the documents I collected for the study. I tried to develop categories such as ‘gender and condom use’, ‘religious affiliation and condom use’ and ‘factors that affect condom use’ and also created some relationships. These categories that were developed while reading the data were inspired by the theoretical perspectives presented.

3.7. SOME FIELDWORK CHALLENGES AND LIMITATION OF THE STUDY

Ghana has been heavily affected with emergence of HIV/AIDS and hence a commission was established to handle the issue of HIV/AIDS in the country. This commission is the Ghana AIDS Commission. I planned to visit this commission to review current literature and study official documents on the cases of HIV/AIDS in the country. However due to reasons beyond my control I was not able to book an appointment with the official of the Ghana AIDS commission. Due to this, it was impossible get access to any current literatures and official document for my thesis as the commission is mandated to handle records and issues with regards to HIV/AIDS in the country.

The Akuse Government Hospital has been of immense benefit to researchers when it comes to accessing information on HIV/AIDS and thus I visited the hospital accordingly, but only succeeded in interviewing one Nurse. This is mainly due to their tight schedule at the hospital. The hospital was under-staffed and it was therefore difficult for nurses to abandon patients on their sick bed to participate in an interview.

Before I left for field work, I planned to use a voice recorder and thus bought a voice recorder accordingly for recording interviews. On the first day of the interview, when I attempted to use the voice recorder, I realised the informant was not feeling comfortable discussing issues about condom and HIV/AIDS with me. To my surprise a nearby person shouted “he is holding a recorder”. As a result of this, and realising the sensitive nature of the questions, I withdrew the recorder and never used it again. It was therefore difficult to write all relevant information since it was a tedious task listening and at the same time taking field notes. The problem was further compounded by the language as I have to translate whatever they said in the local dialect into English. It was quite tedious translating their responses and this might have also resulted in loss of some vital information.

Aside these challenges, a number of the informants were somewhat uneasy and somehow shy to discuss the issues due to the perception that open talk about condom use was improper, indecent and such people who engage in such talks were branded as ‘spoiled’. This actually made my data collection complicated coupled with a long process of introduction as I have to adopt a funny and interesting strategy so as to get them talk. I had to continually navigate my way to the interview questions by sharing some jokes with the informants and discussing issues about sports and politics. I ended up constantly reassuring all interviewees that the

study was for academic purpose and thus showed them the letter of introduction from my supervisor. In addition, I had to convince these informants that the information they provided were useful for the fight against HIV/AIDS epidemic which is a major challenge to the district. Others also turned down my invitation to be interviewed.

Prior to my data collection, I acknowledged there would be problem getting access to female informants. The female informants were more unwilling to discuss issues of condom use simply because I was a male. They seem not to understand why a male should ask those questions that borders on their sexuality. To them it meant asking them question about their private lives which was not very easy to discuss in public. Hence it was difficult to get such women talk freely and some ended up avoiding the specific questions posed.

Most of the interviews took place in the private homes of the informants. Another problem encountered during the interviews was the intrusion of other individuals even though I tried to minimise this by conducting the interviews on a one-on-one basis and especially in the afternoon when most members of the household had gone to the farms and the market. In some cases privacy was just impossible since some of the houses of the informants were compound houses shared with other tenants.

More importantly, the quality of the interviews could have been improved if female assistant was sought to help with interviewing females. However, this study, as a qualitative study does not lend itself to generalization. This does not prevent it from fulfilling the purpose for which it was intended. This study was meant to generate an understanding of young adults' reflections and dilemmas on HIV/AIDS and condom use with a focus on the factors that leads to non use of condom in relation to HIV/AIDS prevention in the study area, which can be used as a basis for an intervention programmes on HIV/AIDS in the community.

3.8. VALIDITY AND RELIABILITY OF DATA

Validity is used in qualitative research to determine whether the findings are accurate from the standpoint of the researcher, the participant, or the readers of the account (Creswell, 2003). As expressed by Silverman (2005), validity in qualitative research means truth. And it is also related to the ability to be specific in the research questions and to interpret the

information correctly. This is also indicated to be the extent to which an account accurately represents the social phenomenon to which it refers (Hammersley, 1992; in Silverman, 2005). Strenuous efforts were made to ensure the responses from the informants are truthful as possible. First, informants were made aware of the academic purpose of the exercise with a proof of an introductory letter. Secondly, owing to the sensitive nature of some of the interview questions, each informant was separated from people as much as possible to ensure privacy of the informants. Aside, they were assured of the confidentiality of their response.

Reliability on the other hand has been referred to as the degree of consistency with which instances are assigned to the same category by different observers or by the same observer on different occasions (Hammersley, 1992; in Silverman, 2005). As typical of qualitative research, the establishment of reliability represents reporting and proper documentation rather than obtaining same results (Opare-Henaku, 2006). The study documented procedures and reports, which allows for evaluation.

3.9. ETHICAL CONSIDERATION

The need for ethical consideration in all research has been emphasized to protect participants. As a result of this, after the study was approved by the academic board, a letter of introduction was taken from the academic supervisor to seek permission from the chief of the town and the community leaders. The same permission was also sought from all informants interviewed. Every possible effort was taken to protect the privacy of the informants in the study and as such no names were required. Informants were told they were free to choose to participate in the interview or not. And in the course of the interview, they were also free to withdraw.

CHAPTER FOUR

CONDOM USE AMONG THE YOUNG ADULTS

4.1. INTRODUCTION

The analysis and discussion in this chapter attempts to examine the HIV/AIDS awareness and risk perception among the study population. The chapter also examines factors that hinder condom use with reference to gender and religious views on condom use.

4.2. CONDOM USE, HIV/AIDS AWARENESS AND RISK PERCEPTION

The HIV/AIDS campaigns at Akuse as well as other parts of the districts and the country in generally emphasize three basic behavioural changes namely; abstinence, being faithful to only one sexual partner and effective condom use. Information on condoms and HIV/AIDS awareness and individual risk perception about the disease can be used to examine the extent to which people have gotten the correct information needed to induce behavioural changes. Moller (2000) noted that, people often misperceive the risk associated with a particular activity because of lack of correct information or they could be overoptimistic. The study shows that condom and HIV/AIDS awareness among the people is high as all the informants said that they have heard about the disease as well as condoms. This is not surprising because HIV/AIDS awareness in Ghana as a whole is very high. The 1998 GDHS indicated that 97% of women and 99% of men in Ghana have heard about HIV/AIDS (Ghana Statistical Service, 1999). The high knowledge of the people about the disease is an indication that the HIV/AIDS campaigns have reached most people. Even though many people have heard of the disease and condom use, the interviews revealed that the depth of knowledge on the disease is somehow low. Some informants seems to believe, for instance, that one can only get HIV/AIDS when he or she sleeps with prostitutes whilst others think that a fat person cannot be HIV positive. As the AIDS risk reduction model (Perloff, 2001) emphasizes such wrong notions about the causes of the disease may make people wrongly think that they are not at risk of HIV infection thus leading to a high risk tolerance. In terms of fear of AIDS and perceived vulnerability to HIV infection, the majority of the informants said their fear of the disease is high. However further interviews show that most of these people, especially men,

whilst afraid of the death associated with the disease, somehow do not actually think that they were at risk of getting the disease. This is what one young man said in response to a question on his fear of HIV/AIDS infection:

“I do not change girls from time to time. I only move along with one girl for a long time.”

On sources of knowledge on the disease and condom use, this study shows that the common avenue from which they receive information on condom use and HIV were through; the Radio, followed by Television, Mobile Van (public address system), Religious Leaders and Newspapers. Through observation, there were Bill Boards and Posters that contained information about condom use and AIDS. It's likely that the people of Akuse also did receive information by these means but these were not mentioned by the informants. There was countless number of corporate names advertising their product on the bill board and posters which can distract information being communicated. During the field work it was observed that some NGOs used vehicles with speakers to carry HIV/AIDS message. It is logical to assume that the shallow knowledge that the people have on the disease is due to the sources through which they get the information. As the people get HIV/AIDS information through non interactive sources such as the radio, they cannot have the opportunity to ask questions and may thus depend on friends for clarification of puzzling questions. This may lead to the spread of false information. Thus as the risk theories posit such informal exchanges may transform the content of correct messages coming from health officials (Bernardi, 2002).

In relation to knowledge of habit which could make one contract the disease, all informants mentioned unprotected sex with an infected person. They also mention other factors such as blood transfusion, using contaminated blade and injections with an infected person. On preventability, the majority admitted that the disease can be prevented and even avoided. When probed further about preventive measures, their response centered on behavioural change towards condom use instead of having unprotected sex with an unknown partner, avoiding casual sex, having a single sexual partner, having HIV test before marriage and using one's own blade. Among those who had some ideas about the preventive measures, the use of condoms appeared most in their responses. Only few people mentioned abstinence. The fact that only a few respondents mention abstinence is an indication that HIV campaigns that emphasize only abstinence are not likely to achieve success. The majority of people who

mention using condoms for protection is thus very interesting since condom use appears to be the best preventive method among populations that are highly sexually active (Afifi, 1999).

4.3. FACTORS HINDERING CONDOM USE

This section of the chapter attempts to throw more light on some of the factors that hinders the use of condom at Akuse. Information obtained from informants suggests that the factors militating against condom use are many and interwoven in very complex relationships. It must be stressed also that the interviews shows that there are wide variations in the reasons for non use of condoms among informants and this might also suggest that condom use may be embedded in different contexts.

4.3.1. Lack of fear for HIV/AIDS

It is widely accepted that for appropriate behavioural response to occur, the individual must feel some sense of fear and feel able to reduce risk by behavioural change (Cutter, 1993; Cleland, 1995). The health belief model emphasizes that readiness to embark on risk behaviour is based on individuals' perceived susceptibility (Scambler and Scambler, 1984). It is therefore obvious that people will be willing to use condoms only when they feel they are at a high risk of getting HIV/AIDS. Most informants do not feel they are at risk of HIV infection and hence non-use of condoms. The opinions of people in Akuse are very different from what one senior nurse told me at the Akuse Government hospital. She was of the view that due to inevitability of death in general most young men often refuse to use condom. She attributes this to the rampant of death in the district as every Friday corpses were taken out of the hospital mortuary. Caldwell (2000) similarly argued that since deaths are so common in Africa, most people do not practice safer sex because they do not care if they die of AIDS. On the other hand, though most of the informants interviewed in Akuse during my fieldwork did not really seem to agree with the statement of the nurse, they also did not think they were at risk of HIV/AIDS. Thus they are optimistic that they have some control over the situation. The interviews show that most of the young adults feel safe because they are in monogamous relationships. The statement of one young man clearly demonstrates this. Asked whether he thinks he is at risk of HIV infection, the man said:

“I have a single lady and I don’t go in for any other woman and therefore I will not get AIDS”.

Asked curiously whether this was his first girl friend, the man said he has had about four girl friends in the past. Like this young man, the majority of young people in Akuse stays in sexual relationships with one partner for some time and drops him or her off and jumps to another partner. This is what can be termed as serial monogamous relationship. Some informant explained that most young men just enjoy jumping from women to women to earn them some respect among their peers. Despite this debate, one thing is clear that the reason why most people in serial monogamous relationships would not use condoms is the trust they have in their sexual partners. The trust increases with time in the relationship and for that matter if they even use condom at the beginning of the relationship, they are likely to stop using it when they stay longer in the relationship. This shows the importance of time in influencing condom use. One informant said:

“I happened to use condoms during our early periods of the relationship but I now know him so much and we no longer use condom”.

The reason why some did not continue using condom in a long relationship was due to trust which develops over time and this is actually based on the kind of information the partners receive from each other. For instance some young men said that when they are able to influence a lady that they want to marry her and that he had been single in past without a girl, the lady is likely not to request for condom use. In the same way a man who receive information from the community that a particular lady he wants to marry has been single for many years, the man is also likely to relegate the idea of using condom. However, it is important to argue that information based on one history and past experiences could be very deceptive and pose danger as it could be wrong since it is possible that people would deliberately hide important information. This suggests that knowledge of a partner is not comprehensive since there could be forgetfulness and sometimes intentional acts of deception so as to carry information across.

This idea that people in serial monogamous relationships do not use condoms despite its high risk imply that the issue of limiting sexual relationship to one partner which is one of the methods advocated by HIV preventive campaigns in Ghana is misinterpreted by the people of

Akuse. The serial monogamous relationships are hereby being equated to the real stable monogamous relationships and as such the people involved feel invulnerable. Hence according to the AIDS risk reduction model these people may run a higher risk of HIV infection since they do not identify their unprotected sexual activities with one partner as risky. Thus as Scott and Freeman (1995) noted trust has become a symbolic solution to the risk of HIV infection to these people in monogamous relationships. Similarly, from the perspective of the trans-theoretical model of change, these individuals may not change their behaviour, not because they may not see the essence of condom use but because they cannot see their behaviour as problematic or risky. They could be said to be in the *pre-contemplation* stage and they need very convincing messages that they are at risk.

Some people also explained that they do not use condoms because they do not sleep with prostitutes and strangers. This statement and indeed interviews with the informants point to the fact that most young adult at Akuse still have the wrong notion that one is only at risk of HIV infection when he sleeps with strangers and prostitutes. The statement also shows that most young adults judge the HIV status of a person based on body appearance and familiarity. Here it was common for men to argue that all their girl friends are familiar people in the neighbourhood and hence they do not need any condom. The same tendency is seen in a research conducted in Peru, where it was realized that some men especially young men were not likely to use condoms due to the idea that they cannot be infected with HIV by refusing sex with gays or prostitutes and rather having sex with only known friends (Gio Cochea, 1996). This supports what the risk theorists mentioned that it is the individuals' perception of risk rather than actual risk that determine behavioural change (Lupton, 1993 cited by Gabe, 1995).

Whilst a few married women interviewed also have this misconception about the disease, the majority of them actually know that their husbands' infidelity puts them at risk of getting the disease. It was revealed that this may be a result of the fact that most HIV messages are also received by women attending prenatal and post natal clinics. Moreover, the gender division of labour means that it is the duty of women to send the sick children to the clinics where detailed information on HIV/AIDS are usually given and this means that even though both men and women are aware of the disease, women get expert information more regularly than the men. Again the hospitals require that pregnant women must undergo a HIV test before delivery and makes most women aware of the disease. However, these married women may

have little power when it comes to negotiating for condom use in marriage. The following statement of a 35 year old woman clearly demonstrates this:

“I do receive report that my husband goes out with other women in town but I cannot tell him to use condom since he is likely to tell me I cannot dictate to him.”

Thus it is clear that these women know they are risky to HIV infection but they just do not have any control over their husbands’ infidelity. Besides they cannot insist on condom use within the marriage as most men may not even understand why they must use condoms with their own wives. In the Ghanaian context, men are head of most families and would not like to be dictated especially on condom use. Men seem to have final authority in decision-making in the community. This finding that men may not be willing to use condom with permanent wives has been reported elsewhere on the African continent (Zenebe, 2006). For instance, it has been reported that whilst miners in South Africa might use condoms with prostitutes they do not use them with their wives (Schoepf, 1993). This has led to the situation whereby many young married women in these areas have been infected with the HIV virus (Epstein, 2002). The problem of these married women exemplifies what has been discussed already that individual risk perception depends on the degree of control they feel they have on their own behaviour as well as their partners’ infidelity. Knowledge does not help if one does not have any power to reduce risk (HIV infection) by behavioural change such as condom use (Bernadi, 2002).

4.3.2. Societal norms and perceptions about sex issues

Societal perceptions about what should be accepted as a normative behaviour go a long way to influence individual behavioural changes. Spousal communication about sexual issues can lead to effective use of condoms (Ezer, 1993; Mehryar et al., 2003). Unfortunately such communication is low in the study area. The perception among many young adult is that those who discuss sexual issues are spoilt and hence people may not even discuss such issues with their own partners. This notion may also imply that people find it difficult to buy condoms. This is what one informant said:

“We don’t talk about this (condom) in our house.”

Similarly, most people in the Akuse area do not discuss sexual issues in general and for that matter condom use with their children. Historically sexual relations in many Ghanaian societies occurred within marriages only. Puberty rites were used to mark the stages a girl had to go through before being considered mature for sexual relationships. If premarital pregnancy occurred it was punished with various sanctions such as ritual cleansing. However in the Akuse Land today, many families do not demand such sanctions anymore. Thus with social change these traditional norms discouraging premarital sexual activities have been weakened. Most people now even accept premarital relationships as a form of trial marriages. This supports the point made by Awusabo Asare et al. (1993) that even in societies where premarital sex was not permitted, it is today considered as normal.

In Akuse, however, premarital sexual activities are only now sometimes traditionally accepted among girls who have reached the age of marriage but are unmarried. Many young adults consequently also still think that it is improper to openly let parents and other elderly people like the teacher know of their sexual activities and as such most of these young adults reported that they could not buy condoms openly and hence non use. Anarfi (1993) noted that there is a tendency of such young people being away from their homes, engaging in high risk unprotected sex.

4.3.3. Lack of Power for women to negotiate for condom use

As previously mentioned the study in general indicates that young women are often not in a position where they can make decisions on condom use in a relationship. This is supported by the woman's previous statement discussed earlier:

“I do receive report that my husband goes out with other women in town but I cannot tell him to use condom since he is likely to tell me I cannot dictate to him.”

In Ghana, the system of inheritance does not favour the women. The inheritance system makes them dependent on their partners and as such they stand to lose if the male partners' unwillingness to use the condom results in the breakage of the relationship. Apart from the inheritance system certain other cultural factors of the community also contribute to the relative powerlessness of women in such domains. For instance, there is a wide spread perception that men can practice extramarital affairs. Traditionally, after paying the full bride

price a man has the freedom to befriend or marry as many women as he can. A man can only be said to have gone against societal norms when he engages in sex with a married woman. However, females engaging in extra marital affairs are considered as an abomination in the community. Most people believe that if a married woman secretly has sex with another man other than the husband, an evil will befall her unless a ritual is performed. The belief is still very strong even among Christians and highly educated people in the study area. As a result of this, most young women in the study area remain very faithful to their husband after marriage.

The women also accept this social construction of men's extra marital affairs and are thus not willing to oppose or challenge their husbands' infidelity as that is perceived as a deviation from the norm. A woman who tries to challenge such a male power is said not to be well cultured by her parents and this is a disgrace. This situation has been encouraged to the extent that even in premarital relationships, men are permitted to befriend more than one girl however a female is seen as a 'spoiled person' if she does so. It was realized that while this belief in male dominance and the acceptance of male infidelity is widespread in the study area, a few highly educated and independent women who are economically independent are more likely to oppose their husbands' infidelity. Such women are likely to take personal decision that borders on their health.

The disturbing issue of the inhabitant is the extramarital affairs of the men. It is reported that men who have sex outside their marital home most often would not use condom but their legal wife cannot deny the husband sex on this ground. This is based on the belief that the women must be submissive to their male partner's demands. This might be due to the fact that in the cultural context, it is the duty of the wife to meet the husband sexual demands without any form of excuse even when it is risking her health. The belief in the community is that if a wife denies the husband sex, she will be subjected to public disgrace, shame and sometime isolation from people coupled with violence. In fact, there is a traditional saying among people in most Ghanaian communities that if a man and the wife are fighting in a room no-person must go there because it may be due to sexual denial which the man can fight for. Apart from violence if a man is perceived to die due to denial of sex from the wife, the community imposes punishment on the woman. She is made to pay a fine to please the gods and pacify the ghost of the deceased since it is believed that ghost of the man will reside in the

community for three days. In some extreme situations, the woman may be asked to relocate to a different community.

Today with modernization, a few families will spare such a woman if it is well established that the husband was HIV positive before death, but unfortunately apart from a few educated people most people will not attribute a sickness or death to HIV/AIDS. It is even disturbing that among some families it will even be said that such a man died because of sex denial. Thus it is logical to argue that as long as these beliefs are strong in the community, it would be very difficult for women to negotiate for condom use. These women may be aware of the risk involved in unprotected sex but have little power to negotiate for condom use. This shows that although it is the individual woman who engages in any given sexual behaviour, it is the society that shapes it, directs it and influences the pattern that evolves. This aptly supports Giddens (1984) structuration theory that individuals are born into societies that entrap them with structures that both enable and constrains them. Thus traditional patriarchal beliefs prevents women from negotiating for safer sex including condom use but the same norms give men the power to dominate their partners and to practice unprotected sex. Programmes to change sexual practices should therefore first redress the balance of power in heterosexual relationships.

If these power relations are not balanced, even young women who are careful about their sexual behaviours are still at risk of HIV infection since they have little control over their male partner's. It is quite evident that being dependent and subordinate make it difficult for women to demand fidelity or divorce, and to negotiate for safe sex through condom use. Thus Mills (2003) and Zenebe (2006) observed that financial reliance, beliefs and customs constrain women from taking full control to avoid contracting HIV/AIDS. To this end, Lydie et al. (2004) argues that male mobility and extra sexual activity is an important feature of the HIV epidemic in Cameroon. Most female HIV victims in Africa have been infected by their husbands (Kalipeni et al., 2004) yet the female are often seen as the cause for the spread of the HIV/AIDS (Alubo et al., 2002). This scenario demonstrates male dominance where women are disempowered due to entrenched asymmetrical pattern of power (Teye, 2005).

The study also indicate that even monogamous marriage which is being encouraged and advocated for the young adult as a way of dealing with the HIV menace is posing danger and risk to these young women, who may be infected not through their own infidelity but through

that of their partner's over whom they have little control. Thus risk perception among these young women is highly a function of the extramarital behaviour of their partner's but risk perception of the men is not significantly dependent on the sexual behaviour of the women because the cultural factors already prevent the women from practicing extra marital affairs. Thus the theories of risk as discussed in chapter two emphasized that risk behaviours actually involve two partners and practice is characterized by constraint. Sexual relationships involve at least two people and sexual risk behaviour is a social rather than an individual activity. Such findings also buttress the argument of Holland et al. (1991) that in many heterosexual relationships, unsafe sex arises out of the strategic power relationships between male and females partners.

Thus young women in this study area have a double agony of checking their own lives so that they are not infected with HIV/AIDS as well as checking the sexual behaviours of their partners. Unfortunately they do not have any control over one of these and that is their partners' extra marital activities. Thus in Giddens terms the cultural norms serve as constraints on these women. This shows that young women may be at a higher risk than even young men as they cannot control these factors. This may explain the reports which shows that HIV/AIDS disproportionally affects women since they are socially and culturally more vulnerable than men (Walsh, 2001).

4.3.4. Religion and beliefs of the society

The impact of faith and beliefs in the supernatural influence on our behaviours are enormous and this transcends to condom use as well in Akuse. Each society has moral standards which reflect the approved ideas we think that the religion has set for us (Foreman, 1999). In both Christianity and Islamic religion, a wife is supposed to be submissive to the husband. It is also the belief of both religions that God created sex to bring fulfillment to husband and wife, thus when a woman even knows that her partner has been having sex with other women and may be also HIV positive, she still considers it her duty to have sex with him (ibid). Thus, since men know that their partner consider it as a duty to have sex with them at all cost, they may decide not to use any condom even if they pose health threat to their female partner.

Another area where religion serves as a hindrance to condom use is in the quest for more children. And this is based on an idea that they must be fruitful in their marriage. Related to

this is a belief by many religious leaders that the campaigns for condom use will promote premarital sex and extra marital activities among adults. This is an issue affecting the collaboration between the religious and the secular bodies in the campaigns against the disease. The religious leaders would only want to emphasize sex within marriage as a mechanism for such protection. Asked; what were the views of their religious leaders towards condom use, this statement run through the response of Christian and Muslims respondents:

“If they accept that people must use condoms and then begin to tell the members to do so then they believe they are promoting high promiscuity among the people.”

The above statement shows that people do not perceive that the religious bodies are prepared to accept condom use as a protection against HIV AIDS. Apart from this, the study has also observed that beliefs about causes of diseases and death serve as a hindrance to condom use. Most people believe that one can get certain diseases as a result of witchcraft, a curse, or as punishment from God or the ancestors. Traditionally, most death in the community is believed to have a spiritual cause. It follows that unlike in the scientific world whereby pathologists conduct tests to establish the cause of deaths, in the district most members of the deceased more often than not, would inquire from gods and traditional priests who are spiritualist to find out what brought about the death and sometimes diseases. It is therefore imperative to say that so long as people in this community hold on to the supernatural cause of deaths and diseases such as HIV/AIDS, it will be very difficult to accept condom use as a measure to curb HIV/AIDS. Hence they may not be using it especially as its use even reduces the enjoyment they seek from sex. Thus the beliefs and religion of the society serve as a hindrance to condom use (Caldwell, 2000).

4.3.5. Practical factors

During the interviews most young adults said that the reason why they were not using condoms were the inconvenience associated with its use. Most respondents said that putting on a new condom at the commencement of each sexual activity is inconvenient but even the more disturbing issue to them is that condoms do not make them get higher gratification. This belief is held by both young women and men. Such complains about dissatisfaction and lack of intimacy with the use of condoms has been reported in some countries in Africa (Kalipeni et al., 2004). This shows that people may not maintain safer sexual behaviour (condom use)

over time if they do not enjoy the physical and psychological result by adopting the safer methods.

In addition, there is the belief by many people that condoms are not trustworthy and therefore, cannot be used as preventive method. Most young adult stated that they have heard that the HIV virus can pass through some of the condoms when it has a hole and hence the method may not be protecting them. It is likely that this idea may have been partly due to the fact that most campaigns for condom use in Ghana explain that it is not 100% safe to use condom for pregnancy and HIV/AIDS prevention. Religious leaders have mostly promoted these kinds of ideas as they think the emphasis on condom use will promote promiscuity among young adults. The religious leaders thus sometimes emphasis the inappropriateness and untrustworthiness of condoms in order to convince people to rely on limiting sex to marriages and abstinence for young adults who are yet to marry. This confirm the statement made by Garcia Gonzalez (2000) when he argued that the campaign on condom use in Africa only end up yielding confusion among the people rather than educating them about the best protective methods. Emphasis on untrustworthiness of condoms also sometimes result when health officials educate people that for condoms to protect people effectively, they must be used properly and consistently. People who do not want to use them will distort such messages to achieve their own aims of having unprotected sex. They just argue with their spouses that condoms after all do not give a full protection so why must they use them, especially as the condoms deprive them of intimacy and even takes enjoyment out of sex and reduces spontaneity. This statement run through the responses of the students interviewed:

“Condom use is not 100% safe and cannot be trusted.”

The argument that seeks to advance untrustworthiness of condoms may also be based on religious beliefs that AIDS can be caused by supernatural powers which are beyond the control of humans. There is a relationship between the perceived untrustworthiness and the enjoyment people have to sacrifice when using condom. This is because if condoms rob users of maximum satisfaction and intimacy, and users are being told that it use also does not even protect them fully, then it is rational for them not to use condom at all so that they can at least get the full satisfaction and intimacy. This buttresses the argument of Perloff (2001) and Cleland (1995) that people will adopt safe sexual behavioural change only when they feel

they are vulnerable and also believe that such a change can fully lead to the reduction of the risk.

4.3.6. Cultural factors

Culture is one term that does not lend itself to a single touch definition but one of the often cited definitions is that of Taylor's which sees culture as "That complex whole which includes knowledge, belief, art, morals, law, custom and any other capabilities and habits acquired by man as a member of society" (Taylor, 1971 as cited by Helman, 2002). Many researchers like Kalipeni et al. (2004) have stated that cultural background has implications for health and health care. The analysis so far has supported this as it demonstrated that even though it is usually individual actors that are blamed for non use of condoms; these people are often constrained by cultural and religious factors in the society in which they live. For instance, the cultural practice of marriage rites and patrilineal inheritance system in Akuse which discriminates against young women makes marriage so important to women and this prevents them from asking for condom use either in marriage or in premarital relationships. Cultural practices allows even married men some extra marital sexual freedom but at the same time there are strict traditional sanctions against women who indulge in extra marital affairs or refuse to have sex with their partners and this make it difficult for a young women to refuse to have unprotected sex with their partners.

One would expect that with social change, most of these traditional practices and cultural beliefs should be diluted but the study indicate that whilst some of these practices have been slightly weakened others are still widespread. The fact that these cultural beliefs are not universal but are part of the socio-cultural environment in which the study population finds itself implies the importance of culture specificity of condom use. In literature of diffusion, it can be argued that the above cultural factors or beliefs leads to a rejection of condom use and thus serve as blockheads to the use of condoms (Agyeman and Casterline, 2001).

4.3.7. Poverty

According to the UNDP, poverty is associated with weak endowments of human and financial resources, such as low level of education and few marketable skills and hence generally poor health status and low labour productivity (UNDP, 1999). Poverty is also associated with lack

of self-esteem and motivation. Poverty is widespread in Ghana as a whole as one out of every three citizens live below the poverty line (ibid). The effects of poverty on the spread of HIV/AIDS are great (Oppong, 1998). Factors such as the number of sexual partners and the injection of drugs which increases the risk of HIV infection are actually caused by poverty (Farmer, 1999). Poor men are more likely to delay marriage and therefore delay having stable sexual partners whilst poor women may engage in commercial sex (ibid). In this study, the influence of poverty as a factor hindering condom use has also been indicated. People do not have much money and as such do not see the reason why they should spend their little money on buying condoms rather than food. It was reported in the community that poverty made women use sex as a survival strategy and this prevents them from insisting on condom use.

In relation to the AIDS risk reduction model such poor people may have moved from stage one to stage two or even three and might have attempted changing their behaviours but poverty could serve as an obstacle. In this way they may regress and hence come to re-label their activities, such as non-use of condom, as non-problematic in order to achieve some satisfaction. Similarly in relation to the trans-theoretical model some of the poor women may be said to be in the stage of *contemplation* or even *preparation* whereby they are considering how to start using condoms but unless they are helped socially and economically they cannot take the action needed for full behavioural change.

It is argued that these poor young adults may be aware of the dangers of having unprotected sex but as the situational rational perspective posits, it becomes rational for them to compromise on condom use in order to survive. This support the concept of homeostasis which state that, people are just taking an optimal risk level rather than trying to eliminate it totally since the latter choice would also endanger their survival. This is why Wilde (2002) also explained that the human beings are strategists, and planners, who will always attempts to optimize the level of risk they take. Bernadi (2002) similarly noted that, for these poor women therefore preventive measures such as condom use are not viable and as such their knowledge does not help to reduce risk. Cutter (1993) also similarly argued that individuals' risk assessment must always be placed in the context of competing social issues and concerns. Here the concern of the poor young men and women is how to survive now.

As it stands now, even if the poor understood how to adopt the recommended behaviours, they would not have the resources to do so. In fact the engagement of some young adult in

unprotect sex and other social vices in Ghana in general is due to poverty and until poverty especially among the young adult is tackled, HIV/AIDS programmes aimed at inducing people to adopt behavioural changes including condom use are not likely to make any significant gains.

4.3.8. Institutional factors

The study also shows that the use of condom in the area has been influenced significantly by institutional factors. One of such factors has been the organization of HIV/ AIDS campaigns in the area by Non-Governmental Organization (NGO). During the fieldwork, I observed some of their activities in the study area. It has been realized that the campaigns are quite intensive in the area. These are mostly done by NGOs and health workers from the Akuse Government hospital. There is no doubt that these campaigns have led to increased knowledge about the disease but the interviews indicate that most of the campaigners are not given enough training and as such they are not able to give the necessary information. Asides, there is lack of collaboration between religious organizations and NGOs and this is affecting the success of encouraging the young adult to use condom. It has also been mentioned that most NGOs operating in the area lack funds as they do not get funds from government and because of this they are not able to train peer educators to advocate for the necessity of condom use.

Indeed the NGOs campaigns seems to be based only on the traditional *knowledge-attitudes-practice model* which operates on the assumption that once people are warned that having unprotected sex is risky, they are likely to take rational decisions including condom use but as Kalipeni et al. (2004:65) again noted “This approach elides the broader context of power relations, economic necessity and resource limitations within which HIV transmission occurs”

As discussed already, there is much poverty even at the national level. There are also no social systems taking care of poor people in Ghana and as such young adult, particularly women who are unemployed, have no alternative than to offer sex for money while men sometime engages in other social vices to get money. It is logical to argue that if the states were stronger and had some social systems as in most developed countries like Norway, Denmark and Sweden, it would have empowered the poor to engage in appropriate protective behaviours. In that case women would have had some power to negotiate for safer sex

including condom use and that would have helped to reduce the spread of HIV/AIDS in the country. HIV/AIDS is no exception and thus Charles Rosenberg argues that disease itself is a social actor (Rosenberg, 1992).

Such a discussion has showed that individual behaviours are also influenced by the societies in which they find themselves. Again this supported the argument by some scholars like Wilde (2002); that risk perception as well as its management (which in this case is condom use) does not depend only on individual characteristics but more so, on the more complex social, cultural and institutional context within which people experience them. The findings thus also point to one fact that, focusing on sexual practices and HIV/AIDS without looking at the socioeconomic contexts of the issues is not helpful. Indeed condom use is embedded within social, economic, and cultural contexts and hence comprehensive solutions are needed rather than merely providing people with information as though increased information would be sufficient enough to change young adults' sexual actions. Thus, there is the need to consider the social, economic and the cultural situations in the fight against HIV/AIDS infections with due reference to gender and religion.

CHAPTER FIVE

SUMMARY AND CONCLUSION

5.1. INTRODUCTION

This chapter begins with an overview on gender and religious differences in condom use. The chapter subsequently brings together the summary and conclusion drawn from the research findings with suggestions for further studies.

5.2. GENDER AND RELIGIOUS DIFFERENCES IN CONDOM USE

By exploring in what ways the views of men differ from women in relation to condom use, the interviews indicated that young men believe that it is important to use condom to prevent themselves from being infected with HIV/AIDS and other sexually transmitted diseases. However some men in general did not like to use it because of the pleasure it takes away from sex. Women on the other hand also advocated for the use of condom in light of the HIV/AIDS pandemic. They also advocate its use to avoid untimely pregnancy and also for family planning purposes. According to Abraham et al. (1992), this is related to positive behaviour towards condom use. But it is important to note that women lack the power to advice or suggest to their male partner to use condom when it comes to sex. Hence, lack of power and male dominance influenced women's use of condoms. This is also supported by Koniak-Griffin et al. (1994). This relation of power between women and men (Agarwal, 1997) is partly due to the fact that the cultural and the traditional setting in Akuse consider the male superior to the female. Though individual women see the importance of using condom, their male counterparts preferences could be brought to bear on them to influence their decision to use condom. This is part of the reason why men have a different behaviour towards condom use since they can decide not to use condom and the woman has little power to negotiate for it use. One might also think that since women lack the power to negotiate condom use, they will rather demonstrate higher fear to HIV infection than the male. But during the interview, it was observed that neither men nor women showed much fear of HIV infection.

It is also important to note that both men and women were quick to say that in as much as condom is a preventive method they still believe it was not a safe method. They were of the

view that some condoms are not durable, which result in tearing and bursting in the course of sexual intercourse. And as such the inconveniency associated with its use and the difficulty involved especially on the part of women to buy condoms in shops was an issue of concern since such people were labelled as bad or promiscuous. This point is buttressed by the findings of Abraham et al. (1992) which explained that men have fewer difficulties in buying and carrying a condom as compared to their female counterparts.

The wide gap between men and women in their views towards condom use is in the process of being bridged gradually. This is due to the implementation of national strategies that seek to advance women's full enjoyment of all rights, promote shared responsibility of women and men to ensure safe sex by empower women to take control over and decide freely and responsibly on matters related to sexuality in order to increase their ability to protect themselves from HIV infection. This is done through the provision of health care and health services, including sexual and reproductive health programmes and education that promotes gender equality within culturally-and-gender sensitive frameworks (UN General Assembly Special Session on HIV/AIDS, 2001). This and other advocacy programs such as girl child education in Ghana I believe had made some difference in bridging the gap between males and females behaviours towards condom use.

The impact of religion on condom use is an important issue of concern when it comes to HIV/AIDS programmes. The fieldwork interviews from the religious point of view indicate that informants that were Christian affiliate advocate that condom should be used for protection against unwanted pregnancy and HIV infection. The informants also encourage people to use condom when they were not sure of the faithfulness of their partner. Informants with Muslim affiliation on the other hand also think alike; that, it is important to use condom for control of HIV/AIDS. To this end, both Christian and Muslim affiliates believe anytime a person uses condom, he/she reduces the risk of HIV infection. They were of the view that a person should use it when he/she cannot control his/her sexual drives. These opinions are actually based on the conscience of the individual and the kind of relationship they find themselves in. However the religious leaders of both Muslim and Christians have advised against using condom on the basis that it against the will of their Creator. Religious leaders see condom use as a sin simply because when semen is passed into a condom and thrown away, it is classified as abortion which their Holy Scripture condemns. They therefore advocate for abstinence from sex till marriage and also being faithful to marital partners as a

measure to prevent oneself from HIV/AIDS infection rather than to resort to condom use. The findings from Takyi (2003) indicate that religion has a significant effect on knowledge of AIDS. However, in relation to his study, he did not find religious affiliation to be associated with changes in specific protective behaviour, particularly condom use as also indicated by this study. So even though religious leaders' advice against condom use, informants believe such a contradictory decision to use condom will protect their health. The religious leaders seem to see HIV/AIDS as a curse from their Supreme Being because of man's immorality and that there will never be a cure for it. Hence the cause of HIV/AIDS is given a supernatural dimension. This could probably explain the reasons why religious leaders are against the promotion of condoms as a means of preventing HIV and that the huge amount of money used to buy condom in their view was only promoting immorality (Pius, 2008). Malinowski (1925) claimed that religiosity is related to a desire to control those things that cannot be controlled given the level of technological sophistication of a society (e.g., diseases), and is also a way of dealing with the fear of death. Thus people focus on a supreme being in an attempt to solve a problem that is beyond their control such as HIV/AIDS. Aside, there are also attempt to follow religious explanation and moral guidance so as to gain emotional support from fear of death that result from a situations that are beyond the control of man. This buttress the views by religious leaders who have advised against condom use. However, it was obvious that Muslim and Christian views towards condom use are by and large influence by the Holy Scripture which the religious leaders advocates strict adherence.

5.3. SUMMARY AND CONCLUSION

The study examined reflections and dilemmas on HIV/AIDS and condom use among young adults in Akuse. The main objectives of this study were to find out the factors that hinder condom use and the awareness of young adult of HIV/AIDS and condom use. Furthermore, the study also explored religious affiliation and gendered views in relation to condom use. The study focused on the young adult in Akuse of the Lower Manya district of Ghana. The analysis of the data was done based on the theoretical perspectives of risk, diffusion, structuration, and gender relations. Semi structured interviews were used as a qualitative tool to conduct this study. A sample of 20 young adults was used. The interviews were to get detail information about condom use from the sampled informants selected. The interviews contain lists of interview questions ranging from knowledge of HIV/AIDS to condom use.

Opinions about factors that affect condom use, opinion of religious and gender views on condom use were also collected from the interviews. Muslims and Christians of both sexes were thus interviewed to find out about their opinions and perceptions towards condom use. This primary source was also supplemented by secondary data sources.

In relation to the specific research questions, the following findings and research are made: First and foremost, condom awareness and HIV/AIDS; the study indicate that condom and HIV/AIDS awareness among the people was high as all respondents said that they have heard about the disease and consequently condom use. Even though many people have heard of the disease and condom use, the interviews revealed that the depth of knowledge on the disease is still very low. On sources of knowledge on the disease and condom use, this study shows the common avenue from which they receive information on condom use and HIV/AIDS were through; the Radio, followed by Television, Mobile Van (public address system), Religious Leaders and Newspapers. On preventive measures against HIV infection response centered on behavioural change towards condom use instead of having unprotect sex with an unknown partner, avoiding casual sex, having a single sexual partner, having HIV test before marriage and using one's own blades.

In relation to the factors that hinder condom use among the people living in Akuse, the study indicated that several reasons have been attributed to factors that affect condom use in the community. The specific factor hindering condom use includes lack of fear for HIV/AIDS, societal norm and perceptions about sex issues, lack of power for women to negotiate for condom use, religion and beliefs of the society, practical factors, cultural factors, poverty and institutional factors. It was realized that these factors hindering condom use were interwoven and so it is only a comprehensive programme that would be able to address these teething issues. The influence of these factors in affecting condom use has given credence by the theoretical perspectives of risk, diffusion, structuration and gender relations.

In relation to how the views of men differ from women towards condom use, the study indicates that both men and women advocated the use of condom for HIV/AIDS prevention. However men were more unwilling to use condom compared to women and this is because of the cultural and the traditional setting which considers the male partner superior to the female. The fieldwork further indicated that Christian affiliate were of the view that condom should be used for protection against unwanted pregnancy and HIV infection and thus encourage

people to use condom whenever they were in doubt of the faithfulness of their partner. Muslim affiliates on the other hand hold similar views and thus see condom use as an important tool for HIV/AIDS prevention.

This present study has sought to generate an understanding of the reflections and dilemmas on HIV/AIDS and condom use among the young adults in Akuse with a special focus on understanding factors that hinder condom use in the study area which can serve as a basis for an intervention programmes on HIV/AIDS. Hence, I would say that analysis of these factors has to be done in relation to gender and religion differences within a particular society.

5.4. SUGGESTIONS FOR FURTHER STUDIES

For future studies, it would be interesting to conduct a quantitative and representative study in the area. This will allow for generalization of the research report. Besides, more case studies should be commissioned to focus on specific districts of the country. Such studies should employ a combination of quantitative and qualitative methods to delve more deep into the issue of condom use.

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APPENDIXES

Appendix A

Interview questions

1. Have you heard of HIV/AIDS and condom use?
2. In what ways is HIV/AIDS transmitted and how can it be controlled?
3. Where did you learn about these things?
4. How do you feel and think about condom use as a method in controlling HIV/AIDS?
5. If you needed condoms, how would you get them?
6. Do you have fear for HIV/AIDS? How and why?
7. Do you consider it important for someone to use a condom? Why?
8. What are the challenges or difficulties involved in using condoms as you see it?
9. Have you been in a situation where you found it difficult to use condom? Can you imagine such a situation? Tell me more about this.
10. Could you tell me about a situation where it would be important to use condom?
11. Do you think that men and women have different views on the use of condoms?
12. How do the religious leaders' advice on HIV/AIDS and condom use?
13. What reasons do they give for their views or how do they argue?
14. Research show that people often know that condoms can protect people from contracting HIV/AIDS. We also know that people often don't use it anyway. What are the factors you think hinder people from using condom in this community?

Appendix B

List of Informants

No.	Informant's Name	Sex	Age	Marital status	Religion	Profession
1	Informant 1	M	26	Single	Muslim	Repairer
2	Informant 2	M	35	Married	Muslim	Farmer
3	Informant 3	M	30	Single	Muslim	Farmer
4	Informant 4	M	20	Single	Muslim	Student
5	Informant 5	M	23	Single	Muslim	Student
6	Informant 6	M	29	Engaged	Christian	Storekeeper
7	Informant 7	M	30	Engaged	Christian	Farmer
8	Informant 8	M	30	Married	Christian	Worker
9	Informant 9	M	28	Single	Christian	Repairer
10	Informant 10	M	32	Married	Christian	Storekeeper
11	Informant 11	F	27	Engaged	Muslim	Trader
12	Informant 12	F	26	Single	Muslim	Trader
13	Informant 13	F	31	Married	Muslim	Trader
14	Informant 14	F	27	Single	Muslim	Trader
15	Informant 15	F	25	single	Muslim	Student
16	Informant 16	F	27	Single	Christian	Trader
17	Informant 17	F	22	Single	Christian	Student
18	Informant 18	F	28	Engaged	Christian	Trader
19	Informant 19	F	35	Married	Christian	Trader
20	Informant 20	F	33	Married	Christian	Nurse

Appendix C

Map of Ghana



Source: <http://www.travelblog.org/Maps/map-of-ghana-gh.gif>