

WOMEN, SEXUAL RIGHTS AND HIV IN THE KUMASI METROPOLITAN AREA OF GHANA

By

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DECLARATION

This thesis is my original work while a student in MPhil Development Studies with specialisation in Geography at the Norwegian University of Science and Technology (NTNU).

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June 2007

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DEDICATION

To my dearest husband Adubofour Frimpong for your love, support and especially being around when I needed you most. I really appreciate your effort and sacrifice to help my dreams come true. May God richly bless you.

To my lovely son Kwabena Sarkodie Adubofour Frimpong for joining the family and putting joy in our heart and laughter on our faces.

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ABSTRACT

This study is about women, HIV/AIDS and sexual rights in the Kumasi Metropolitan Area in Ghana. The study aimed at discovering the factors that undermine women's ability to negotiate safe sex and consequently become exposed to HIV infection and the subsequent stigmatisation and discrimination.

The study applied ideas generated mainly from the theories of risk, stigmatisation and discrimination and feminist geography to explain its findings. However, some ideas were also utilised from the empowerment approach. Of particular importance is that concepts like worry, risk perception, risk assessment, risk tolerance, risk optimisation, risk reduction, stigma, discrimination, gender inequality, gender identity and gender relations were applied in the interpretation of the findings.

The study focused mainly on women within the age group of 20 to 39. They included women whose HIV/AIDS status are not known, prostitutes, and HIV/AIDS positive women. In addition, the study included a few men within similar age group, key informants and stakeholders. A total number of 111 informants participated in the study. 80 women were selected for the questionnaire survey using semi-random sampling by age and sex and the remaining informants were purposely sampled. Both quantitative and qualitative methods were used for data collection and data analysis. Methods used for collecting primary data include questionnaire, in-depth interview, and direct observation. Secondary data were also collected from documentary sources. Univariate, bivariate, and multivariate methods were used.

The study revealed that gender inequality in HIV/AIDS persists in the study area. It further reveals that most women are worried for contracting HIV. Also it found out that women have higher perception about HIV and this has influence on their behaviour. However, there is exceptional case where some women with high perception about HIV still engage in risky behaviour. The study also reveals that HIV risk tolerance is generally high at both the local and national level. Caution was revealed as the most preferred measure for risk reduction. Low income or low economic status was revealed as the most important factor undermining women's inability to negotiate for safe sex. Most women also favour that women are given some form of control over their sex. Furthermore, the study reveals that gender inequality which is evident through biological, economic, socio-cultural and political subordination of women make them vulnerable to HIV, stigmatisation and discrimination.

The study recommends measure such as expanding women's access to sexual and reproductive health, expanding public education programmes, promoting and protecting women's right, empowering women, giving women access to antiretroviral treatment and political commitment for reducing women's vulnerability to HIV, stigmatisation and discrimination.

LIST OF ACRONYMS/ABBREVIATIONS

AHFG.....	African Hope Foundation of Ghana
AID	Acquired Immune Deficiency Syndrome
CBOs.....	Community Based Organisation
GAC	Ghana AIDS Commission
GDHS.....	Ghana Demographic and Health Survey
GSS.....	Ghana Statistical Survey
IPPF.....	International Planned Parenthood Federation
HIV	Human Immune Virus
MOH.....	Ministry of Health
MTCT.....	Mother to Child Transmission
MWCA.....	Ministry of Women and Children's Affairs
NAC.....	National AIDS/ STI Control
NACP	National AIDS Control Program
NGOs.....	Non-Governmental Organisations
NMIMR	Noguchi Memorial Institute of Medical Research
ORC.....	Opinion Research Corporation
SNCCFR....	Sir Norman Chester Centre for Football Research
STIs	Sexually Transmitted Infections
STDs.....	Sexually Transmitted Diseases
SWAA.....	Society for Women against AIDS in Africa
TB.....	Tuberculosis
UNAIDS.....	United Nations Programme on AIDS
UNFPA.....	United Nations Population Fund
WHO.....	World Health Organisation

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CHAPTER ONE: INTRODUCTION

1.1. Background of the Study

AIDS is a serious public health challenge globally and it threatens to halt social and economic gains in many countries, especially in Africa. At the beginning of the epidemic there was no real idea what caused it, and consequently, no real idea how to protect against it. Now we know from bitter experience that AIDS is caused by the virus HIV, and that it can devastate families, communities and whole continents. We have seen the epidemic knock decades off countries' national development, widen the gap between rich and poor nations and push already-stigmatized groups closer to the margins of society. We are living in an 'international' society, and HIV has become the first truly 'international' epidemic, easily crossing oceans and international borders (Avert, 2004). Its impact is felt among all populations although there are marked variations among various regions, countries and population groups.

In 2003, almost five million people became newly infected with HIV through out the world, the greatest number in any one year since the beginning of the epidemic. At the global level, the number of people living with HIV continues to grow - from 35 million in 2001 to 38 million in 2003. In the same year, almost three million were killed by AIDS; over 20 million have died since the first cases of AIDS were identified in 1981 (UNAIDS, 2004). The AIDS epidemic is affecting women and girls in increasing numbers. Globally, the percentage of HIV-positive female adults has risen from an estimated 25% in 1990 to 43% in late 1997 and it appears to be rising. It is estimated now that 50% of those living with HIV/AIDS are women (GAC, 2004). AIDS is affecting women most severely in places where heterosexual sex is a dominant mode of HIV transmission, as is the case in sub-Saharan Africa and the Caribbean (UNAIDS, 2004).

African women are at greater risk, becoming infected at an earlier age than men. Women and girls make up almost 57% of adults living with HIV in sub-Saharan Africa. Overall, three quarters of all women with HIV worldwide live in this region. The gap in HIV prevalence between men and women continues to grow. At the beginning of the epidemic in Sub-Saharan Africa, women living with HIV were vastly outnumbered by men. However, according to recent population-based household surveys, adult women in sub-Saharan Africa are up to 1.3 times more

likely to be infected with HIV than their male counterparts. This unevenness is greatest among young women aged 15–24 years, who are about three times more likely to be infected than young men of the same age.

With the identification of the disease in the country, Ghana responded to HIV/AIDS with the effort of Ministry of Health (MOH), Ghana AIDS Commission (GAC), and also currently many Non-Governmental Organisations (NGOs) and Community-based Organisations (CBOs) who are all working in order to bring the disease under control. In spite of all these, HIV sentinel surveys done over the previous years show that there has been a steady increase in HIV prevalence since 2000 although the increase from 2002 was relatively slower than previous years. Indeed the median HIV prevalence rate increased from 2.3 % in 2000 to 3.6% in 2003 (NACP, 2004).

Furthermore, UNAIDS 2004 estimates show that about 180 000 out of the total number of people living with HIV in the country are women within the age 15 to 49. This represents more than half of the total number of people living with HIV in the country. According to GDHS (2003) HIV prevalence in women's age 15-49 is nearly 3 percent, while for men 15-59, it is under 2 percent. Thus female to male ratio is almost 2 to 1. However; there is little variation in knowledge about HIV between men and women (99% to 98%). Although there is little variation in HIV knowledge between men and women, more women are infected than men because most women in the country are unable to negotiate safe sex. This together with other factors makes them more vulnerable to the disease. Against this background, this study is to find out the factors which prevent women from negotiating safe sex and hence become more vulnerable to HIV infection in the study area.

Kumasi was chosen as the study area because according to the 2003 Sentinel Surveillance it has a prevalence rate of 5.0 which is above the national average of 3.6. Also Kumasi is the second largest city in Ghana and it has a mixture of population which is a broad reflection of the different ethnic groups in the country. It has a strategic position within the country, serving as a nodal town from where movements to/from the northern and southern parts of the country do occur. Furthermore, I was born and brought up in this area and therefore I have a good knowledge about

the area and the lifestyle of the people and this will help me in the interpretation of data. Apart from these I have the ability to speak and understand the Akan language spoken in this area.

1.2. Statement of Problem

HIV was first identified in Ghana in March 1986. Since then the epidemic has spread slowly but steadily. In Ghana, as in the rest of Africa, heterosexual contact and mother-to-child transmission (MTCT) are the two most common ways by which HIV/AIDS infections are spread.

Analysis of sentinel surveillance data indicates that HIV prevalence in the country rose from 1% in 1990 to 2.7 percent in 1994 and to 3.0 percent in 2000 (NACP 1995, NAC 2001). The 2003 Sentinel Surveillance Survey Report also shows that at the end of 2002 the median prevalence of HIV in Ghana was 3.4 % (NACP 2003). According to UNAIDS (2004) about 350 000 people were living with HIV/AIDS in Ghana in 2003 and 20 000 people died from the disease the same year. Out of these number of people living with HIV/AIDS, 180 000 are women within the age 15 to 49. This represents more than half of the total number of people living with HIV/AIDS in the country. Also according to the Director General of the Ghana AIDS Commission, Prof. S. A. Amoah 63% of all reported HIV/AIDS cases in Ghana are females and these women usually suffered the most discrimination.

Furthermore, according to GDHS (2003) HIV prevalence in women age 15-49 is nearly 3 percent, while for men 15-59, it is under 2 percent. Thus female to male ratio is almost 2 to 1. Although this shows an improvement from 6 to 1 in 1987 (Dawuona 2005), it is higher than that found in most population-based studies in Africa (GSS, NMIMR, ORC Macro, 2004). The female to male gap is particularly large among women and men age 25-29, where women are nearly three and a half times as likely to be HIV positive as men. The peak prevalence (5 percent) among women is at age 35-39 during which most women are likely to be married or in cohabitation. However, despite these gender inequalities in the rate of infection, GDHS (2003) results show that there is no marked variation in HIV knowledge between men and women.

In Ghana heterosexual intercourse is the main mechanism for the transmission of HIV. Women are therefore disproportionately affected in the country mainly because they do not have control

over the circumstances under which sex occur. Tackling this issue of higher HIV vulnerability for women is very important because women can easily transmit the disease to their unborn and newly born children and hence worsen the impact of the disease. Also they suffer violence and rejection after disclosure of HIV -positive status. The purpose of this study is therefore to find out the factors that prevent women from negotiating safe sex and hence become more vulnerable to HIV infection and the subsequent stigmatisation and discrimination.

This study mainly targeted women within the age group 20 to 39 because they are within the reproductive age group and are usually sexually active and therefore are at higher risk. Furthermore, the study target women because they are disproportionately affected and they bear the brunt of the disease. However, the study would involve few men whose views would be sought through interview to supplement that of the women.

1.3. Objectives

The main objective of the study is to find out the factors that constrain women in the study area from negotiating safe sex and hence become vulnerable to HIV infection. The specific objectives of the study are:

- To investigate whether gender inequality in HIV/AIDS, particularly, for specific age groups persist in the study area.
- To explore women's perception about HIV risk, particularly, their worry for HIV risk, risk tolerance, risk taking behaviour and risk reduction; as well as their perception about their sexual right in the study area.
- To find out the extent to which the subordinate position of women in society make them vulnerable to HIV, stigmatisation and discrimination.

- To come out with suggestions and recommendations on measures and strategies for reducing the vulnerability of women to HIV infection, and for preventing stigmatization against HIV stereo-positive women.

1.4. Organisation of the thesis

Chapter two outlines the concepts and theories used for explaining the findings of this study. The theoretical and conceptual framework is composed of three main theories, which are the theory of risk, stigmatisation and discrimination theory and feminist geography, as well as the empowerment concept. Chapter three outlines the methods used for the collection of data and data processing. It also discusses the characteristics of the respondents and the procedure used for their selection. In addition, the validity, reliability and the limitations of the study have been discussed. Chapter four also describes the geography, history, the demographic characteristics and HIV/AIDS situation in the study area.

Chapter five explore the perception of women and men on HIV/AIDS risk and sexual rights. It is mainly based on the quantitative data collected with questionnaire but it is also supplemented with qualitative data. Chapter six examines how the subordination of women exposes them to HIV, stigmatisation and discrimination. Chapter seven explains how the subordinate position of women exposes HIV/AIDS women to severe stigmatisation and discrimination. It also informs us on some of the support given to HIV women. Finally, chapter eight discusses the results of the study. It gives a general conclusion for the study and outlines recommendations to help minimised the problem researched.

CHAPTER TWO: THEORETICAL AND CONCEPTUAL FRAMEWORK

2.1. Introduction

Theories and concepts play critical role in social science research in generating ideas. Due to this, it is very important to choose theories and appropriate concepts for the problem to be researched. With complex issue like HIV/AIDS, wide-ranging explanatory theories might help to explain the problem.

Behaviours and practices that put people at risk of HIV acquisition and transmission are often the result of many complex factors operating at multiple levels. Theories of behaviour change usually addresses one or more of these levels which include individual, interpersonal, community, structural and environmental factors. Many researchers use a combination of factors from several theories to guide their research programs. Theories and concepts used in HIV research and prevention can therefore be drawn from several disciplines, including health sciences, psychology, sociology, geography, anthropology and social epidemiology.

Geographers use different approaches and explanations for their research, for instance to study how and why a phenomenon such as disease varies from one place to another. Some apply the positivist approaches which employ the method of natural science and concern with the measurements and recording of the disease patterns aimed at generalisation. Others also apply the social interactionist or humanistic approaches which are concerned with individual meanings and focus on what is less readily measured and quantified. Such approaches emphasize on human beliefs, values and intensions. Other perspectives include the structuralist approaches which examine health and disease from the political economy point of view and thereby stress on the macro-scale, political, and economic structures (Gatrell, 2000), the feminist approaches which emphasize the need for renegotiation of the role and structure of institutions and power relations, using qualitative and/or quantitative techniques and political ecology approach. Each of these approaches can be used separately or in conjunction with the others in respect to the different objectives set in a given study.

In choosing theories and concepts for my study, I considered those theories and concepts that would be helpful in giving account of biological, economic, socio- cultural and political factors that make women vulnerable to HIV, stigmatisation and discrimination in society. Also I considered those that will help me explore and assess the perceptions of the informants. In addition, I focused on factors that recognise that intervention programs need to take into consideration factors beyond individual behaviours and particular practices. This study applied the risk theory in conjunction with stigmatisation and discrimination theory and feminist geography approach to explain findings. Since women's empowerment is important for addressing women's issues, the study did not overlook the empowerment concept although it does not form a major part of the theoretical framework.

2.2. Theory of Risk

2.2.1. The meaning of risk

A common definition for risk is probability times the consequence of an unwanted event (Jones and Boer 2003). It also includes the degree of worry about the risk situation. Risk is an unavoidable feature of human existence. Neither humans nor the organisations and societies to which they belong can survive for very long without taking risks. On a personal level every decision or action carries risk which ranges in severity from loss of face, status, money, employment, health, and liberty to the loss of life itself. At another level we are confronted by threats from infectious diseases, fatal accidents, economic disasters, famines, political upheavals, and the possible consequences of the irreparable damage being done by humans to the environment and the very ecological system which supports their existence (Ansell and Wharton 1995).

The word risk has different meanings in different contexts. However, clearly over time and in common usage the meaning of the risk has changed from one which simply describes any unintended or unexpected outcome, good or bad, of a decision or course of action, to one which relates to undesirable outcomes and the chance of their occurrence (Ansell and Wharton, 1995). According to Yates and Stone (1992), risk is a slippery concept and it is described in different ways in different articles or book. Risk has been conceived as danger, loss, uncertainty, threats,

peril, hazard etc. In medicine and epidemiology, risk is the chance of some adverse outcome, such as death or the contraction of a particular disease, while in the economics, business opportunities whose returns are not guaranteed are described as risk. In technology, risk is defined as the existence of threats to life or health (Yates and Stone 1992). According to Crichton (1999) risk is the probability of a loss, and depends on three elements, hazard, vulnerability and exposure. Vulnerability is defined as a high degree of exposure to risk, shocks and stress (Chambers 1989; Davies 1996). In general, the literature states that individuals or groups are considered vulnerable if they are predisposed to illness, harm or some negative outcome. This predisposition can be genetic, biological or psychosocial (http://www.phac-aspc.gc.ca/ncfv-cnivf/familyviolence/html/fvrisk_e.html 11.05 2007).

According to Kronick (1997), how we think about risk and what we do about risk might be regarded as social constructions. However, Yates and Stone (1992) argue that risk should be viewed as a multidimensional concept that, as a whole, refers to the prospect of loss. In addition Carter (1995) also argues that the fact that most forms of risk assessment rely heavily on probabilistic reasoning, the idea of risk points simultaneously to the presence of and possibility of danger. Johnson et al (2000) states that even though it has been argued by several writers that there is no single definition of risk, literally the term risk can be conceived as the likelihood of a range of possible outcomes resulting from a decision or course of action. Risk exist when known probabilities can be assigned to these outcomes. Risk is thus distinguished from uncertainty, under which probabilities can not be established. These definitions imply, among other things that risk involves both the probability and consequence of an action. Unfortunately, we often define and study risk in a narrow manner, focusing on the individual who is at risk or take risk rather than on the broader context that generates and sustains the risk or supports high-risk behaviour (Kronick, 1997).

2.2.2. Worry about risk

A person might say he/she is worried about something and simply mean that he/she considers that there is a risk at hand. With the word “worry” is denoted preoccupation with thoughts about uncertain and unpleasant events. To be worried means to be in an unpleasant state of mind (Sjoberg 1997). The worry that individuals have about uncertain or unpleasant events influence their perceived risk about that particular event. Since in every activity there is some form of risk,

individuals try to minimise the level of risk. However, some people do not worry to take higher risk and as a result they do not weigh the costs or losses of taking the risk against the gains and benefits. Usually men worry about risk probability while women worry about risk consequence.

People's worry about risk has influence on their risk perception which in turn influence their risk assessment which subsequently affect their attitudes and behaviour and these also influence their risk tolerance which in turn affect the culture of the people.

2.2.3. Risk perception

Risk perception is one's opinion of the likelihood of risk (the probability of facing harm) associated with performing a certain activity or choosing a certain lifestyle (Moller, 2000). From the perspective of Social Sciences, risk perception involves people's beliefs, judgements, and feelings as well as the wider social or cultural values and dispositions that people adopt, towards hazards and their benefits (Demoz 2003). According to Sjoberg (1997), when the words "risk perception" are used, reference is made to a judgment that there is a risk of a certain size at hand. Based on the above definitions, risk perception can be used to mean people's views or beliefs about the likelihood and consequence of risk. Risk perception has a number of dimensions since it has influence on individuals risk assessment and subsequently their attitudes and behaviours as well as their risk tolerance.

The perception of risk is multidimensional, with a particular hazard meaning different things to different people (depending upon, for example their underlying values systems) and different thing in different contexts (Royal Society 1992). People often misperceive risk associated with a particular activity because of the lack of information or misinformation. Without factual information, or with misinformation, we are faced with making an uninformed decision. Lack of information on a particular activity may cause one to have exaggerated fears regarding the possible risk of certain situation (Demoz 2003).

With regard to HIV, having the perception of being at risk of infection is one of the necessary conditions for preventive behaviour to be adopted. Paicheler (1999) states that since knowledge about HIV transmission seems very good, many observers are surprised that more people do not

practise behaviour, like safer sex, designed to minimise risk of contracting the disease. Yet, previous studies have shown no clear relationship between knowledge, attitudes and practices. Several theories of health behaviour suggest that it is an individual's perception of risk rather than the actual risk involved that determine behaviour. Hence it is important to assess the risk perception of those at greater actual risk (Fenaughty et al, 1995).

Jackson and Carter (1992) in their work 'The Perception of Risk' argues that the minimisation of risk through increasing rational behaviour is unattainable goal. Since perception determines what is rational, we need to concentrate on perception rather than rationality (Ansell and Wharton 1992).

2.2.4. Risk assessment

Risk assessment is nothing more than the careful examination of what could cause harm to you and other people so that you can weigh up whether you have taken enough precaution or you should do more to reduce harm. Risk assessment is a step in the risk management process. Risk assessment is measuring two quantities of the risk, the magnitude of the potential loss, and the probability that the loss will occur.

(http://www.mywiseowl.com/articles/Risk_assessment, 18.05.2005).

According to Slovic, risk is socially constructed. Risk assessment is inherently subjective and represents a blending of science and judgment with important psychological, social, cultural, and political factors. Judgement is inherent in, and indeed essential to, all forms of risk assessment. Judgement can arise in the selection of risk index, in the assessment of consequences and uncertainties, as well as in the initial structuring of risk problem.

According to Bernardi (2002), individual risk assessment and shared common sense attitudes influence the perceived value attached to the consequence of actions and to the balance of gains and losses behavioural choices imply. If the magnitude of the potential loss is perceived as small enough, then the acceptability of undertaking the action is higher. Risk assessment relies on problematic reasoning (Carter 1995). Individuals may take greater risk with more benefit today than minimise risk with less benefit that could occur in future.

Location, lifestyles and other factors likely influence the amount of risk a person is exposed to. Thus in assessing risk, particular care is taken to determine the exposure of the susceptible population such as prostitutes, smokers, women and children etc. In addition, the differences between individuals due to genetics or other factors mean that the hazard may be higher for particular groups, called the susceptible population.

(http://www.mywiseowl.com/articles/Risk_assessment, 18.05.2005).

2.2.5. Risk taking behaviour

In an attempt to understand risk, some people have the view that individuals seek to optimise rather than eliminate the risk they are exposed to in their actions. Just as Wilde (2002) argues, while some actions entail more danger (probability \times magnitude of loss) than others, there is no behaviour without some risk. The challenge, therefore, is to optimise rather than eliminate risk.

Adam in his theory of risk thermostat and Wilde in his theory of risk homeostasis argue that every individual is comfortable with a certain level of risk and aims to balance the rewards of risk-taking against perceived hazard. Thus when a safety device, for example condom for HIV prevention, is introduced that leads to perception of lessened risk, the rewards of risk-taking become more attractive and engendered a compensatory increase in risk-taking (risk compensation), which may bring the risk back to its original level (risk homeostasis), or may produce a rearrangement of hazard with the new risk being transferred to others (risk displacement) (Richens et al 2000).

Adam idea of risk thermostat is an assemblage of cultural filters, rewards and costs which influence our perception of risk. In his theory Adams analyses perceptual filters, which for example rewards (e.g. money, power, love, glory, sex) influence propensity to take risk. The main idea in his theory is that changes in behaviour act on the rewards and the “accidents”(e.g. death, injury, financial loss, embarrassment), which only influence the perceptual controls (perceived danger and propensity to risk) through cultural filters. So if we do not see a particular "accident" (e.g. HIV) as likely, we may be inclined to take balancing behaviour bringing more "reward" (e.g. more sex) than is actually justified by the real level of risk posed

(<http://www.chapmancentral.co.uk/web/public.nsf/Documents/Risk> , 12.05.2007).

Wilde (2002) in his risk homeostasis theory maintains that, in any activity, people accept a certain level of subjectivity estimated risk to their health, safety, and other things they value, in exchange for the benefits they hope to receive from that activity (transportation, work, eating, drinking, drug use, recreation, romance, sports or whatever). In any ongoing activity, people continuously check the amount of risk they feel they are exposed to (perceived risk) and compare this to the amount of risk they are willing to accept (tolerable risk), and try to reduce any difference between the two to zero. Thus if the level of perceived risk (the subjectivity experienced risk) is lower than is acceptable, people tend to engage in actions that increase their exposure to risk. However, if the level of subjectivity risk is higher than is acceptable, they make an attempt to exercise greater caution. Consequently they will choose their next action so that its subjectivity expected amount of risk matches the level of risk accepted.

From the above discussions, it is clear that people's perception of risk tends to influence their risk taking behaviour. Thus if they perceive the level of risk to be less, then they tend to engage in more risky behaviour which expose them to more risk and if they perceive the level of risk to be high, they take caution in engaging in a risky behaviour.

Wilde (1994) has highlighted that there are some variations in target risk between individuals. Some of the variations are long-lasting such as those due to cultural values, the state of the economy, the socio-economic status of the person, occupation, peer-groups attitudes, level of education, gender, age, etc. in addition there are short term variations that occur within the same individual and these include factors like current pre-occupations with stressing life events, being under the influence of alcohol, mood, fatigue, etc.

2.2.5. Risk Tolerance

As argue by Chapman, we tolerate and even enjoy an element of risk in our lives.

<http://www.chapmancentral.co.uk/web/public.nsf/Documents/Risk> 12.05.2007

However, arriving at a consensus decisions over the question of acceptable risks in society is not a simple matter. At minimum, one might ask of any hazard, 'to whom might be acceptable or unacceptable, when, where and under what circumstances?' In practical terms, individuals, organisations and governments are faced constantly with the need to take decisions involving actual or projected hazards and as a consequence with problem of what is being acceptable?

However, in the UK the use of acceptable risk as a guiding principle was criticised by Sir Frank Layfield, who chaired the 1983-5 public inquiry into the Sizewell B nuclear plant (Royal Society, 1992).

The word 'tolerance' means 'bearing or putting up with someone or something not especially liked'. This implies that tolerable risk can be defined as the bearing or putting up with risk or hazard not especially liked but to secure certain benefits. As a result of the Layfield inquiry from 1983 to 1995, the UK Health and Safety Executive (HSE) produced a report in which tolerable risk is defined as follows:

“Tolerability does not mean acceptability. It refers to the willingness to live with a risk to secure certain benefit and in the confidence that it is being properly controlled. To tolerate a risk means that we do not regard it as negligible or something we might ignore, but rather as something we need to keep under review and reduce still further if and as we can”.

In the HSE approach this definition of tolerability is taken to imply that risks should be monitored, balanced against possible benefits, and whatever possible reduced to ‘As Low as Reasonably Practical’ (the ALARP principle). Although the use of such definition to guide regulatory decision making is clearly a significant development, the HSE approach has nevertheless been criticised on the grounds that it does not relate benefits clearly enough to tolerability.

2.2.6. Risk mitigation

Risk mitigation encompasses loss prevention, loss control, and claims management. Structured effectively, a risk mitigation program will prevent losses and reduce the cost of losses that do occur while creating a safer environment for individuals and the communities

(http://www.aon.com/us/busi/risk_management/risk_mitigation/default.jsp, 15.05.2005).

It is acknowledged that risk perception is a fundamental problem in the increasing complex socio-technical systems, and that misconstrued perceptions about the results of our actions are the greatest source of risk. Risk can not be avoided or eliminated entirely and it is suggested that in all forms of risk management there are essentially three principles at play: The maximisation of

expected values, the avoidance of catastrophe, the counting of remote responsibilities (Ansell et al, 1992).

Individual practice of risk reduction behaviour is the primary avenue for prevention of HIV/STD. Hence, the development of effective educational programs that will achieve this expected outcome is vital in societal efforts to control HIV/STD. Given the complex nature of many risky sexual and injecting drug behaviours, preventing and changing risk HIV/STD-related behaviour represents a significant challenge to educators (Demoz, 2003).

Studies have shown that increasing knowledge may not always change risky behaviours. Attention to other individual traits related to HIV/STD avoidance, such as perceptions of vulnerability to disease and peer norms, beliefs about the value of prevention behaviour, recognition of high risk behaviour, behavioural intention and self-efficacy are considered necessary(<http://www.indiana.edu/~aids/fact/fact3.html>,14.04.2005).The government can mitigate the overall HIV/STD risk by ensuring the access to (subsidised) prevention to all groups and areas, by informing and campaigns combating HIV risk behaviour.

2.2.7 HIV/AIDS -Risk related factors

Risk factors are variables or characteristics associated with an individual that make it more likely that she or he, as opposed to another person randomly selected from the population, will develop a problem. They include attributes, processes, conditions, events and interactions/relationships that affect the person or his or her environment. Risk factors could be internal characteristics such as heredity, biological, behavioural and external variable such as environmental, socioeconomic, demographic risk factors

(http://www.phac-aspc.gc.ca/ncfv-cnivf/familyviolence/html/fvrisk_e.html,11.05 2007).

With regard to HIV/AIDS several factors including biological, behavioural, socio-cultural, economic and political interrelate to put people at risk of contracting the virus. For instance biological factors such as a child being breast fed by an HIV/AIDS –Positive mother and the biological disposition of women exposes children and women to HIV(UNAIDS, 2004; Agyei-Mensah, 2005). Male-to-female transmission is much more likely to occur than female-to-male.

In fact, studies have shown that women are twice as likely as men to contract HIV. Also laboratory tests have shown that male semen contains higher concentrations of virus than female secretions per unit volume. Additionally, because the reproductive systems of young girls are underdeveloped, they are more prone to micro lesions, especially when sex is coerced or not wanted. The presence of STIs further increases their vulnerability to HIV infection (UNAIDS 2004). Conseil du statut de la femme(2002), WHO (2003) and other authors have pointed out that poverty and harsh economic conditions compel some women to engage in risky behaviours such as bartering sex and hence become exposed to HIV.

2.3. Stigma and Discrimination Theory

2.3.1. Stigma as a concept

Stigma has ancient roots. Stigma was a physical mark that was burnt or cut into the body and the mark publicly identified the person as having immoral status or deviant from the norms of society, and as one to be avoided (Crawford, 1996; Lorentzen & Morris, 2003; Talja, 2005). Stigma is today defined in many ways but what is common in the different definitions of stigma is that the person that is subject to stigma is someone that differs in the eyes of others, in some way from the rest of their social group. Discrimination is seen as the consequence of stigma and it is therefore important to understand the concept of stigma to be able to understand what discrimination is (Bond, 2004).

The modern understanding of disease stigma owes much to Goffman. Goffman defined stigma as “*an attribute which is significantly discrediting*”. The attribute in the eyes of society, serves to reduce the person who possesses it. It could be both a physical mark and non-physical characteristics (Goffman, 1963; Goffman, 1990). It also has important consequence for the way in which the individuals come to see themselves (UNAIDS 2002.43E). Goffman (1963; 1990) argued that the stigmatized individual is a person who possesses ‘*an undesirable difference*’. Person who possesses a characteristic defined as socially undesirable (HIV/AIDS in this case) acquire a ‘*spoiled identity*’ which then leads to social devaluation and discrimination. Goffman noted that stigma is not a static attribute of the person, but something that is attributed to the

person in a social interaction. He therefore proposed that the normal and the stigmatised were perspectives, rather than persons (Lorentzen & Morris 2003).

Aggleton and Parker (2003), argued that although Goffman's explanation of stigma is important for adequate understanding of stigmatization in the context of HIV/AIDS, his emphasis on stigma as a "*discrediting attribute*" has led many people to think of stigma as though it were a "thing"—a cultural or individual value. The emphasis given to possessing an '*undesirable difference* that leads to a '*spoiled identity*', in turn, has encouraged highly individualistic analyses. Thus stigma, understood as a negative attribute, is mapped onto people, who in turn by virtue of their difference, are understood to be negatively valued in society (Aggleton and Parker 2003). According to Aggleton and Parker (2002:2003), stigmatization is a process. Within a particular culture or setting, certain attributes are seized upon and defined by others as discreditable or unworthy, for instance, within the context of HIV/AIDS. Undesirable differences and spoiled identities do not naturally exist; they are actively created by individuals and by communities. Stigmatization therefore describes a systematic process of devaluation rather than a "*thing*" (Aggleton and Parker 2002; Aggleton and Parker 2003).

HIV/AIDS-related stigma is closely related to sexual stigma. The fact that HIV is mainly sexually transmitted (UNAIDS 2002/02.43E; Parker and Aggleton 2002; Aggleton & Parker 2003; Kalipeni et al, 2004), and that in most areas of the world, the epidemic initially affected populations whose sexual practices or identities are different from the "norm" subjects the disease to stigmatisation. Much of HIV/AIDS –related stigma therefore builds upon and reinforces earlier negative thoughts. People with HIV/AIDS are often believed to have deserved what has happened by doing something wrong. Often these "wrongdoings" are linked to sex or to illegal or socially frowned-upon activities, such as promiscuity, prostitution and homosexuality (UNAIDS 2002.43E; Parker and Aggleton ,2002; Aggleton & Parker, 2003). Given that the most common form of HIV transmission is through sexual intercourse, countries that have "conservative" attitudes to sex and sex education can have difficulties with open discussions on HIV/AIDS (Lawson, 1997).

Heterosexual mode of transmission of HIV/AIDS has contributed to the silence surrounding HIV/AIDS, and the construction of HIV/AIDS as a “disease of the others”. This is because in the early years of the global epidemic, focus was mainly on people with so-called “high risk behaviour” such as prostitutes and male homosexuals etc. However, it has become increasingly obvious that many others, who had false impression that the disease was not a threat to them, have been infected (UNFPA, 2000; UNAIDS, 2002.43E).

The family and community often perpetuate stigma and discrimination, partly through fear, partly through ignorance, and partly because it is convenient to blame those who have been affected first (UNAIDS 2002.43E; Aggleton & Parker, 2003).

Different groups experience stigma differently, in particular, men and women are differentially affected by stigma. HIV/AIDS-related stigma thus reinforces, existing social inequalities. These include inequalities of wealth, inequalities that make women inferior to men, inequalities of nationality and ethnicity, and inequalities linked to sexuality and different forms of sexual expression (UNAIDS 2002/.43E; Aggleton & Parker, 2003). For example, People living with HIV/AIDS who are poor have less space to hide from stigma when they are sick. They do not have the possibilities to pay for anti retroviral therapy. They are sick more often, and they “die faster” or “when they are not supposed to” and occasionally alone (Bond et al., 2003).

Stigma is linked to power and domination throughout society as a whole. It plays a key role in producing and reproducing relations of power and control (UNAIDS 200.43E; Parker & Aggleton, 2002; Aggleton & Parker 2003; Talja 2005). It serves to reinforce social norms by defining deviance (Taylor, 2001). It therefore has its origins deep within the structure of society as a whole, and in the norms and values that govern much of everyday life. Importantly, it causes some groups to be devalued and others to feel that they are superior in some way. For instance, in settings where heterosexual transmission is significant, long lasting ideology of gender has resulted in women being blamed for the transmission of sexually transmitted infections or HIV, despite clear evidence to suggest that in the majority of cases they have acquired the infection from husbands and regular male partners (UNAIDS 2000; UNAIDS, 2002; Parker & Aggleton, 2002; Aggleton & Parker, 2003; Talja, 2005; Centre for Reproductive Right, 2005). The

construction of women as the carriers of the infection may reflect entrenched asymmetrical patterns of power, where dominance and relative impunity are maintained over disempowered and “blameworthy” women (Ratele & Schefer, 2002; Lorentzen & Morris 2003). Furthermore, due to unequal power relation which is entrenched in the culture of the society, men are usually forgiving for being promiscuous but women are not. This stigmatization and discrimination does not come from HIV/AIDS itself but rather HIV stigma often reinforces pre-existing stigma toward marginal or powerless groups like women (Parker & Aggleton, 2002; Parker and Aggleton 2003) Ultimately, HIV/AIDS-related stigma creates, and is reinforced by, social inequality. Hence ‘stigmatization is an exercise of power over people’ (Gilmore & Somerville 1994; Taylor 2001; Parker & Aggleton, 2002; Aggleton & Parker 2003) and a means of social control by marginalizing or excluding a group from the wider community and so reinforcing societal values (Taylor, 2001).

Goffman distinguished between three different types of stigma. The first one is abomination of the body, which refers to disfiguring conditions and physical handicaps such as rashes and leanness (Lorentzen&Morris2003; Talja, 2005). According to Goffman (1963), someone that differs physically is more likely to be stigmatised. This is especially so when the stigmatising attribute is not something the affected is born with. The second type is blemishes of individual character, which refers to individual traits and/or actions that are deemed unacceptable in the culture, for example, alcoholism and unacceptable sexual practices like prostitution and homosexuality. According to Talja (2005) the fact that HIV is sexually transmitted has probably led to a way of regarding an infected individual as someone with a weakness of character. HIV/AIDS can be understood as proof of sexual promiscuity and is often conceptualized as a “prostitutes disease” (Lorentzen & Morris,2003). The last one, tribal identity refers to group membership in marginal groups, e.g. sex-workers, migrant workers, the poor and women (Lorentzen & Morris 2003; Talja, 2005).

Stigma is a complex and multifaceted phenomenon that can take many forms. HIV/AIDS-related stigma and discrimination are manifested at different levels and can occur everywhere such as in the family, the community, the education sector and the workplace and in different contexts (UNAIDS 2000; UNAIDS, 2001; UNAIDS, 2002/o243E; UNAIDS, 2002-2003; Lorentzen &

Morris 2003). In societies with cultural systems that place greater emphasis on individualism, HIV/AIDS may be perceived as the result of personal irresponsibility, and thus individuals are blamed for contracting the infection. In contrast, in societies where cultural systems place greater emphasis on collectivism, HIV/AIDS may be perceived as bringing shame on the family and community (Kegeles et al. 1989; Panos 1990; Parker & Aggleton, 2002).

Self-stigmatisation is the term for the shame that people living with HIV/AIDS experience when they internalize the negative responses and reactions of others. Self stigmatization can lead to depression, withdrawal, and feelings of worthlessness. It silences and saps the strength of already-weakened individuals and communities, and causes people to blame themselves for their predicament (UNAIDS, 2002; Talja, 2005). Self stigmatization can be seen as a way of discrediting oneself (Lorentzen & Morris, 2003).

In contexts where HIV/AIDS is highly stigmatized, fear of HIV/AIDS-related stigma and discrimination may cause individuals to disintegrate from the local community to the extent that they no longer feel part of civil society and are unable to gain access to the services and support they need (Parker & Aggleton 2003). According to Goffman (1963), someone that differs physically is more likely to be stigmatized and interaction with others can be more complicated and isolation may be the consequence. The affected herself probably has stigmatized and regarded others who are HIV/AIDS-positive as less worthy and finds it now difficult to be in that situation. Interaction between the stigmatized and others can be stiff and uncomfortable and therefore a social contact may be avoided. Aggleton writes that Gilmore, Somerville and Hasan explains how a highly stigmatizing environment can lead to the withdrawal of an HIV-Positive Person from his company as a means of self-preservation, to prevent himself from being subject to bad treatment (Talja, 2005).

2.3.2. Discrimination

While most research on stigmatization typically acknowledge Goffman and his work as intellectual precursors, discussions of discrimination are rarely framed in relation to any clear cut theoretical tradition. Aggleton and Parker in explaining discrimination writes that stigma is harmful not only in itself (since it can lead to feelings of shame, guilt and isolation), but also because of its larger societal impact. Negative thoughts or prejudiced ideas can lead individuals to

do things or omit to do things that harm others or deny them services or entitlements (UNAIDS 2002.43E; Aggleton & Parker 2003). In the hospitals for example, stigma and discrimination can take the form of disclosure of one's status to preferential treatment for the poor and the rich. (Parker & Aggleton, 2003 Dvergsda 2005). At the work place employers may terminate a worker's employment on the grounds of his or her actual or presumed HIV-positive status. Families and communities may reject and ostracize those living, or believed to be living, with HIV/AIDS. Such acts constitute discrimination based on presumed or actual HIV-positive status and violate human right. Thus they stated concisely that "discrimination occurs when a distinction is made against a person that results in his or her being treated unfairly and unjustly on the basis of their belonging, or being perceived to belong, to a particular group (UNAIDS 2002.43E; Aggleton & Parker 2003). Talja (2005), also pointed out that discrimination signifies an unequal treatment of a person or group and that it is one possible cause of inequality.

Due to HIV/AIDS-related discrimination, the rights of people living with HIV/AIDS and their families are often violated, simply because they are known or presumed to have HIV/AIDS. This violation of rights increases the negative impact of the epidemic at many levels (UNAIDS 2002.43E; Aggleton & Parker 2003).The conceptualization of HIV/AIDS as a disease of shame, sexual promiscuity and immorality has consequences for disclosure and help-seeking behaviour. The fear of HIV/AIDS-related stigma and its negative impacts (discrimination) force many PLWHA to face the dilemma of whether to disclose their status or not (Lorentzen & Morris 2003).

Stigmatization and discrimination theory is used by this study to explain how women's subordinate position in society exposes them to HIV infection and subsequently stigmatization and discrimination. It is also used to explain how HIV/AIDS stigma reinforces existing stigma entrenched in the culture and hence further fuel the spread of the disease.

2.4. Feminist Geography

Feminist geography is an approach to study in human geography which applies the theories, methods and critiques of feminism to the study of the human environment, society and

geographical space (http://www.eparanoids.com/f/fe/feminist_geography.html), retrieved 10 March 2007).

Brayton (1997), states that feminism is about challenging gender inequalities in the social world. According to her while she fundamentally recognizes differences in social location, such as orientation, age and race, as structuring the way women experience their lives as women, she believes that at a basic level feminism recognizes that the social world is organised by gender. Feminist geography is often considered part of a broader postmodern approach to the subject which is not primarily concerned with the development of conceptual theory in itself but rather focuses on the real experiences of individuals and groups in their own localities, upon the geographies that they live in within their own communities.

Feminist geography approach is applied in conjunction with other theories for explaining my findings without emphasizing on feminist-specific theories. I apply feminist geography because it addresses issues of gender inequality, gender relations and gender identity, which are important in dealing with any social group such as women. In particular, it is used for addressing the social borders and boundaries between men and women in the study area which are constructed through gender relations of power and gender identities. Such social borders and boundaries have created gender inequalities in the study area, making women subordinate to men and consequently making them vulnerable to HIV/AIDS, stigmatization and discrimination.

2.4.1. Gender inequality

Gender inequality refers to the social, cultural, economic, and political disparities between men and women. It describes how men and women are given different opportunities because of their gender. Gender inequality has resulted in the marginalization of many women which in turn perpetuate the inequalities between men and women in society.

Due to gender inequality, women the world over are poorer than men. This has compelled many women to engage in behaviour that are risky to their health. Indeed, there is a relation between the low economic status of women and their involvement in prostitution. (Conseil du statut de la femme, 2002). Poverty and harsh economic realities are the underlying causes of women bartering sex for economic gain or survival (Visvanathan et al 2002; UNAIDS 2003). Poverty has

made many women dependent on men. Due to dependency on men, women are unable to assert their right to refuse sex with their husband or partner

(<http://www.gwsafrica.org/knowledge/ap2.html> , 14 March 2007). Economic dependency and cultural subordination put women in vulnerable position. Without economic power, women do not have peace, and cannot make decisions to take control of their lives.

Furthermore, gender inequality has created social inequalities in many societies. Due to the demand on household work many women have been denied access to education which has been shown to reduce risk of infection, to enhance self-esteem and provide livelihood alternatives (IPPF, UNFPA, Young Positive, 2007). Nussbaum (2003) quoted the Supreme Court of India, Unnikrishnan J.P.V state of Andhra Pradesh that “the *right to education flow directly from the right to life and this is related to the dignity of the individual*”. According to her, women’s education is both crucial and contested. A key to the amelioration of many distinct problems in women’s live, it is spreading since the education of a woman has impact on the life of many people, but it is also under threat, both from custom and traditional hierarchies of power and from the sheer inability of states and nations to take effective action. She argues that promoting economic growth alone is not a sufficient way of promoting education for women but rather it requires additional focused state action (Nussbaum, 2003).

2.4.2. Gender identity

Gender identity describes the gender with which a person identifies: whether one thinks of oneself as a man (masculine) or as a woman (feminine). The Society also prescribes arbitrary rules or gender roles (that is how one is supposed to and not supposed to dress, act, think, feel, relate to others, think of oneself, etc.) based on one's sex (that is whether one has a vagina or a penis.) These gender roles are called feminine and masculine (<http://feminism.eserver.org/sexual-gender-identity.txt> , 23 April 24, 2007).

The dominant ideologies of femininity and masculinity cast women in a subordinate, dependent, and passive position with virginity, chastity, motherhood, moral superiority, and obedience as the key virtues of the ideal woman. In sharp contrast, the dominant ideology of masculinity characterizes men as independent, dominant, invulnerable aggressors and providers whose key virtues are strength, virility and courage (WHO 2003). The norm of masculinity encourages

multiple partnerships as a means of a man demonstrating his manhood. However, the dominant ideal of femininity emphasizes uncompromising loyalty and fidelity in partnerships. It is this ideal that distinguishes a 'good' woman from a 'woman of the street' and defines sexual practices linked to reproduction as moral and those that are linked to pleasure as immoral (WHO 2003). However, there are multiples of masculinity and feminity as they vary by social class, ethnicity, sexuality and age (WHO 2003; Berg and Longlundt, 2003).

2.4.3. Gender relations

Gender relations refer to relations of power between women and men. They are revealed not only in the division of labor and resources between women and men, but also in ideas and representations—the ascribing to women and men of different abilities, attitudes, desires, personality traits and behavior patterns. Gender relations are both constituted by and help constitute these practices and ideologies, in interaction with other structures of social hierarchy such as class, caste, and race. They are neither uniform across societies nor historically static. They are usually seen as socially constructed rather than biologically determined (Agarwal 1997).

Whitehead (2006) argues that one of the specific forms of oppression which women suffer is that in every social relationship and social situations they find themselves gender is present. According to her, women are being always perceived and treated as members of a gender category about which there are all kinds of stereotyped beliefs, and which is inferior to the alternative gender category, that of men. This is because males are socialized to accept to be providers and heads of the family whiles women are socialized to be obedient and submissive housekeepers. The cause of such differentiation is the fact that the society view women as being more sexual beings instead of human beings (Charvet 1982; Kambarami 2006; UNAIDS/01.24E). Women are thus defined in relation to men and also as subordinate and dependent on men (McDowell and Pringle 1992). Relations between husbands and wives are marked by the behavioural components of inferiority, superiority and deference (Whitehead 2006).Male superiority and control is constructed and enforced not only through every day attitudes and behaviours but also through the legal system and social systems (McDowell 1999). Patriarchal attitude is also rooted in the Christian religion and this has reinforced the traditional customs which men use to control women's sexuality (Human Rights Monitor, 2001; Kambarami 2006).

2.5. Empowerment

Empowerment is first and foremost, about power; changing power relations in favour of those who previously exercised little power over their own lives. Batliwala (1993) defines power as having two central aspects -- control over resources (physical, human, intellectual, financial, and the self), and control over ideology (beliefs, values and attitudes). If power means control, then empowerment therefore is the process of gaining control.

Empowerment may be achieved through the enhancement of the abilities and capacities of those who are lacking in power, or through the development of collective organisation and decision-making. With regard to the first sense, it is concern with the capacity and capabilities of the poor person. This could be achieve by relieving poverty, action by state to enhance the frame work of rights, by facilitating social skills, improving communication or developing services more able to improve the quality of choices for the poor(Pinderhughs, 1983). In the second sense, empowerment is a product and process of collective action. As a process collective action enabled people to develop social capital and to exercise political power and as a product it gives the poor the ability to voice their concerns and represent their interest. Collective action makes it possible for the poor to expand the range of their capabilities and commodities.

The empowerment concept is used to explain how women could be empowered in order to be able to gain control or autonomy over their own lives and hence be in a good position to control the circumstances under which sex do occur and subsequently reduce their vulnerability to HIV/AIDS.

CHAPTER THREE: METHODOLOGY

3.1. Introduction

In any activity that requires concrete results, a well-defined methodology for achieving those results is important. With a methodology, the process of achieving a result can be studied and the result verified. Without a methodology, this type of debugging and assurance is very difficult. According to Marshall and Rossmann (1999), methodological decisions should be linked to the research questions developed in the conceptual framework for the study. The choice of methodology for a particular study should bear relation to the objectives of the study and the theories to be used to explain findings. In general the specific methods chosen to attack a problem depend upon the nature of the specific problem (Rudestam et al, 1992) and the type of data the researcher is seeking. This study seeks to use the triangulation method (mixture of quantitative and qualitative methods for achieving results.

3.2. Research Design

3.2.1. Justification of methodology

In most cases, researchers fall into either relying exclusively upon "objective" survey questionnaires and statistical analyses (quantitative methods) and avoiding qualitative methods, or using only qualitative methodologies, rejecting the quantitative approach as decontextualizing human behaviour. However, social marketing researchers recognize that each approach has positive attributes, and that combining different methods can result in gaining the best of both research worlds (<http://www.social-marketing.com/research.html> ,05.05. 2005).

According to Patton (1990), considering the research design alternatives lead directly to consideration of the relative strengths and weaknesses of qualitative and quantitative data. Quantitative research designs are characterised by the assumption that human behaviour can be explained by what may be termed "social facts", which can be investigated by methodologies that utilise "the deductive logic of the natural sciences" (Horna, 1994, p. 121). Quantitative investigations look for "distinguishing characteristics, elemental properties and empirical boundaries" and tend to measure "how much", or "how often" (Nau, 1995). They are appropriate

to examine the behavioural component of disease causation such as HIV risk behaviour. A quantitative research design allows flexibility in the treatment of data, in terms of comparative analyses, statistical analyses, and repeatability of data collection in order to verify reliability (SNCCFR, 1996, 1997).

Quantitative methods produce quantifiable, reliable data that are usually generalised to some larger population. Quantitative measures are often most appropriate for conducting needs assessments or for evaluations comparing outcomes with baseline data. The methods state the research problem in very specific and set terms (Frankfort & Nachmias, 1992). They clearly and precisely specify both the independent and the dependent variables under investigation, following firmly the original set of research goals, arriving at more objective conclusions, testing hypothesis, and determining the issues of causality. They eliminate or minimize subjectivity of judgment (Kealey & Protheroe, 1996). According to McCullough (1997), the results of quantitative research are able to be projected to the population. That is there is the probability that the proportion of respondents answering a certain way is similar to the proportion of the total population that would have answered that way if they all had been asked.

Though there are many advantages to quantitative research, there are also many disadvantages. The primary disadvantage of quantitative research is that issues are only measured if they are known prior to the beginning of the survey (and, therefore, have been incorporated into the questionnaire) (McCullough, 1995). They usually fail or are limited to provide the researcher with information on the context of the situation where the studied phenomenon occurs. Furthermore, they are unable to control the environment where the respondents provide the answers to the questions in the survey. Their outcomes are limited to only those outlined in the original research proposal due to closed type questions and the structured format. Also they do not encourage the evolving and continuous investigation of a research phenomenon (http://www.russcom.ru/eng/rca_biblio/m/matveev01_eng.shtml, retrieved, 05 May 2005). Quantitative research also has "the disadvantage that the resulting theory often fails to take account of the unique characteristics of individual cases" (Edwards, 1998).

Qualitative methodologies on the other hand are strong in those areas that have been identified as potential weaknesses within the quantitative approach. For example, the use of interviews and observations to provide a deep, rather than broad, set of knowledge about a particular phenomenon. This depth allows the researcher to achieve empathetic "understanding". This empathetic understanding has become the basis for a critique of quantitative research designs, and their empiricist emphasis. The argument used is that quantitative methods measure human behaviour "from outside", without accessing the meanings that individuals give to their measurable behaviour (Jones, 1997). With qualitative research, the researcher places much emphasis on gaining an understanding of how the subjects themselves view their own particular situations. A qualitative research design allows these understandings to be investigated from the informant's point of view. It allows the moderator (or interviewer) to interact with respondents, i.e., the moderator can ask questions based on previous responses. This allows for in-depth probing of issues and yields great detail in response. It allows for interaction between group members. This interviewer and informant interaction often stimulates discussion and uncovers issues unanticipated by the researcher (McCullough, 1995).

The main argument against qualitative method is the concept of validity, in that it is difficult to determine the truthfulness of findings. The relatively low sample numbers often encountered may also lead to claims of findings being unrepresentative of the population. They are therefore unreliable predictors of the total population (McCullough, 1997) because they can not capture broad structures, for example, national and regional disease studies, inequality conditions. Another weakness of the method is the difficulty in explaining the difference in the quality and quantity of information obtained from different respondents and arriving at different, non-consistent conclusions. Furthermore, the respondent can choose to tell story about particular stories and ignore others (http://www.russcom.ru/eng/rca_biblio/m/matveev01_eng.shtml, 05.05 2005). Due to the fact that both quantitative and qualitative methods are stronger in the areas where the other is weak, this study considered it advantageous to combine the two methods in order to overcome some of these weaknesses associated with a single method in the study.

3.2.2. Triangulation method

According to Olsen (2004), by combining multiple theories, methods, and empirical materials, researchers can hope to overcome the weakness or intrinsic biases and the problems that come from a single method or a single theory studies. Often the purpose of triangulation in specific contexts is to obtain confirmation of findings through convergence of different perspectives. The point at which the perspectives converge is seen to represent “reality”.

The crucial aspect in justifying a mixed methodology research design is that both single methodology approaches have strengths and weaknesses (Nau, 1995; Jones 1997). Single method data are associated with a number of problems. It does not show the “big picture”. If only quantitative methods are used, respondents are limited by the questions asked and if only qualitative methods are used, results can not be analysed statistically and therefore can not be generalised. Also it does not provide “hard” evidence.

However, using multiple methods is associated with certain advantages such as providing more complete data and more reliable results. They are more likely to show the “whole” picture. Furthermore, inconsistencies from survey data can be clarified qualitatively. Also they increase validity of outcomes. That is approaching the question from various angles moves closer to the “truth”. (<http://www.cyfernet.org/training/evaluation.ppt#348,1>, 30.05.2005).

Since it is the aim of this study is to explore factors such as opinions, beliefs, attitudes, feeling; to measure “how much” and “how often”; and to explore the behavioural component of HIV causation, as well as to generalise the views of a population, both quantitative and qualitative methods of data collection would be used. Multiple methods of data collection are useful because they increase reliability and validity as well as present more accurate picture of outcomes than a single method.

However, triangulation method is not without limitations. Weinreich argues that combining qualitative and quantitative methods is better. According to him, the potential for problems however exists when attempting to combine such divergent research paradigms; one may end up

not doing either type of research well. This integrative approach therefore requires a research team with expertise in both types of methods. He stated that using multiple approaches can also be time-consuming and labour-intensive and expensive

<http://www.social-marketing.com/research.html>, 05 May 2005). Also at times important qualitative data are insufficiently integrated with quantitative findings. Silverman (1993) has criticised triangulation method on the grounds that rarely does the inaccuracy of one approach to the data complement the accuracy of another. Also he argued that the aggregation of data even when grounded in same theoretical perspective does not produce an overall truth.

3.3. The Study Population and Selection Procedures

In any research it is incumbent on the researcher to clearly define the target population. According to Nichols (2000), the group of people the researcher is interested in, is mainly determined by the purpose as well as the nature of the study. Sometimes, the entire population will be sufficiently small, and the researcher can include the entire population in the study. However, usually the population is too large for the researcher to attempt to survey all of its members. Due to this, a small, but carefully chosen sample can be used to represent the population. The sample reflects the characteristics of the population from which it is drawn (StatPac Inc. 1997).

Since the aim of this study is to explore and uncover the social, economic, political, cultural and other related factors that constrain women from negotiating safer sex and hence fall vulnerable to HIV, women were purposefully selected as the target population of the study. Due to the fact that Kumasi, the study area is a big city (with over one million population), consisting of ten sub-metropolitan districts, four suburbs, Adum, Bantama, Boshen and Asokwa which are considered to be high risk areas within the metropolis by Health Authorities and Health NGOs were purposefully selected to be representatives of the other suburbs of Kumasi (see Figure 2.1 in chapter four).

HIV/AIDS is transmitted mainly through heterosexual intercourse, moulded by other immediate and underlying factors and since women are disproportionately affected, the study population was

composed of majority of women within the ages of 20 to 39, who are considered to be the main target of the study. Women within this particular age group were purposely chosen as the target group because they are sexually active and also HIV prevalence is higher among certain age groups within this age span. This study population included both married and unmarried women, commercial sex workers, and HIV/AIDS -positive women. In addition, key informants such as health workers, HIV/AIDS officers, women activist, respected social figures (old women) as well as few selected men were included in order to get valuable information from them. Also NGOs working on HIV/AIDS were contacted selectively depending on the type of interventions they have in the Metropolis. Furthermore, the Ministry of women and Children's Affairs was contacted on matters regarding interventions for women and policies regarding the sexual rights of women.

3.3.1. Respondent characteristics

The total number of respondents in the surveys was 111 individuals (The surveys are referred to in the following sub chapters). Of these, 80 were women (both married and unmarried women) within the ages of 20 to 39 who responded to survey questions. In addition, thirty-one informants comprising of ten women (HIV/AIDS status not known), five men (HIV/AIDS status not known), three HIV- positive women, five commercial sex workers and eight key informants who are also stakeholders (including 2 HIV/AIDS officers from NGOs, 2 Health workers, and 2 officers from The Ministry of Women's Affairs and two elderly women) participated in the face-to-face interview.

The HIV positive women were selected through contact with health personnel at the HIV/AIDS Counselling Section at the Komfo Anokye Teaching Hospital. Three of the commercial sex workers were contacted through the Executive Director of an NGO dealing with commercial sex workers in the Kumasi with a focus on HIV/AIDS. The remaining two were contacted at some well known night clubs in down town at Kumasi. However, I had to disguise myself in order to gain their confidence.

With regard to the sampling techniques used to select the study population, both probability and non-probability sampling methods were employed. As mentioned above since Kumasi is big city consisting of ten Sub-Metropolitan Districts and many suburbs, four high risk areas, Adum,

Bantama, Boshen and Asokwa were purposefully sampled to represent the other suburbs in the city. They are considered high risk areas because of the presence of poverty ridden “*zongo*” or “*ghetto*” residences and “home seated” prostitutes (in Adum) . They were purposefully sample due to the limited time for the study and also in order to reduce cost. After these areas have been sampled, the Assemble-Men of the suburbs were contacted for permission to conduct the data collection and also to help in identifying the target population. Due to the fact that data compiling and complete surveys are problems in Ghana, with the help of the Assemble-men, four young secondary school graduates (males and females) from each suburb were trained to register the women within the ages of 20 to 39 in their respective suburbs. The intention was to register the women within a stipulated time period. This implies that only women met at the time of registration could be registered. Due to the large size of the selected areas, it was impossible to register all the women in the areas. Systematic sampling method was therefore adopted to select houses at every five counts. Women within the age group of the target population found in the selected houses were then registered. After this the names of the registered women in each suburb were written on small papers and put in a container. Then 80 women, 20 women from each suburb were randomly sampled to respond to the questionnaires. The sampled women were later contacted to answer questions in the questionnaire. A quasi-random sampling method was used to select respondents for the questionnaire because I wanted to give the target population equal chance of being selected, to achieve some representativeness and to avoid bias. However, a complete list of potential informants to draw from was not available.

Furthermore, 23 informants and 8 key informants were non-randomly selected for in depth-interview based on judgment. They included 10 women (married and unmarried), 5 men (married and unmarried), 5 female commercial sex workers, 3 HIV-positive women, 2 health workers, two officers from Health NGOs , two officers from The Ministry of Women and Children’s Affairs and two elderly women. Before an informant was sampled I set certain criteria he/she must fulfil in order to be included in the study. The main criteria used include simple knowledge about women, HIV/AIDS, its mode of transmission and means of avoiding infection. The major reason for setting this criterion was to get assess to information-rich individuals in order to achieve the purpose of my study. However, in order to avoid the selection of like-minded people, effort was made to avoid the selection of individual from the same family. No criterion

was set for key informants representing an organization, commercial sex workers and the HIV/AIDS -positive women. Also apart from being sampled for interview, one of the sampled HIV/AIDS -positive women was selected for observation. This observation involves visiting her in the house, watching her and her household members and other neighbours within the house. However, The study used purposeful sampling procedure in addition to the random sampling mainly because it allows the selection of individuals who are more informative and who can provide a great deal of information about the issue of HIV/AIDS and the sexual right of women in the study area.

3.4. Methods of Data Collection

This study employed the triangulation method, in which multiple methods of data collection were used in order to achieve the objectives of the study and to find answers to the research questions. The questionnaire was used for collecting quantitative data mainly because I wanted to avoid bias and achieve some form of representativeness and also to statistically analyse some of my data and give statistical information about some of my findings. In-depth-interview, direct observation and informal discussions were also used for collecting qualitative data. These qualitative methods were used in order to get in depth understanding of the phenomena under study and to allow this understanding to be investigated from the individual point of view. In addition, data were collected from documentary sources.

The main reason for applying the triangulation method is that it is argued that limitation or weakness in one method is compensated by the strength of a complementary method. The various sources of data and data collection methods employed in the study are briefly discussed below.

3.4.1. Questionnaire

A questionnaire aimed at collecting data about the background characteristics of respondents as well as factual information about women's HIV risk perception and worry, risk tolerance, behaviour and need for risk reduction, and also perception about women's ability to negotiate safe sex and their sexual right was administered in the study area (Appendix I). The questionnaire was administered to 80 women within the ages of 20 to 39 who were randomly selected from four high risk areas in the study area. The data collected by the questionnaire were used to explore

women's perception about HIV risk and their sexual right in the study area. They were used for showing variation in perception among women from different backgrounds.

The questionnaire consisted of mainly pre-coded questions designed in order to make the analysis of data much easier. However, respondents were sometimes given the freedom to specify their answer if not included in the available ones. Specifically, the questionnaire demanded questions such as age, marital status, level of education, occupation, religion, personal/average income level (personal/household), size of household, head of household and perception about HIV risk and sexual rights.

3.4.2. Semi- structured and unstructured interviews

Semi-structured and unstructured interviews were used to collect data from the field. Semi-structured interview consisted of in-depth open-ended questions aimed at uncovering and describing the views and opinions of both informants and key informants. Three separate standardised- interview guides, Appendix II, Appendix III, Appendix and IV were designed and guided in the collection of data from informants (married and unmarried women within the ages of 20 to 39 and married and unmarried men within the ages of 20 to 45), HIV/AIDS -positive women within the ages of 20 to 39 and key informants respectively. Audio recorder was at times used for recording responses from the interaction with the respondents. Also some of the data were transcribed during the interviews because background information made it difficult to get adequate recording information.

The focus of the interview was mainly on general topics by contacting few individuals who are particularly knowledgeable about some factual matters on HIV/AIDS and the sexual rights of women in the Kumasi Metropolis. Since the key informants were selected from various institutions (with the exception of the elderly women), there were questions directed only to specific key informant although most of the questions were common to all. Also some of the questions for the married and unmarried women and men were directed specifically to the women. The commercial sex workers and two elderly women were interviewed based on unstandardised general conversation. This was done in order to remain as open and adaptable as possible to their nature and priorities. Generally, the interviews were made standardised open-ended to enable me ask same question in different ways.

3.4.3. Direct observation

One of the HIV/AIDS positive women was directly observed in order for me to personally find out whether HIV/AIDS persons are stigmatised or not. Random visit was paid to this woman at the house within a period of two weeks (but not every day) and I was observing the way she was treated by family members, friends and neighbours. Although the HIV-positive woman was aware I was conducting studies as I informed her and also interviewed her, the observation was informal because I did not want people to be aware of it in order to study how she is treated and how she behaves within her close surroundings. Thus my observations were later written down after I have left the house.

3.4.5. Focus group discussion

Although focus group discussion was considered as an important data collection method which can help provide insight into issues which can not be uncovered by a survey or questionnaire, it could not be used for collecting data for this study. The reason for not including focus group discussion in this study is that the study area, Kumasi, is a big commercial city where people are busily going about their daily schedules. It was therefore very difficult to bring people together at one particular time to have such interview or discussion. This is because each individual may have his/her own time schedule which may conflict with others.

3.4.6. Secondary Data

HIV/AIDS data for the study area for the period 2000 to 2004 was collected from the Ministry of Health, Ashanti Regional office, HIV/AIDS Division to determine whether gender inequality in HIV for specific age group persist in the study area. These were data compiled based on the sentinel surveillance survey report and other means of data collection (such as voluntary testing, blood screening, testing for diseases). However, it 's unfortunate the data does not show details for specific age groups and may therefore not help to fully achieve my first objective. Some documents on HIV/AIDS and women were also collected from the Ministry of Women and Children's Affairs in Accra.

Furthermore, data on the study area was collected from the Planning office of the Kumasi Metropolitan Assembly. Also a map of the study area showing the representative suburbs was obtained from the Cartography section of the Department of Geography, University of Ghana. In addition other information on HIV/AIDS was collected by from text books, journals, articles,

bulletins, internet sources, and by watching video and television clips on HIV/AIDS, as well as HIV/AIDS documentaries.

3.5. Data Processing and Interpretations

The bulk of primary and secondary data collected from the field raises such questions as ‘how can I sort out my data?’ ‘how do I find answers to my research questions?’ ‘Can the data help achieve the objectives of my study?’, and ‘how do I make sense of the data?’ Etc. Currently I am faced with the challenges of organising, analysing, interpreting and drawing conclusions from the large quantities of data that represent words, ideas, and numbers.

3.5.1. Methods of data analysis and interpretation

Quantitative data collected with the questionnaire was coded and processed using the SPSS. Univariate, bivariate and multivariate analyses were all conducted in order to gain detail information about the respondents. Univariate analysis (frequency tables) was used for analysing data on each variable and for describing the variables on their own. Data was grouped into classes and categories and frequency distribution for each category was obtained. Bivariate analysis was used to analyse data on two variables in order to explore their association or relationship. Methods used for the bivariate analysis are crosstabulation, which was used to show how variables are interrelated and Pearson correlation which was also used to quantify the linear relationship between variables. In addition, chi-square test was conducted but the results were not significant, due to a small sample and small number problem many cells with low numbers. Also multiple linear regression analysis (multivariate analysis) was conducted in order to test how a dependent variable could be predicted on the basis of multiple independent variables. However, it yielded no meaningful results since it could not establish fruitful and significant relationships between the independent variables and the dependent variable, and showed a low explained variance.

With regard to qualitative analysis, audio recordings on interaction with respondents were first listened to in order to familiarise myself with the data. After that the data was transcribed and edited. Also some of the data were already transcribed during the interviews because background information made it difficult to get adequate recording information. Similarly, data from direct observation were edited. After the data were processed, I looked for similarities or connection

and differences, agreements and contradictions among the various participants based on their background information.

The results of the study were presented in tables, frequencies, percentages, quotations and pictures. The results were interpreted with references to information from text books, journals, articles, bulletins, internet sources, and information accumulated by watching video and television clips on HIV/AIDS, as well as HIV/AIDS documentaries. Also they were interpreted with reference to the theoretical and conceptual frameworks selected for the study in the light of the objectives and research questions. Effort was made to relate the empirical finding to the ideas argued in those theories.

3.6. Validity and Reliability of Research Methodology

For a research study to be accurate, its findings must be valid and reliable. According to Dare and Cleland (1994), validity signifies the extent to which an instrument used to collect information is able to approximate the truth about people's behaviour or knowledge. That is it refers to the truthfulness of findings; if you really measured what you think you measured, or more precisely, what, others think you measured. Reliability on the other hand concerns the replication of the study under similar circumstance (Rudestam & Newton, 2001). That is the findings would be consistently the same if the study were done over again.

Some measures were taken to ensure as much validity as possible in the study. The use of the triangulation method enabled me increase the validity of the results by cross-checking one result against another and supplementing data obtained in one method by the other. Follow-up questions were asked to clear up possible confusion. Also I combined both quantitative and qualitative methods for collecting data in order to achieve some precision and at the same time in-depth knowledge about the phenomenon under study. Some questions were asked again in a different form to ensure that the informants are speaking the truth.

With respect to the reliability of the data, effort was made to minimise bias and errors in data collection and the possible impact on interpretation. To achieve this, some degree of representativeness was ensured. Also the use of the triangulation method enabled me to use a relatively larger study population than I would have used in only a qualitative study. Furthermore, conducting the interviews personally enabled me probe further, clear up any misunderstandings resulting from miscommunication and to ensure that the information had been accurately recorded. It also enabled me to directly observe the respondents since most of the interviews took place in their houses . Again questions in the questionnaire and interview guides were explained to the informants in order to make them clear to them. In addition, the interview questions were asked in local language that is “*Akan*”. Despite the necessary measures taken to ensure the validity and reliability of this study, it is not without limitations.

3.7. Problems and Limitations of the Study

According to Marshall and Rossman (1999), no research is without limitations; there is no such thing as perfectly designed study. Patton (1990) has also stated that “There is no perfect research design. There are always trade –offs”. Similarly, this study is not an exception of these statements or facts. Some of the problems associated with the study are directly or indirectly related to the research method and subsequent techniques of data collection and analysis while others are linked to the nature of the study. Due to the nature and purpose of this study, it is not without drawbacks and this can affect the validity and reliability of the data. While some of these drawbacks were inescapable, others were deliberately imposed by me.

A major limitation of the study was the problem of accuracy and complete information. It was very difficult obtaining any data that gives detail information such as names, house numbers, and street names of the specific members of the population in the study area. I was therefore faced with the challenge of selecting my study population. This is because the study seeks to achieve some form of representativeness by giving all women in the selected suburbs equal chance of being selected for the study. I was therefore compelled to conduct my own registration for my target population (women aged 20-39) with the help of field assistance (trained for the registration of names and not taking part of the actual conduction of data collection) and the Assembly-Men of the four selected representative suburbs. This did not only cost me financially

but also it delayed the collection of the data. Also although these field assistance were well trained to undertake the task, not all the women in the selected suburbs may have been contacted and registered due to the limited time on my part, inability to meet some of them and the large sizes of the suburb and the population within them. Also due to the data problem and the difficulty in registering all the women within the targeted age group, quasi sampling method was used for selecting the respondents. Thus all the women were not given equal chance of being selected for the study. As a result, it may be concluded that there was some form of bias in the registration and selection of the women targeted for the study. Thus it is possible that the poorest and most high risk women may not have been contacted. The sampled population may therefore not be a true representative of the population in the area as the study seeks to achieve.

Furthermore, during the field work it was clearly observed that interviewees were unwilling or uncomfortable to share all the truth I hope to explore. Most of them were found to be embarrassed by the sensitive questions. The fact that doing a research on sensitive topics poses a substantial threat to the respondents have resulted in situations which directly or indirectly affect the credibility of the study. It was clear during the field work that a good number of the respondents did not give expected answers. They were trying to cover from me what they really mean, what they say, what they do and what they have especially when the topic becomes more personal. It was observed during the field study that what they say are contrary to what they really are or do. Some of them were trying to cover part of the truth while others were trying to exaggerate their responses by positioning themselves to the safe side. These problems are inevitable since it is difficult to cross-check people's sexual behaviour and the fact that the problem of data compilation in the country makes it difficult to cross-check people's income. These problems were especially faced when administering the questionnaires and during interview with informants.

Usually, "*true*" data were difficult to obtain on questions like average monthly personal income, average monthly household income, religion, the number of sexual partners within last 12 months and other sex related issues which would help in determining the income level, background and the sexual practices. For example, most of the respondents were unwilling to give their true personal and household income, especially if other people are around for the fear that people may

either consider them to be rich and worry them with financial burden or poor to loose respect built in others. Some too did that for the fear of being taxed by the government although effort was made to explain that the study was for academic purpose. Thus most of them either underestimated or overestimated their income.

The pre-coded nature of the questionnaire also constitutes a major setback on the quality of data collected. Although it made it easier for respondents to answer questions, the flexibility and availability of answers did not compel most respondents to think and come out with their own genuine views. It was observed that some of the respondents were only trying to make the circumstances convenient to them by choosing from among the answers provided.

It was very difficult contacting commercial sex workers and HIV/AIDS informants. The commercial sex workers, particularly those working in bars and other night clubs resisted participating in the study because they saw it as embarrassing. They are reluctant to disclose any personal information when they realised you are not part of them. This is because most of them are practising prostitution in anonymity, without the knowledge of family members, friends and neighbours as this may undermine their integrity. I therefore had to disguise myself and established rapport with two of them at a night club they use to attend. The only means of collecting data from them was through informal discussion without them knowing the purpose of such discussion. It was therefore not possible to record information in their presence as that may undermine their confidence in me. However, with the help of the Executive Director of an NGO, I was able to contact some few commercial sex workers stationed at Adum at the later part of my field work. Yet still access to such people too was difficult and requires a lot of effort. It was also very difficult to contact the HIV/AIDS women as most of them were unwilling to share their experience while others were embarrassed and saddened. Access was only gain to these people through contact with a know health personnel at the HIV/AIDS counselling section at Okomfo Anokye Teaching hospital. Their consent to participate in the interview was first sought for them to agree to participate before the investigation could commence. Also they were informed about the aims of the study and they were assured their identity would be kept strictly confidential.

In addition, the quality of information recorded using tape recorder was at times altered, particularly when the interview is conducted in a noisy environment. At some instances I was compelled to go back to reconduct the interview if the respondent is willing to participate again. Some respondents too were unwilling to have their answers recorded. The reason for doing that is that they were afraid that later their recordings would be played on the television or radio. I encountered this problem with especially people with low educational background. Thus ignorance played a major role in this.

Getting access to the HIV/AIDS data for the study area did not pose a serious problem to me although I was delayed a little due to bureaucracy or contacting the right person for the data. However, the data that was given me does not give details for the specific age groups. It may therefore be difficult for me to fully achieve my first objective.

Apart from the unavoidable problems and limitations, others were deliberate as stated earlier. For instance although Kumasi is a city with a population of over one million, a small sample size was selected for the study in order to reduce cost and time as well as to be able to speed the processing of data. This may therefore affect the credibility of the data as the views and opinion of the sampled population may not truly represent the views and opinions of the entire population of the study area.

Also it is the aim of the study to explore HIV risk in the study area. As a result, Bantama, Adum, Boshen and Asokwa were purposely selected to be representative areas. The other suburbs were therefore not given the chance of being selected although there are equally high risk areas in the metropolis. Similarly, respondents for the interview were purposefully selected based on factors like knowledge about HIV/AIDS and sexual rights. This therefore represents a bias in the study.

Although women were the main target of the study, only few men were included in the study although their views and opinions may be valuable for the study. This was purposely done due to time limitation for the collection of data. It was also done in order to reduce the burden of processing the data since this study is for academic purpose and must be carried on within a specified time period.

CHAPTER FOUR: DESCRIPTION OF THE STUDY AREA

4.1. The Geography and History of Kumasi

Kumasi, the study area is the second largest city of The Republic of Ghana, which has a total estimated population of 19,894,014 (Photius Cousoukis 2001; CIA World Fact Book 2001) over 100 ethnic groups (with the Akans being the major tribal group) and agriculture as the backbone of its economy. The current population is over 1.17 million people with a growth rate of about 5.4 percent, and occupies an area of approximately 254 square km ([http://www.citiesalliance.org/cdsdb.nsf/Attachments/Ghana+Proposal/\\$File/Ghana+Kumasi+CDS+proposal+07+Mar03.doc](http://www.citiesalliance.org/cdsdb.nsf/Attachments/Ghana+Proposal/$File/Ghana+Kumasi+CDS+proposal+07+Mar03.doc), Retrieved 29 April 2007).

Kumasi was founded in the late 17th Century by King Osei Tutu I, who was the Asantehene or King of Asante state on the advice of Komfo Anokye, his senior priest. Situated at the crossroads of the Trans-Saharan trade routes, its strategic location contributed significantly to the growing wealth of the town. Kumasi is both a historical and cultural city having been the capital of the famous old Ashanti Empire as well as the cultural seat of the Kingdom. Kumasi is both a historical and cultural city having been the capital of the famous old Ashanti Empire as well as the cultural seat of the Kingdom

([http://www.citiesalliance.org/cdsdb.nsf/Attachments/Ghana+Proposal/\\$File/Ghana+Kumasi+CDS+proposal+07+Mar03.doc](http://www.citiesalliance.org/cdsdb.nsf/Attachments/Ghana+Proposal/$File/Ghana+Kumasi+CDS+proposal+07+Mar03.doc), 29.04. 2007). Its attractive layout and greenery accorded it the status of a “garden city”, the only one of its kind in West Africa. From the nucleus of Adum, Krobo, and Bompata, the city has grown in a circular form to cover an area with approximate radius of about 14 miles.

Kumasi was once a city with beautiful environment and overall ambience. It was a city of industry, trade and commerce. These have given way to a city of slum or ghetto, unemployment, and social decay. There is growing urban poverty, poor infrastructure, polluted streams, and congestion.

([http://www.citiesalliance.org/cdsdb.nsf/Attachments/Ghana+Proposal/\\$File/Ghana+Kumasi+CDS+proposal+07+Mar03.doc](http://www.citiesalliance.org/cdsdb.nsf/Attachments/Ghana+Proposal/$File/Ghana+Kumasi+CDS+proposal+07+Mar03.doc), 29.04. 2007).

4.2. Demographic Characteristics

The growth direction of Kumasi was originally along the radial trunk roads due to the accessibility they provided producing an initial radial pattern of development. Kumasi is now a fast growing metropolis with a growth rate of 5.2 per annum with over 90 suburbs, many of which were engulfed into the city with process of growth and physical expansion. The 2000 population census reported the population as 1,170,270. Currently, the population of Kumasi is estimated at 2.5 million.

(<http://www.charmeck.org/Departments/Sister+Cities/Sister+Cities/Kumasi,+Ghana.htm>,

17.10.2005). About 65 percent of the population is Christians and 20 percent Muslims, with the remaining being traditionalist and people without defined religious denomination.

The strategic location of Kumasi coupled with its status as a brick administrative and commercial nerve centre has made it the destination of both internal and international migrants. It attract migrants from neighbouring African countries such as Burkina Faso, Togo, Mali, Nigeria, Ivory Coast and abroad especially Europe. Kumasi is composed of people from different tribes who have settled in the city with the Asantes dominating all tribes.

4.3. Economy

Although many people in Kumasi are engaged in a form of employment (that is about 86%) either with the private or public sector, about 60% of the residents still have a lower standard of living. The economy of the metropolis is propelled by the service (commercial inclusive), industry and agricultural sectors with employment levels of 71%, 24% and 5% respectively. Kumasi has established itself as a major service centre. Commercial activity is centred on wholesaling and retailing. Ancillary services are offered by both banking and non-banking financial institutions. Other areas worth mentioning are the professionals in planning, Medicine, engineering, teaching and law practice. Another group of service providers are hairdressers, dressmakers/tailors, technicians, barbers etc.

There are three important estates. These are the formal estate of large industries engage in milling and plywood manufacturing for export, the famous Suame Magazine where small engineering based industries are sited and the woodworking business at Anloga produce to meet the needs of clients from Accra and abroad. Another area of interest is handicraft-industry. These include basket weavers, potters, wood cavers and cane weavers. Subsistence agriculture is practiced on a limited scale. Crop farming is along valleys of rivers and streams that traverse the metropolis. It is also carried out in open backyards and in the peri-urban areas. Another area worth considering is animal production in sheep/goats, cattle, poultry and fish farming (Development Plan, KMA 2003).

4.4. HIV/ AIDS Situation in the Study Area

Kumasi the capital of the Ashanti region is marked as one of the sentinel sites in Ghana. Although according to the 2004 Sentinel Surveillance Survey Report the metropolis has HIV prevalence of 2.4 per cent (which is lower than other Sentinel sites in the region, Obuasi 3.4, Mampong 3.2, and Amansie West 2.8), report from the HIV/AIDS Division of the Ashanti Regional Office of the Ministry of Health reveals that it has the largest number of people, about 58 per cent (both men and women) living with HIV/AIDS. In addition, about 60 per cent of the people living with the disease in the metropolis are females. This makes the study in the Metropolis to be of particular interest since women are the main target of the study.

The HIV/AIDS situation in Kumasi is not surprising since it is the capital of the Ashanti Region, the most populous region in the country and also the second commercial city in Ghana with its attended social problems. Contact with the Health Authorities and HIV/AIDS NGO officers in the Metropolis as well as careful study of the lifestyle in various towns in the Metropolis reveals that Adum, Bantama, Boshen and Asokwa are among the high risk areas in the metropolis (see map in the end of the chapter. As a result these towns were selected to be representative towns for the study, considering the size of the metropolis.

All the four representative towns are located closer to the centre of the city (within 3 miles radius as shown by Figure 1. Adum is one of the oldest towns in Kumasi which forms the nucleus of the city. As part of the centre of the city major commercial activities as well as other services take

place in this area. The Regional offices of the government ministries and other important offices as well as the branches of many banks are located within this area. Of particular importance is the fact that most of the “*home seated*” commercial sex workers are located within this area. Bantama is within a walking distance to the city centre. It is one of the active towns in the city, consisting of many drinking bars and night clubs which are located mainly along the Bantama high street. Most often, “*roam about*” sex workers anonymously operate around these drinking bars and night clubs where they come into contact with some men who buy drinks for them and trade sex with them. Commercial activities also take place in this area. Asokwa is part of the industrial stretch of Kumasi while Boshen is located at about 3 miles away from the city centre. Both Asokwa and Boshen are composed of a mixture of good quality communities and poverty ridden slum communities, normally called “*Zongo*” in Ghana. There are also some drinking bars in these towns too. All the suburbs are made up of residents with varied economic and social background: people with high-income, middle income, and low income class as well as people with high level education, middle level education, low education and illiterates. Some of the residents are employed in the public and private sectors. However, others are businessmen and women while majority of them are employed in the informal sector, engaging in vocational trading or petty trading. Yet many people, especially the youth are either unemployed or underemployed with no regular income. Most often, the “*roam-about*” sex workers usually operate within clubs and bars which are not of close proximity to their areas of residence in order to keep their anonymity although some are more visible in the local area. Most of them usually operate at well noted night clubs and hotels in the city. Usually, the populations in the selected study towns are mixture of Christians and Muslims with the Christians dominating in most areas while the Muslims dominate in the slums or “*Ghetto*” areas in Asokwa and Boshen. Although there are few people with good standard of living, the standard of living of majority of the people is low, particularly in the slum or “*ghetto*” areas.

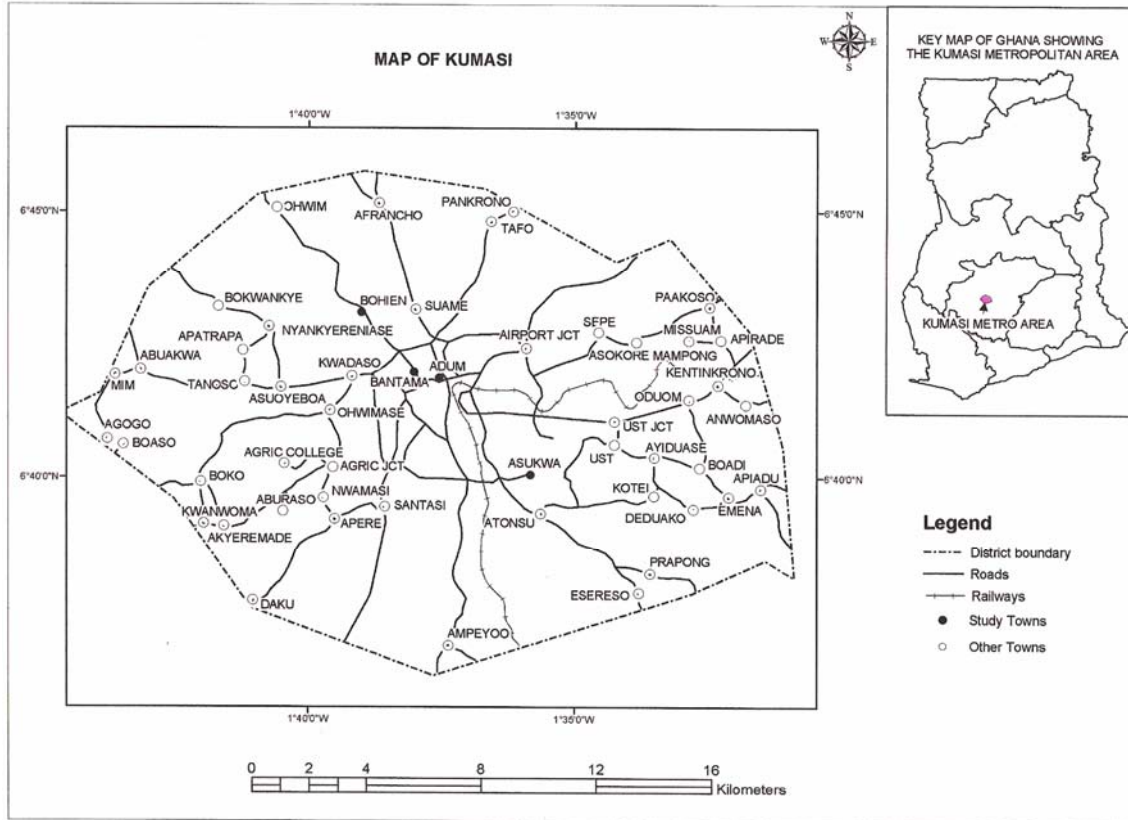


Figure 2.1: Map of Kumasi showing the representative towns
Source: Cartographic Department, Department of Geography, University of Ghana

CHAPTER FIVE: PERCEPTION ABOUT WOMEN'S HIV/AIDS RISK AND SEXUAL RIGHT

This chapter explores the perception of women and men on HIV/AIDS risk and the sexual right of women in the study area. It is mainly based on the quantitative data collected with questionnaire from 80 female respondents in the study area and partly on in depth interviews with 10 female respondents and 5 male respondents as well as other informants like prostitutes, HIV/AIDS positive women and key informants in the study area. In analyzing and interpreting the findings emphasis was given to women's HIV risk worry, risk perception, risk tolerance and risk behaviour. In addition importance was also attached to the perception about women sexual right in the study area. These are done in order to answer some of my research questions and to achieve part of my research objectives.

5.1. Gender Distribution of HIV/AIDS in Kumasi

In Kumasi, inequality in the distribution of HIV/AIDS cases among the various sexes is a critical women health problem that needs to be addressed. As many studies such as Crane (1991), UNAIDS (2004), and GDHS (2003) have reported, a greater proportion of people living with HIV/AIDS are women and this indicates that women are at greater risk of contracting the disease than men. As shown by Table 5.1 although both men and women are at risk of HIV, women are more vulnerable to infection than men.

Table 5.1 shows incidence figures (new cases) and that more women were infected with HIV over a period of five years, that is from 2000 to 2004. In 2000, out of the 1720 HIV adult cases reported in Kumasi, 57 percent were females. Also in 2001, 57 percent of the 1749 reported adult cases were females. Similarly, 58 per cent, 58 per cent and 60 percent out of the total number of adult cases reported in 2002, 2003, and 2004 respectively were females. Thus 58 percent of the total number of 7744 adult cases reported from 2000 to 2004 were women. This high female vulnerability to HIV infection is due to certain factors that constrain women from negotiating safer sex and such factors would be discussed as we go further into this chapter. It should however be noted that the drop in 2004 was due to incomplete data.

Table 5. 1: Distribution of HIV incidence by Sex, 2000-2004, Kumasi

Year	Females		Males		Total
	No. of cases	Percentage %	No. of cases	Percentage %	
2000	979	57	741	43	1720
2001	997	57	752	43	1749
2002	980	58	700	42	1680
2003	894	58	646	42	1540
2004	631	60	424	40	1055
Total	4481	58	3263	42	7744

Source: based on MOH HIV/AIDS data, 2000-2004, Kumasi

Although the study was able to explore whether gender inequality in HIV is present in the study area, it was unable to investigate whether gender inequality for specific age group persist in the study area because it was impossible to obtain HIV data for the specific age groups for the period stated above. This inability to obtain data on HIV for the age groups is due to the fact that data for the age groups is only available on a regional basis and not on a district or metropolitan basis. Thus since the study area Kumasi is a metropolis in the Ashanti Region, it was impossible to use such data for the study.

5.2. Women's HIV Risk Worry and Perception

A person might say she is worried about something which simply means that she considers that there is a risk at hand. With the word “worry” is denoted preoccupation with thoughts about uncertain and unpleasant events. To be worried means to be in an unpleasant state of mind (Sjoberg, 1996). The study reveals that women in the study area are very much worried for contracting HIV/AIDS. Worry is particularly higher among women in their thirties, especially those in their early thirties (that is women age 30 to 34). The reason why most women are very much worry for contracting HIV/AIDS may be due to the fear of stigma which is a consequence of the fact that women who are infected with the disease are considered as sexually immoral. This because of the fact that HIV infection in Africa is mainly transmitted during heterosexual intercourse (Kalipeni et al, 2004;Agyei-Mensah, 2005). Since women who are HIV/AIDS

positive are considered or equalized to prostitutes in Ghana; women usually feel more shame for being HIV/AIDS positive. Table 5.2 shows that 66 percent of the total number of women who responded to the questionnaire are very much worried for contracting HIV/AIDS, 20 percent are more worried, 10 percent are worried, and only 4 percent are either not worried or less worried for contracting HIV/AIDS. Also 78 percent of the women within the age group of 30 to 34 are very much worried for contracting HIV/AIDS while 70 percent, 59 percent, and 69 percent of the women with the age groups 35 to 39, 25 to 29, and 20 to 24 are very much worried for contracting the disease respectively. Pearson correlation test shows that there is a weak, but not significant relationship between age and worry for contracting HIV/AIDS.

Table 5. 2: Percentage distribution of worry for contracting HIV/AIDS by age, Kumasi, 2005.

Age	Worry for contracting HIV/AIDS				Total
	Not/less worried	worried	More worried	Very much worried	
20-24	3 9%	4 14%	3 9%	22 69%	32 100%
25-29	0 0%	3 10%	9 31%	17 59%	29 100%
30-34	0 0%	0 0%	2 22%	7 78%	9 10%
35-39	0 0%	1 10%	2 20%	7 70%	10 100%
Total	3 4%	8 10%	16 20%	53 66%	80 100%

Source: own survey, Kumasi, 2005

Women without sexual partners within the last 12 months are most worried for contracting HIV/AIDS than women with one or more sexual partners. As revealed by Table 5.3, 89 percent of the women without sexual partners within the last 12 months are very much worried for contracting HIV/AIDS while 61 percent, 57 percent and 50 percent of women with only one sexual partner, women with 2 to 5 sexual partners and women who do not know the number of sexual partners within the last 12 months are very much worried for contracting HIV/AIDS respectively. None of the women without or with only one sexual partner within the last 12 months is not or less worried for contracting HIV/AIDS while 14 percent of the women with 2 to 5 sexual partners and 13 percent of women who do not know the number of sexual partners are not or less worried for contracting HIV/AIDS. Also 75 percent of the women who prefer not to answer the question on the number of sexual partners within the last 12 months are very much

worried for contracting HIV/AIDS and 5 percent are not or less worried for contracting HIV/AIDS. A greater proportion of the women without sex partners within the last 12 months are very much worried for contracting HIV/AIDS partly because of the fear of the premature death that most AIDS persons experience in Ghana and also because of the fear of being stigmatized and discriminated against. Women have suffered disproportionately from discrimination against people living with HIV/AIDS. The pandemic has led to increased gender-based violence as HIV-positive women are assaulted, prevented from having children, dismissed from employment, disowned, and shunned by their families and communities. Women are more likely than men to be held responsible for spreading the disease and to be labelled as promiscuous. Thus fearing violence, stigma, and ostracism, many women even avoid taking HIV tests, thereby denying themselves crucial information about their health and excluding themselves from programs to prevent HIV transmission to their to even their newborns (Centre for Reproductive Right, 2005). Such treatment that women living with HIV/AIDS suffer even explain the reason why the women have chosen to remain single.

Table 5.3: Percentage distribution of worry for HIV/AIDS by number of sexual partners within the last 12 months, Kumasi, 2005.

Number of sexual partners	Worry for contracting HIV/AIDS				Total
	Not/less worried	worried	More worried	Very much worried	
None	0 0%	1 11%	0 0%	8 89%	9 100%
Only one sexual partner	0 0%	3 8%	11 31%	22 61%	36 100%
2 to 5sexual partners	1 14.%	1 14%	1 14%	4 57%	7 100%
Don't know	1 12.5%	2 25%	1 12.5%	4 50%	8 100%
I prefer not to answer	1 5%	1 5%	3 15%	15 75%	20
Total	3 4%	8 10%	16 20%	53 66%	80 100%

Source: own survey, Kumasi, 2005

This study aims at exploring the perception of women and men about HIV/AIDS risk. One way of achieving this was to find out women and men’s perception about the fatality of AIDS. About 95 per cent of the women who answered the questionnaire believe AIDS is fatal. Solely one out of 77 females who responded to the questionnaire believes AIDS is not fatal and 3 answered that they do not know. Similarly, all the women and men who were interviewed believe that AIDS is

fatal. However, some of the respondents were of the view that there are some people who still believe that HIV/AIDS do not exist.

Early HIV prevention efforts revealed that information alone was not enough to effect the changes in behaviour necessary to slow the spread of the disease. Beyond a certain level, increasing what a person knows about AIDS does not seem to affect behaviour. This finding led researchers to look for other factors related to behaviour change. One promising variable is risk perception. Several theories of health behaviour suggest that it is an individual's perception of risk rather than the actual risk involved that determines behaviour. Hence it is important to assess the risk perception of those at greatest actual risk (Fenaughty et al, 1995). This study therefore assesses the risk perception of women in the study area in relation to their age and other behavioural assessment variables such as sex with anonymous or casual partner, ever had sex for any form of support, and whether changes have been made to avoid HIV. It was found that 54 percent of the women who responded to the questionnaire are of the view that they are likely (29%) or more likely (25%) of contracting HIV within a period of 5 years. Contrary, 46 per cent of the women think they are unlikely (23%) or more unlikely (23%) of contracting HIV within a period of 5 years. Also relatively older women believe they are at higher risk of contracting HIV than younger women. Table 5.4 shows that a greater proportion of the women who are aged 35 to 39 years (80%) and women who are aged 30 to 34 (67%) think they are likely or more likely of contracting HIV within a period of 5 years respectively. Women who are 30 years and above think they are likely or more likely to contract HIV within a period of 5 years because they may have had more sexual experience due to their relatively older age than the women below 30 years and therefore they may be exposed to more risk. Also most of the women above 30 years are usually married, and since engaging in multiple partnership by men is condoned in the study area, the belief of these women that they are at higher risk of contracting HIV may be probably due to the risky sexual behaviour of their husbands.

The study found out that although women's HIV risk perception is generally high, women who usually have higher risky behaviour have relatively lower HIV risk perception than women who have lower risky behaviour. That is women who think they are at higher risk of contracting HIV usually have lower risky behaviour than women who think they are at lower risk. This finding

therefore confirms the suggestion of other theories of health behaviour that it is the individual's perception of risk rather than the actual risk involved that influences behaviour (Fenaughty et al, 1995). As argued by Adams and Wilde, the reason why some women have low risk perception and a high risk behaviour may be probably due to the introduction of condom(safety measure) which is believe to help protect against the transmission of the AIDS virus. Thus with the introduction of such safety measure, they find the rewards of risk taking as more attractive and therefore tend to engage in more risky behaviour (Richens et al 2000).

Table 5. 4: Perception of contracting HIV within a period of 5 years by age, Percentages, Kumasi, 2005

Age	Likelihood of contracting HIV/AIDS				Total
	More unlikely	Unlikely	Likely	More likely	
20-24	9 29%	7 23%	7 23%	8 26%	31 100%
25-29	6 21%	9 31%	10 35%	4 14%	29 100%
30-34	1 11%	2 22%	1 11%	5 56%	9 100%
35-39	2 20%	0 0%	5 50%	3 30%	10 100%
Total	18 23%	18 23%	23 29%	20 25%	79 100%

Source: own survey in Kumasi, 2005

Number of missing cases: 1

As shown in Table 5.5, 17 percent and 42 percent of the women who have had sex with anonymous or casual partner within the last 12 months think they are unlikely and more unlikely to contract HIV within a period of 5 years respectively whiles 23 percent and 19 percent of the women who have not think they are unlikely and more unlikely to contract HIV within a period of 5 years. On the other hand, 25 percent and 17 per cent of these think they are likely and more likely to contract HIV respectively. For those who had not, 28 percent and 30 percent think they are likely and more likely to contract HIV within a period of 5 years respectively.

Also 30 percent and 28 percent of the women who have never had sex with a man for any form of support think they are likely and more likely to contract HIV within a period of 5 years respectively while 23 percent and 19 per cent think they are unlikely and more unlikely to contract HIV within a period of 5 years. None of the women who have ever had both protected and unprotected sex with a casual partner think she is more likely to contract HIV within a period

of 5 years, 38 think they are likely while 38 per cent and 25 per cent think they are unlikely and more unlikely to contract HIV within a period of 5 years respectively.

Furthermore, where as 20 percent and 60 percent of women who have ever had protected sex with a casual partner think they are likely and more likely to contract HIV within a period of 5 years respectively, none of those who have ever had unprotected sex think they are likely or more likely to contract HIV within a period of 5 years. On the other hand, all the women who have ever had unprotected sex with a casual partner think they are either unlikely (50%) or more unlikely (50%) to contract HIV within a period of 5 years while 20 per cent of those who have ever had protected sex think they are more unlikely to contract the disease within a similar period. Yet again, 25 per cent and 32 per cent of the women who have made changes to sexual behaviour to avoid HIV think they are likely and more likely to contract HIV within a period of 5 years respectively. 41 per cent and 9 per cent of those who have not think they are likely and more likely to contract the disease within the same period. 27 per cent and 23 per cent of the women who have not made any changes to their sexual behaviour think they are unlikely and more unlikely to contract HIV within a period of 5 years while 21 per cent of those who have made changes to their sexual behaviour think they are unlikely and 21 per cent think they are more unlikely to contract the disease within the same period.

There is a significantly positive correlation between the likelihood of contracting HIV within a period of 5 years and the likelihood of becoming a victim of other diseases. That is the more likely a woman is to contract HIV within 5 year period, the more likely she is to fall vulnerable to other diseases like malaria, tuberculosis (TB), typhoid, and other sexually transmitted diseases (STDs) such as gonorrhoea and syphilis etc. This relationship is significant at 0.01 levels for TB, typhoid and STDs and at the 0.05 level for malaria and the Pearson correlation coefficient is 1.00 TB and 0.7 for all the other diseases mentioned above. The reason for this positive relationship may be attributed to the fact that women who are likely to contract HIV within a period of 5 years may have a relatively weaker immune system which will make them similarly vulnerable to other diseases as mentioned above. Also there is a weak negative correlation between the likelihood of contracting HIV within a period of 5 years and the level of education. That is women with lower

Table 5. 5: Assessment of women’s HIV risk, Percentages, Kumasi, 2005.

		Likelihood of contracting HIV within a period of 5 years				Total
		More unlikely	Unlikely	Likely	More likely	
Sex with casual/ anonymous partner within the last 12 months	Yes	5 42%	2 17%	3 25%	2 17%	12 100%
	No	10 19%	12 23%	15 28%	16 30%	53 100%
Ever had sex with man for money or any form of support	No	10 19%	12 23%	16 30%	15 28%	8 100%
	Yes, protected and unprotected	2 25	3 38%	3 38%	0 0%	8 100%
	Yes protected	1 20%	0 0%	1 20%	3 60%	5 100%
	Yes unprotected	1 50%	1 50%	0 0%	0 0%	2 100%
Have changes been made to sexual behaviour to avoid HIV?	Yes	12 21%	12 21%	14 25%	18 32%	56 100%
	No	5 23%	6 27	9 41%	2 9%	22 100%

Source: own survey in Kumasi, 2005

level of education have a higher likelihood of contracting HIV within a period of 5 years, the reverse is true. Pearson correlation coefficient for this relationship is -0.23 and significant level is 0.05. This negative relationship between the level of education and the likelihood of contracting HIV within a period of 5 years may be due to the fact that women with higher level of education are more knowledgeable about HIV and the mode of transmission than women with low level of education. Also they are not poverty ridden and therefore they either do not exchange sex for money or if they do they are able to ensure that they have safe sex. Women with higher level of education who may exchange sex for money do it for luxury because they are usually not poor and therefore they may not have unprotected sex.

Although Malaria still remains the top killer in Ghana (Angola Press, 2007), it is more acceptable to be a victim of malaria than to be a victim of HIV/AIDS, especially, and other diseases like TB, typhoid, other STDs, and traffic accidents. Table 5.6 shows that out of the 80 women who answered the questionnaire, 75 chose malaria as one of the three diseases they are most likely to be a victim of. 64 per cent of these women ranked malaria as the disease they are most likely to be a victim of. It is more acceptable to be a victim of malaria because it has no stigma, although

Dela Cruz et al(2006) has stated that it is hyper endemic in Ghana, accounting for 44 per cent of out patient attendance, 13 per cent of all hospital deaths, and 9 per cent of over all mortality in Ghana. The next disease ranked after malaria is traffic accident which about 37 per cent and about 33 per cent of the 49 women who chose it as one of the three diseases they are most likely to be a victim of, ranked it as the disease they are likely and most likely to be a victim of respectively. Traffic accident was highly ranked because you can be a victim of traffic accident even if you do not engage in risky behaviour. This is because you can be hit by a car or you can be innocent passenger in a car.

Table 5. 6: Likelihood of becoming a victim of HIV by selected diseases, Percentages, Kumasi, 2005

	HIV/AIDS	Malaria	Tuberculosis	Typhoid	Other STDs	Traffic accident
Less likely	19 50.0%	7 9.3%	12 38.7%	21 58.3%	5 35.7%	14 28.6%
Likely	12 31.6%	18 24%	13 41.9%	12 33.3%	5 35.7%	18 36.7%
Most likely	6 15.8%	48 64.0%	5 16.1%	1 2.8%	2 14.3%	16 32.7%
Missing cases	1 2.6%	2 2.7%	1 3.2%	2 5.6%	2 14.3%	1 2.0%
Total	38 100.0%	75 100.0%	31 100.0%	36 100.0%	14 100.0%	49 100.0%

Source: own survey in Kumasi, 2005

It is evident from this study that there is a strong positive correlation between the likelihood of becoming a victim of HIV/AIDS and the likelihood of becoming a victim of other diseases like TB, malaria, typhoid and other STDs. This association is significant at the level 0.01 and the Pearson coefficient is 1.0. This is due to the fact that such opportunistic diseases such as malaria TB, Typhoid ultimately compromise the immune system and increase susceptibility to HIV infection (Kalepeni et al, 2004). It is also due to the low socio-economic status of the women.

Women’s perception about HIV consequence is generally high. From this study, it is evident that most women perceive the consequence for contracting HIV within a 5 year period as very large. Table 5.7 shows that 65 percent of the women in the study area consider the consequence for contracting HIV within a 5 year period as very large, 23 percent consider it to be large whiles only 9 percent and 4 per cent consider it to be minimal and very minimal respectively. In order to understand why most of the women consider the consequence for contracting HIV within a 5 year period as very large, some of the women were further questioned on the issue. It was found out

that most of them consider the consequence for contracting HIV within a 5 year period as very large because HIV/AIDS is associated with many opportunistic diseases such as TB, typhoid, malaria, and STDs. There is a significantly positive correlation between the age of a woman and the consequence for contracting HIV within a 5 year period. That is older women consider the consequence for contracting HIV within a 5 year period as very large. This relationship is significant at 0.02 (Pearson correlation). From table 5.7 one can observe that 100 per cent of women aged 30 to 34 and 70 percent of those aged 35 to 39 consider the consequence of contracting HIV within a 5 year period as large even though the absolute numbers are small. None of these women consider the consequence as very minimal. However below 50 per cent (that is 47%) and 72 percent of the women aged 20 to 24 and 25 to 29 consider the consequence of contracting HIV within a 5 year period as very large while 6 percent of the women aged 20 to 24 and 3 percent of those aged 25 to 29 consider the consequence as very minimal. Also 19 percent of the women aged 20 to 24 consider the consequence of contracting HIV within a period of 5 year as minimal.

Table 5. 7: Consequence for contracting HIV within a period of 5 years by age, Percentages, Kumasi, 2005.

Age	Consequence for contracting HIV within a 5 year period				Total
	very minimal consequence	minimal consequence	large consequence	very large consequence	
20-24	2 6.0%	6 19.0%	9 28.0%	15 47.0%	32 100.0%
25-29	1 3.0%	0 .0%	7 24.0%	21 72.0%	29 100.0%
30-34	0 .0%	0 .0%	0 .0%	9 100.0%	9 100.0%
35-39	0 .0%	1 10.0%	2 20.0%	7 70.0%	10 100.0%
Total	3 4.0%	7 9.0%	18 23.0%	52 65.0%	80 100.0%

Source: own survey in Kumasi, 2005

According to Bernardi (2002), the individual's risk assessment and shared common sense attitudes influence the perceived value attached to the consequence of actions and to the balance of gains and losses behavioural choices imply. If the magnitude of potential loss is perceived as small enough, then the acceptability of undertaking the action is higher. In order to find out how the individuals perception or assessment of risk consequence of HIV influence their behaviour, this study conducted a bivariate analysis of the consequence for contracting HIV within a 5 year

period and the number of sexual partners within the last 12 months using crosstabulation. It was found out (as shown in table 5.8) that although 57 percent and 43 percent of women with 2 to 5 sexual partners perceive the consequence for contracting HIV as large and very large respectively, they tend to engage in such risky sexual behaviour. About 19 percent and 75 percent of women with only one sexual partner perceive the consequence to be large and very large respectively. Likewise 33 percent and 56 percent of the women with no sexual partner consider the consequence to be large and very large.

Table 5. 8: consequence for contracting HIV within a 5 year period by number of sexual partners within the last 12 months, Percentages, Kumasi, 2005.

Number of sexual partners	Consequence for contracting HIV within a 5 year period				Total
	Very minimal consequence	Minimal consequence	Large consequence	Very large consequence	
None	1 11.0%	0 0%	3 33.0%	5 56.0%	9 100.0%
Only one partner	0 0%	2 6.0%	7 19.0%	27 75.0%	36 100.0%
Between 2 to 3 partners	0 0%	0 0%	4 57.0%	3 43.0%	7 100.0%
Don't know	1 13.0%	2 25.0%	1 13.0%	4 50.0%	8 100.0%
I prefer not to answer this question	1 5.0%	3 15.0%	3 15.0%	13 65.0%	20 100.0%
Total	3 4.0%	7 9.0%	18 23.0%	52 65.0%	80 100.0%

Source: own survey in Kumasi, 2005

As argued by Bernadi (2002), because the women with no sexual partner and those with only one sexual partner perceive the magnitude of the potential loss in engaging in risky sexual behaviour as high, they have chosen not to engage in a more risky behaviour. However, contrary to Bernadi's argument, the women with 2 to 5 sexual partners have still chosen to engage in risky sexual behaviour although they consider the magnitude of the potential loss in engaging in risky sexual behaviour as high. The reason for such risky behaviour is most likely that the women are probably despair or desperate for money. Also their propensity to take risk is influenced by the rewards or benefits, for example, money, gifts, and protection, that they intend to receive (Richens et al 2000).

5.3. Women Risk Behaviour and Tolerance

In order to assess the HIV risk behaviour of the women in the study area, data was collected on the sexual behaviour of the women in the study area. It was revealed that the age of a woman is inversely related to the number of sexual partners within the last 12 months. That is younger women have more sexual partners while older women have fewer sexual partners. This relationship is significant at 0.02 (Pearson correlation) and 0.001 (chi-square test).

Table 5.9 shows that 16 percent and 7 percent of women within the age group 20 to 24 and 25 to 29 have had 2 to 5 sexual partners within the last 12 months respectively. None of the women above 30 years have had more than one sexual partner within the last 12 months. The reason why younger women have more sexual partners than older women is that they are usually unemployed and underemployed than the older women. Also their lifestyle may influence them to engage in such risky behaviour (http://www.mywiseowl.com/articles/Risk_assessment, 18.05.2005).

This is because younger women tend to follow more fashion than older women and since their own income can not afford they tend to depend on multiple partners or resort to prostitution to meet their standard of living.

Table 5. 9: Number of sexual partners within the last 12 months by age, Percentages, Kumasi, 2005.

Age	Number of sexual partners within the last 12 months					Total
	None	Only one sexual partner	2 to 5 sexual partners	Don't know	I prefer not to answer	
20-24	7 22.0%	3 9.0%	5 16.0%	6 19.0%	11 34.0%	32 100.0%
25-29	1 3.0%	18 62.0%	2 7.0%	2 7.0%	6 21.0%	29 100.0%
30-34	1 11.0%	7 78.0%	0 .0%	0 .0%	1 11.0%	9 100.0%
35-39	0 .0%	8 80.0%	0 .0%	0 .0%	2 20.0%	10 100.0%
Total	9 11.0	36 45.0%	7 9.0%	8 10.0%	20 25.0%	80 100.0%

Source: Own survey, Kumasi, 2005

Furthermore it was revealed that poorer women have a stronger propensity to indulge in sex with a man for money or other forms of support than rich women. When asked whether they have ever had sex with a man for money or any form of support, about 89 percent of the women with an average monthly personal income of about \$111 or more said they have never had sex with a

man for money or any form of support and about 11 percent of them prefer not to answer the question as indicated in Table 5.10. The majority of the women (about 65 percent) with average monthly personal income between \$56 and \$110 have never had sex with a man for money or support. Also, 57 percent of the women with an average monthly personal income of \$22 and \$55 have had no sex with a man for money or support while about 11 percent and 14 percent have had both protected and unprotected sex and solely protected sex respectively. Also 43 percent of women with average monthly personal income below \$22 have never had sex with a man for money or any form of support while about 29 percent have had protected sex and 29 percent have had unprotected sex. However, there is an exceptional case where 75 percent of the women with no income have never had sex with a man for money or any form of support. This implies that although poorer women tend to have sex with a man for money or support, the situation is not always true for all poor women. Thus to accept to engage in such risky behaviour will also normally be influenced by the person's moral values and self discipline. Some of the women may have higher income; however they may conceal this income, not reporting in the survey. This is because they are afraid of being taxed or they are unwilling to let others know their income probably to avoid financial demands from the extended family and friends etc. Since the questionnaire was not designed specifically for prostitutes, it would be very difficult to conclude that the women who have ever had sex for money are prostitutes. Some may be professional or

Table 5. 10: Ever had sex with a man for money or any form of support by income, percentages, Kumasi, 2005

Income \$	Ever had sex with man for money or any form of support						Total
	No	Yes protected and unprotected	Yes protected	Yes unprotected	I prefer not to answer	Missing	
0	6 75.0%	0 .0%	0 .0%	0 .0%	1 12.5%	1 12.5%	8 100.0%
1-21	3 42.9%	0 .0%	2 28.6%	2 28.6%	0 .0%	0 .0%	7 100.0%
22-55	16 57.1%	3 10.7%	4 14.3%	0 .0%	4 14.3%	1 3.6%	28 100%
56-110	11 64.7%	4 23.5%	0 .0%	0 .0%	2 11.8%	0 .0%	17 100.0%
111+	8 88.9%	0 .0%	0 .0%	0 .0%	0 .0%	1 11.1%	9 100.0%
Total	44 63.8%	7 10.1%	6 8.7%	2 2.9%	7 10.1%	3 4.3%	69 100.0%

Source: Own survey, Kumasi, 2005

“self-styled” prostitutes but some are not. Interview with some of them reveals that they exchanged sex for money or other form of support due to the circumstances they found themselves at that particular time.

However, through in-depth interview with some prostitutes, it was revealed that although some women engage in prostitution for varied reasons such as for “fun” or pleasure and out of desperation for money, some rich women still engage in prostitution or exchange sex for money. Nonetheless most of these women amassed their wealth through prostitution. Interview with some of them revealed that they have hierarchy in prostitution with the low profile (“luxury”) prostitutes earning between \$5 and \$25 per customer while the high profile prostitutes earn between \$500 and \$1000 per customer. According to some of them such high profile prostitutes are able to earn higher income because they usually engage in prostitution with rich business men and high local and foreign officials. An interview with one prostitute (aged 25-29) confirmed this. In the interview she said:

“I wish prostitution is legalized. It has helped me to acquire such properties as car, house and boutique. Yet these are not enough, I need more. Everybody needs more money so there is no limit to what one can acquire.”

Despite the fact that this woman is not financially constrained, though her wealth is made from prostitution, she still has the desire to exchange sex for money in order to make more wealth to the extent that she is yearning for the legalization of prostitution in Ghana. She has accepted to engage in such risky behaviour because of the benefits she hopes to gain from it. As maintained by Wilde (2002), interview with the prostitutes reveal that they are usually willing to accept some level of risk at the cost of their health for the benefits they hope to receive. That is they are willing to have unprotected sex for higher pay. According to them whether they would have protected or unprotected sex depends on the man they trade with that is whether he is willing to pay higher fee for unprotected sex or less fee for protected sex. Only 16 percent of the women who responded to the questionnaire answered the question on casual sex partner. The major group was 7 respondents out of 13.

According to this study, HIV risk tolerance is high (above 50%) at both the local (study area) and national level. Interview with some of the respondents reveal that HIV risk is highly tolerated because in Ghana in general, there are many people who do not believe the disease actually exist while some attribute it to witchcraft. An interview with one of the HIV/AIDS respondents aged 34-35 confirmed this. She said in an interview:

“I got this disease spiritually. Because the witches in my family want to disgrace me and kill me because I have a bright future, they have infected me spiritually with AIDS.”

This woman like other people thinks she was spiritually infected with HIV because the witches in her family are against her prosperity and thus want to eliminate her from the earth. In fact in Ghana, it is a common attitude that certain sickness, particularly those that threaten life and premature death are attributed to witchcraft. Some people are of the believe that if you prosper in the family and the witches in your family are against that or if they realize you have a bright future, then they either infect you with a disease or kill you or both. Due to such believe, many people who think they can not find the cause of their sickness and currently HIV/AIDS people in particular, resort to spiritualist such as pastors and traditional priests for healing. So there are various types of “rationality” regarding their judgements. Yet most of such believes are superstition because usually such diseases are the consequence of the risky behaviour of the person, unhealthy medical practice like the transfusion of contaminated blood, poor nutrition or unhealthy environmental conditions.

Although HIV risk tolerance is high at both the local and national level, the study shows that it is more highly tolerated at the national level than at the local level. Table 5.11 reveals that out of 80 women who responded to the questionnaire, 70 percent were of the view that HIV is either tolerated to a high degree or very high degree at the national level (that is Ghana) while 54 percent were of the view that HIV risk is tolerated to a high degree or very high degree at the local level. Also 19 percent and 11 percent of the women were of the view that HIV risk is tolerated to a low degree and very low degree at the national level respectively while 26 percent and 20 percent were of the view that risk is tolerated to a low degree and a very low degree at the local level respectively. Most of the women think HIV risk is highly tolerated at the national level

than at the local level because there is variations in the HIV/AIDS prevalence in Ghana with some areas or localities such as Manya Krobo and Koforidua in the Eastern Region of Ghana well noted for relatively higher HIV prevalence rates and hence risky behaviour than Kumasi. Also a locality like the Kwame Nkrumah Circle in Accra is well noted for commercial sex activities by young women who usually stand along the road sides and other points to attract men.

Table 5. 11: The extent of tolerating the risk level for contracting HIV/AIDS in Ghana and Kumasi, 2005, Percentages

	Ghana		Kumasi	
	Frequency	Percent	Frequency	Percent
Tolerate to a very high degree	17	21.3	20	25.0
Tolerate to a high degree	39	49.0	23	29
Tolerate to a low degree	15	19.0	21	26.0
Tolerate to a very low degree	9	11.0	16	20.0
Total	80	100.0	80	100.0

Source: own survey in Kumasi, 2005

5.4. The Need for Risk Reduction

Individual risk perception depends on the individual's perceived control of his or her capability to take preventive measures against the infection, and of course, on actual behaviour. In order to understand respondents' perception of risk, we need information on the preventive measures they themselves perceived to be effective. In addition, risk perception is affected by the degree of control people feel they have on their and their partner's behaviour. If preventive measures are not viable, their knowledge does not help in reducing the sensation of risk (Bernardi, 2002). Most of the women in the study (both respondents of questionnaire and interviews) mentioned caution as their preferred measure for risk reduction if they discover their partners' behaviour is a health risk to them. From Table 5.12, it is evident that about 28 percent of the women chose caution as the measure for risk reduction if they think their spouse or partner's behaviour is a health risk to them, about 24 percent chose to demand the use of condom, 20 percent chose divorce, about 11 percent chose abstinence, and 5 percent chose just ignore as most preferred measure.

Also about 13 percent of the women said they do not know the measure they would take if their spouse or partner's behaviour is a health risk to them. Similarly, 4 out of the 10 women who were interviewed said they would use caution as a measure for risk reduction if they realize their spouses' or partners' behaviour is a health risk to them. Also 4 said they would use condom while the remaining 2 said they would use abstinence. As Bernadi (2002) have stated, women's risk perception is affected by the degree of control they feel they have on their behaviour and that of their spouse or partner and also such control in turn influence their capability of reducing the risk. Thus women who do not have control over their spouses or partners behaviour as well as their own behaviour are usually incapable of adopting effective risk reduction measures to reduce their vulnerability to HIV infection. The study reveals that married women in particular, about 60 percent of them, prefer to use cautioning of their spouse than any other measure for reducing the risk of contracting HIV. Only 20 percent of the married women prefer to use condom, 5 percent prefer to divorce, and 5 percent prefer to abstain from sex. In addition, 10 percent of the married women said they do not know the measure they can take if their spouse or partners behaviour is a health risk. A greater proportion of married women prefer to use caution while some also prefer to just ignore because most married couples in Ghana have the desire for children, especially if they do not have one, in order to prove their fertility. Women hope that

Table 5. 12: Measures to take if partner's behaviour is a health risk by marital status, percentages, Kumasi, 2005.

Marital status	Measures to take if partner's behaviour is a health risk						Total
	I will demand the use of condom	I will abstain from having sex	I will caution him	I will just ignore	I will divorce him	I don't know	
Single	12 25.0%	8 16.7%	5 10.0%	3 6.3%	13 27.1%	7 14.6%	48 100.0%
Married	4 20.0%	1 5.0%	12 60.0%	0 .0%	1 5.0%	2 10.0%	20 100.0%
Separated	2 50.0%	0 .0%	1 25.0%	0 .0%	1 25.0%	0 .0%	4 100.0%
Cohabitated	0 .0%	0 .0%	0 .0%	0 .0%	1 100.0%	0 .0%	1 100.0%
Widowed	1 14.3%	0 .0%	4 57.1%	1 14.3%	0 .0%	1 14.3%	7 100.0%
Total	19 23.8%	9 11.3%	22 27.5%	4 5.0%	16 20.0%	10 12.5%	80 100.0%

Source: Own survey, Kumasi, 2005

children will provide long-term stability, while men generally desire many offspring as a proud maker of virility and status (UNAIDS/01.24E; Kalipeni et al, 2004). Thus they may usually not favour the use of condom or abstinence.

Furthermore, the cultural values and norms in the Ghanaian society favour male supremacy in marriage to the extent that it may be difficult for a woman to demand that her customary or legally married husband use condom or that they abstain from sex unless they have decided to practice family planning or the woman has given birth. Thus through an in- depth interview, some of the married women who said they prefer to use caution as the measure of risk reduction if their partners behaviour is a health risk further said their next option is that they would resort to divorce if their husband does not heed to their caution. One of the female respondents (aged 20 to 25) in an interview said:

“I will first caution him but if he does not heed to that then I will divorce him. I will divorce him because I don’t want to get infected with HIV and die a shameful death.”

This woman does not want to be infected with HIV but since she is married, she can only reduce risk of contracting the virus in collaboration with her husband. Since she is a married woman, she thinks she has to be a bit liberal by first adopting caution. Yet if this measure fails, then she thinks she can then adopt a more strict measure by divorcing her husband because she wants to avoid the shame associated with HIV/AIDS. In addition, the study found out that women with higher education mainly prefer to use condom (28%) as a measure for HIV risk reduction whiles women with low education prefer to use caution (33%).

The study further reveals that a greater proportion of the women in the study area have made changes to their sexual behaviour to avoid HIV infection. Only 28 percent of the women in the study area have not made changes to their sexual behaviour to avoid HIV infection. When asked the type of changes they have made to their sexual behaviour to avoid HIV infection, 34 percent of the women said they have abstained from sex, 34 percent said they have only one sexual partner, and 32 percent said they use condom. The majority of the women (61%) think it is very much important that the Ghanaian Health Authorities implement HIV/AIDS risk reduction

measures. Only 1 percent, 3 percent and 1 percent (total of 5%) think that it less important, least important and not important respectively.

5.5. Perception about Women’s Ability to Negotiate Safe Sex and their Sexual Right

A combination of biological, social, cultural and economic factors contribute to women's increased vulnerability to HIV infection. In particular, gender inequalities prevent women from asserting power over their own lives and controlling the circumstances that increase their vulnerability to infection. In their sexual relationships, women are often denied the power to make decisions that may lower their risk of HIV infection

(<http://www.globalhealthreporting.org/diseaseinfo.asp?id=251,2> 2 March 2007). This study therefore aimed at finding out the underlying factors to women’s inability to negotiate for safer sex and hence fall vulnerable to HIV infection. The study reveals that the low income or low economic status of women is the most important factor that undermines the capability of the women in the study area to negotiate safe sex. According to the perceived knowledge of the women who responded to the questionnaire, low income or low economic status of the women in the study area account for about 43 percent of women’s inability to negotiate safe sex as shown in Table 5.13. This is followed by the lack of social power which account for about 23 percent, lack of self or sexual control (15 %), cultural constraints (13%), lack of legal protection (6%), and other factors such as low self-esteem and the fear of being criticized (1%).

Table 5. 13: The most important factor that makes women incapable of negotiating safe sex, Percentages, Kumasi, 2005.

Factor	Frequency	Percent
low income/economic status	34	42.5
lack of self/sexual control	12	15.0
lack of social power	18	22.5
lack of legal protection	5	6.3
cultural constraints	10	12.5
other factors	1	1.3
Total	80	100.0

Source: Own survey, Kumasi, 2005

Some of the women also confirmed through interview that the low income or economic status of women undermines their ability to negotiate sex. According to one female respondent (aged 30 to

34): *“The women depend on the men for their economic needs and other support and therefore it is very difficult to demand that the man uses a condom”.*

The fact that some women in the study area depend on their husbands or partners for financial and social support weaken their ability to negotiate for safe sex. This is because dependency on the man implies that you also have to satisfy his desire in order to ensure that your needs are always met. Demanding safe sex in relationships in which the man provides for the woman may imply mistrust and this can cause misunderstanding and lead to the break down of such relationship. Thus to secure their relationship, most women would not even think about safe sex even if they suspect their spouse or partners' sexual behaviour is risky.

Furthermore, low income or poverty, the fear of losing the man/divorce and the supremacy of men were ranked as the three most important reasons why women are unable to negotiate for safer sex. Low income or poverty was ranked by 34 per cent of the women who responded to the questionnaire as the first most important reason why women in the study area are unable to negotiate for safe sex. The fear of losing the man/divorce was ranked next after low income or poverty with 29 percent of the women choosing it as the first most important reasons why women are unable to negotiate for safe sex. These were followed by the supremacy of men in society (13%), women's dependence on men (8%), men's inability to control sexual desire (8%) and women's inability to control sexual desire (8%). Apart from women's inability to negotiate for safe sex, unfaithful spouse or partner is perceived by the women to be the other most important factor that makes women liable to HIV infection. The society condones multiple partnerships by men but is very strict with women who engage in multiple partnerships. Due to this, many men engage in polygamy or sexual liaisons thus exposing their wives to HIV. In addition to unfaithful sexual partner, other factors such as having multiple sexual partner, prostitution, cultural practices like educating the male child at the expense of the female child, as well as encouraging male supremacy and female submissiveness, untreated STDs, and weak immune system were perceived by the women who responded the questionnaire to make women liable to HIV infection in the study area. Many of these factors are interrelated with poverty being a root cause.

Most women in the study area (81%) are of the view that women should be given the right to make decision on sex. However, as shown by table 5.14, about 43 percent of the women are of the view that women should be given full control while 38 percent are of the view that they should be given limited control. In addition, about 3 percent of the women are of the view that they should not be given any control on sex, 6 percent said they are indifferent and 11 percent said they do not know. A total of about 82 percent of women with high education (secondary and tertiary education) think women should be given the right to make decision over sex and about 78 percent of women with low or no education (primary and no formal education) think women should be given the right to make decision on sex. However, 49 percent and 33 percent out of the women with high education are of the view that women should be given full control and limited control over sex respectively while 33 percent and 44 percent of the women with low education are of the view that women should be given full control and limited control over sex respectively. Thus in general women with different background have the desire that they are given some amount of autonomy over their body.

Few women and majority of the men however did not support the idea of giving women control over sex. They argue that giving women such control will lead to divorce in most marriages. Some women were also of the view that some women would compromise their right and therefore it is not necessary to give women any right. In an interview one of such women stated that:

“It is not necessary to give women control over sex. This is because a lot of women would compromise their right because the whole act of sex will change”.

As she argues, giving women control over sex will change the whole act of sex. This is because most men particularly those in temporal partnership with women would be reluctant to support the women especially when they realize the women are not submitting to their desires. Due to the fact that most women are poor and need financial and other forms of support, they would be compelled to compromise their right. Thus it is very critical that women are empowered economically before their sexual right could be protected.

The women who responded to the questionnaire were of the view that such factors as political and economic empowerment of women, breaking down of cultural barriers against women, balancing male and female power relations, introduction of women to sex education, organizing counselling for women, educating women on self-esteem, education on abstinence and particularly encouraging formal female education are important measures to give women control over sex.

Table 5. 14: Should women be given the right to make decision on sex by level of Education, Percentages, Kumasi, 2005

Level of education	Should women be given the right to make decision on sex?					Total
	Yes, should be given full control over sex	Yes, but should be given limited control	No, should not be given any control	I'm indifferent	Don't know	
Low education	9 33.3%	12 44.4%	0 .0%	2 7.4%	4 14.8%	27 100.0%
Higher education	22 48.9%	15 33.3%	2 4.4%	2 4.4%	4 8.9%	45 100.0%
Total	31 43.0%	27 37.5%	2 2.8%	4 5.6%	8 11.1%	72 100.0%

Source: own survey, Kumasi, 2005

5.6. Chapter Summary

The study reveals that like many areas in Africa, gender inequality in HIV/AIDS persist in the study area. The study also shows that women in the study area are very much worried for contracting HIV with worry being particularly higher among women within their early 30's (table 5.7). Generally, women in the study area have higher perception about HIV risk with relatively older women having higher perception about HIV risk than younger women. Although women's HIV risk perception is generally high, the study reveals that women with higher HIV risk perception usually have lower risky behaviour than women with lower HIV risk perception. Again the study found out that women who are likely of becoming a victim of HIV/AIDS are also likely of becoming a victim of other diseases like TB, malaria, typhoid, and STDs because such opportunistic diseases weaken the immune system and hence increases one's vulnerability to HIV infection. The study reveals that a greater proportion of the women in the study area, consider the consequence for contracting HIV within a period of 5 years as very large. Also older women consider the consequence for contracting HIV within a period of 5 years as very large. In accordance with Bernadi (2002), women with no or single sexual partner consider the

consequence for contracting HIV as high and therefore have chosen not to engage in a more risky sexual behaviour. However, contrary to Bernadi (2002) assertion, although women with 2 to 5 sexual partners perceive the consequence for contracting HIV as high, they have still chosen to engage in a more risky sexual behaviour.

The women in the study area are of the view that HIV risk tolerance is generally high, above 50 percent, at both the local and national levels (that is Kumasi and Ghana). However, according to them, HIV risk is highly tolerated at the national level than at the local level. Through questionnaire survey, it was found out that poorer women tend to exchange sex for money or other forms of support than rich women.

Finally it was found out that most of the women, particularly married women, preferred to use caution as a measure for risk reduction because most married couples in Ghana have the desire for children. More than 70 percent of the women have made changes to their sexual behaviour to avoid HIV infection, with the major changes being abstinence and sticking to only one sexual partner. Finally, the study reveals that about a greater proportion of the women in the study area favour that women are given some form of control over sex. Generally the women are of the view that empowering women economically, socially and politically are important measures to give them control over sex.

CHAPTER SIX: WOMEN SUBORDINATION AND HIV VULNERABILITY

Vulnerability is defined as a high degree of exposure to risk, shocks and stress (Chambers 1989; Davies 1996). In the sense of this study, it refers to the degree of exposure to HIV risk. In addition, subordination in this study is used to refer to the general character of gender relations that is male/female relations. This chapter tries to explore the extent to which the subordination of women in society makes women vulnerable to HIV. This is done by uncovering the biological, economic, socio-cultural and political factors that exposes women to HIV/AIDS. The chapter was mainly based on the qualitative data with some reference to findings from quantitative data. In analysing and interpreting the views and opinions of the informants, ideas generated from the theoretical and conceptual frameworks selected for the study were applied.

6.1. Biological Factors of vulnerability

The biological disadvantage of women has been recognised as one of the cruelties of HIV infections. Women by the nature of their biological disposition have relatively weaker immune system than men and this makes them more vulnerable to HIV infection. Male-to-female transmission is much more likely to occur than female-to-male because of the form of their sexual organs. In fact, studies have shown that women are twice as likely as men to contract HIV. In the developing world at the end of 2003, more than half of those living with HIV were women, and in sub-Saharan Africa, young women aged 15 to 24 were 2.5 times more likely to be infected than young men (UNAIDS 2004; Agyei-Mensah 2005). In depth interview with both male and female respondents during my field work reveals that the biological disadvantage of women can not be overlooked when discussing issues of female vulnerability to HIV infection. Most of the respondents of the interview, both males and females, were of the view that the weaker immune system of women place women at a disadvantage in terms of contracting HIV and it also hasten the progression to AIDS.

Physiologically, women are more vulnerable to HIV infection because of their more likelihood of developing micro lesions during sexual intercourse, greater area of mucous membrane exposed during sex in women than in men, and the greater quantity of fluids transferred from men to women during sex. Also laboratory tests have shown that male semen contains higher

concentrations of virus than female secretions per unit volume. Additionally, because the reproductive systems of young girls are underdeveloped, they are more prone to micro lesions, especially when sex is coerced or not wanted. The presence of sexually transmitted infections (STIs) further increases their vulnerability to HIV infection (UNAIDS, 2004; http://www.who.int/gender/hiv_aids/en/, 12.03. 2007). In expressing her views about the factors that makes women vulnerable to HIV infection, one women activist and the Executive Director of an NGO said:

The biological disadvantage of women. The nature and the way sex take place and how women's pubic area is handled by the men result in them having cuts and bruises within their vagina. This makes it easier to contract HIV. Also sexually transmitted diseases expose the women to HIV infection.

It is a fact that naturally women are at greater disadvantage of contracting HIV and other sexually transmitted infections which in turn make them more vulnerable. Yet it is pertinent that women are given the necessary aid to enable them overcome such natural circumstances which are not beyond human control if the required action is taken. As UNAIDS (2004) explains, while condom use and distribution have received widespread support and financing, microbicides and female-controlled protection methods have been under-researched and under-funded. Since women continue to be at a disadvantage in negotiating safe sex, more resources need to be channelled towards finding new methods of protection that are designed for and accessible to women.

6.2. Economic Status

As indicated by Conseil du statut de la femme, (2002), women the world over are poorer than men and this gender inequality in income and access to economic resources makes them vulnerable to HIV infection. The low income of women and lack of access to resources including credit and technology leaves most women no option than to depend on men as a means of survival. Thus some women, particularly young women agree to intercourse with men they would have avoided (UNAIDS/01.24E). This economic subordination of women in society undermines their ability to negotiate for safe sex. In order to find out why women are most vulnerable to HIV

infection than men, the reasons for the prevailing HIV infection level among women and the extent to which the subordinate position of women makes them liable to HIV were investigated. Findings from the questionnaire survey reveal that the low income or economic status of women in society is the most important factor that constrains women from negotiating safer sex and hence becoming susceptible to HIV. As already discussed in chapter five, 43 percent of the women in the survey were of the view that low income or economic status of women is the most important factor that makes women incapable of negotiating safe sex. Furthermore, low income or poverty was viewed by the women in the survey as the first most important reason why women are unable to negotiate safe sex. In depth interviews with both informants and key informants also confirms this. When asked about what she thinks are the major reasons for the prevailing HIV infection level among women, one woman (aged 20-24) in response said:

“Poverty is a major reason. Many women don’t have money. Most young women and even girls in this area have now become prostitutes because of their need for economic support or money. Although they are not professional sex workers, they are having more than one sexual partner, engaging different men because they don’t have money.”

Although it is not acceptable for a woman to engage in multiple sexual relationship in the study area, many women have no other option than to depend on men either to supplement their low income or as a total means of survival. That is they do not have any other means of making income except depending on the men for all their needs. Some of the young women although they are not “home-seated” commercial sex workers who are clearly known as prostitutes or “*tutufuo*” in Akan with their base at Adum, a suburb of Kumasi, they act as “*roam-about*” commercial sex workers, moving around “spots” or drinking bars and hotels where they can attract men. Other women who are “*home seated*” commercial sex workers work clearly as prostitutes with their base in Adum, a suburb of Kumasi. Yet again some women engage in multiple relationships with no intension of working as prostitutes but in reality they are prostituting. As noted by Conseil du statut de la femme (2002) there is a relation between the low economic status of women and their involvement in prostitution. Unemployment, poor education, few available jobs, inadequate salaries are some of the factors, which compounded, forces some women into prostitution. The absence of a social security net also contributes to the problem.

Some of these women are married but they engage in prostitution at the consent of their husbands in order to make income to support the family. The worse thing is that because these women derive their livelihood from the exchange of sex for money, they are unable to control the circumstances under which sex take place. Interview with some of the commercial sex workers in the study area reveals that the use of condom depends on the men rather than the women themselves. That is, it is determined by how much the man is willing to pay. If the man is willing to pay for the fix fee, then the woman will ensure that she has a protected sex. However, in situations whereby the man is willing to pay more for unprotected sex, the woman has no option than to succumb to his desire because she is in need of the money to meet her needs. The woman therefore accepts some level of risk to her health in exchange for money. Thus the women's ability to negotiate for safe sex is compromised due to limited finances, making them vulnerable to HIV.

In expressing her view about the factors that make women vulnerable to HIV infection, the Executive Director of an NGO that deals with women, particularly prostitutes, mentioned prostitution as one of the main factors. When explaining how it makes them vulnerable she said:

“Most of the women have children who are not taken care of by their fathers. They are abandoned by the men with whom they gave birth. Since some of them are orphans without any relative or person to support them financially, they fall or open up to other men in order to gain support for themselves and their children.”

Her statement indicates how dependent some women are on men. They have no other means of livelihood for themselves and that of their children except depending on men for financial support. Thus when the men they have children with abandon them, they are compelled to turn to other men as a means of living. It also shows how imperative it is for women to take responsibility for their children in the study area than it is for the men. Some men easily and insensitively abandon their responsibility of taking care of their children but most women even in the hard times do all they could in order to make a living for themselves and their children. In the process some become exposed to risky sexual behaviours which make them vulnerable to HIV. The abandonment of women and their children by men may be one of the reasons why female

headed household is common in the study area. The questionnaire survey found out that about 51 percent of the households in the study area are headed by women as shown in table 6.1. In such households, the women who are the head have to provide for the needs of the household members. Since there are limited economic opportunities for women as a result of gender inequalities and that their incomes are not sufficient the support them and their families, they are compelled to turn to the men who have relatively higher income in order to support themselves and their families. Apart from this the only other alternative is to resort to the immediate family members like parents and siblings or extended family members for support but such support is currently difficult to come by, due to changing economic conditions.



Figure 6. 1: Interview with the Executive Director of AHFG
Source: own picture, Kumasi, 2005

Table 6. 1: Percentage distribution of head of households, Kumasi, 2005.

	Frequency	Percentage
Female	41	51.3
Male	39	48.8
Total	80	100.0

Source: own survey, Kumasi, 2005

Poverty and harsh economic realities are the underlying causes of women bartering sex for economic gain or survival (Visvanathan et al 2002; WHO 2003). When sex ‘buys’ food, shelter,

or safety, it is very difficult to follow prevention messages that call for a reduction in the number of sexual partners. Although commercial sex work is the most well-known way for women to exchange sex for money, there is a range of other types of 'transactional' sexual partnerships that women use as a rational means to make ends meet (WHO 2003). One female respondent (aged 25 -29) in expressing her views on the extent to which women dependence on men make them vulnerable to HIV mention some factors including how some women use other "transactional" sexual partnerships as a rational means of making ends means:

"Some wives are housewives or unemployed and thus they depend on their husbands for all their needs. Thus by virtue of their financial status they are subjected to the desires and wishes of their husbands. They are not in any good position to caution their spouses when they realize their sexual behaviour is risky to their health. Also the parents of some girls or young women are incapable of catering for them or providing them with their financial needs due to poverty. In addition the parents of some girls or young women may be dead and such orphans usually do not get support from the family. These usually compel them to depend on their boyfriends or partners for support since most of them are either unemployed or underemployed. Furthermore, there are some women who tend to follow fashion and have the desire for many things which can not be met by their own finances. For example, new dresses and shoes, car, outing, and renting a descent house. These compel them to depend on men who can provide them such wants, especially the rich men such as "burgers" (person who have returned from abroad), business men, high public official and even some government officials. Because of this they are not able to demand safe sex even if the mans sexual behaviour is questionable."

Housewives are in either a customary or legal relationship with their spouses and although they are usually dependent on their husbands because they are restricted to domestic duties, such relationships have different intentions than to just secure financial support. Yet their dependence on their husbands weakens their ability to assert their power to refuse sex when their husbands engage in sexual liaisons. This is because such action by them would set them packing from their marital home. Apart from being a housewife, it is a common practice for women in the study area to be in a relationship with the aim of securing financial support either as a means of survival or to satisfy their wants such as buying fashionable dresses and shoes, renting a descent house, going for outing, and securing luxuries like cars. At times some of the men they depend on,

especially the rich men, have their permanent relationship elsewhere or they may have other girl friends. Yet these women although they may be aware of the men's sexual behaviour tend to accept such risk at the cost of their health because of the benefits they hope to gain from such relationships. Thus at the end such men put many women at risk of contracting HIV.

The gender inequality in poverty in the study area is also fuelled by social beliefs in the society that makes women dependent on men. Men are seen as having the responsibility of taking care of women and children. In expressing her views about why women are more susceptible to HIV, the Director in charge of HIV/AIDS Program in the Ministry of Women and Children Affairs (MWCA) said:

“Our social settings make women dependent on men. We see men as having the responsibility of taking care of women and children. This weakens their ability to negotiate safe sex.”

With such a belief that men are responsible for taking care of the women and children entrenched in the society, many women are constrained from securing alternative livelihoods than to depend on their spouses or partners. Some women act as house wives with the burden of unpaid domestic and reproductive work whiles their spouses go out to work to make income. Likewise, some boys are taken to school to the detriment of their sisters because of the belief that it is the man who is responsible for taking care of the woman. However, with education through feminist advocate and changing gender roles such notion is currently changing. Due to dependency on men, women are unable to assert their right to refuse sex with their husband or partner (<http://www.gwsafrica.org/knowledge/ap2.html> , 14 March 2007). Economic dependency and cultural subordination put women in vulnerable position. Without economic power, women do not have peace, and cannot make decisions to take control of their lives.



Figure 6. 2: Interview with the Director in charge of HIV/AIDS Program, MWCF, Ghana, 2005
Source: own picture, Accra, 2005

6.3. Socio-cultural Factors: Customs, norms and ideologies

Customs, gender norms and ideologies in many societies create unequal balance of power between women and men and they are rooted in the socio-cultural context of each society and are enforced by that societies institutions, such as schools, work places, families, and health systems etc(2000; WHO 2003). Societal and cultural norms and attitudes which rigidly prescribe what is considered appropriate behaviour, limit women's power to negotiate safer sex or resist unwanted sex. Also they make it hard for women to opt out of abusive or violent relationships, and promote expectations of dependence on men, a dependence further anchored by poverty. (IPPF, UNFPA, Young Positive, 2007). The extent to which societal customs, norms and ideologies make women socially and culturally subordinate to men and hence make them vulnerable to HIV/AIDS in the study area are discussed below.

6.3.1. Education

Female education is believed to be an important factor that will help provide livelihood opportunities as well as enhance self-esteem. Yet certain customs and norms in society usually hinder women access to education, particularly higher education, and subsequently undermining their social right and ability to control their lives. The customs and norms in the study area often ensure that there is gender inequality in the distribution of domestic duties between males and females. Women and girls are usually burden with most of the household work. Demands on women's care work within the household often mean that girls are pulled out of school to help in

the home, denying them access to education which has been shown to reduce risk of infection, to enhance self-esteem and provide livelihood alternatives (IPPF, UNFPA, Young Positive, 2007). Through the in-depth interviews with female and male informants as well as some key informants, the study found out that the norm of women being subordinate to men in the society has prevented many women from being sent to school, attaining higher qualifications and accessing information. During an interview with a female respondent (aged 30 to 34), she said:

“Our culture makes women subordinate to men and this has led to high female illiteracy and polygamy. The high illiteracy among the women makes them ignorant and this affect their knowledge about HIV/AIDS, thus exposing most of them to the disease. Also because of the high ignorance among the women, they sometimes don’t care to become second wives or they are forcefully given out as second wives. This polygamy sometimes exposes the women to HIV infection.”

The subordination of women relative to men in fact has hindered many women from accessing school or progressing in their education and this in turn affected their access to economic opportunities by either making them unemployed, underemployed or limiting them to the informal sector. The fact that women are considered subordinate to men and that the society is socially structured to make them dependent on men influence some parents to give priority to their male children in terms of sending them to school to the detriment of the female children. Although this trend is currently changing , as recently many parent are sending both the male and female children to school, the gender inequality in the distribution of household duties still persist and this negatively affect the educational progress of the girl child. Most often the girls are burdened with household work whiles the boys are left alone to either study or play. Subsequently, many girls fall out of school with time due to poor academic performance.

However, it is noted that the preference in sending the male child to school at the expense of the girl child is influence by the financial status and hence the area of residence. Usually poor people, especially those in “shanty” or “ghetto” communities prefer sending the males to school whiles the females are made to take care of domestic work or engage in petty trading to support the family. Thus female literacy rate in such communities is relatively lower than the males. Illiteracy

and low education exposes many women to HIV/AIDS because it has influence on the acquisition of information about the disease. Thus with limited information about the mode of transmission, some women engage in risky behaviours which make them vulnerable to the disease. As noted by the woman, due to illiteracy, some women are ignorant about the mode of HIV transmission that they do not care to engage in polygamous marriage which sometimes exposes them to the risk of contracting HIV. Nussbaum (2003) quoted the Supreme Court of India, Unnikrishnan J.P.V state of Andhra Pradesh that “ the right to education flow directly from the right to life and this is related to the dignity of the individual.” According to her, women’s education is both crucial and contested. A key to the amelioration of many distinct problems in women’s live, it is spreading since the education of a woman has impact on the life of many people, but it is also under threat, both from custom and traditional hierarchies of power and from the sheer inability of states and nations to take effective action. She argues that promoting economic growth alone is not a sufficient way of promoting education for women but rather it requires additional focused state action (Nussbaum 2003).

6.3.2. Violence against women

Through in-depth interview, it was revealed that rape is a common issue in the study area. Both female and male respondents were of the view that lack of self-control on the part of some men and the exposing nature of dressing by some women particularly the youth tend to attract the men and thus contribute to rape issue in the area. However, the study further revealed that young girls are the people who are particularly the victims of such rape issue or defilement. Some of the respondents were of the belief that some men defile young girls because they believe that they are virgins and therefore do not have HIV. The excuse that the exposing dressing of women tends to attract men is however questionable because there has been some instances where some men have been reported as hiving rape children as young as two years. I do not think this could be attributed to the exposing dressing of women. Violence against women and the girl child in particular needs to be effectively tackled as it expose the victims to HIV infection.

6.3.3. Gender Identity: Norms of masculinity and femininity

Gender identity plays a major role in exposing women to the risk of contracting HIV/AIDS in the study area. The dominant ideology of femininity and masculinity cast women in a subordinate, dependent, and passive position with virginity, chastity, motherhood, moral superiority, and obedience as the key virtues of the ideal woman. In sharp contrast, the dominant ideology of masculinity characterizes men as independent, dominant, invulnerable aggressors and providers whose key virtues are strength, virility and courage (WHO 2003).

The ideology of femininity in the study area dictates that a woman of good virtue is submissive and obedient to her husband because he is the head of the family. Women are therefore expected to be dependent on others, particularly their husbands to make decisions and access resources. Such female subjectivity and male supremacy is usually expressed in the Akan saying as “*obaa to tuo a etwene obarima dem mu*”, which when literally translated means when a woman buys a gun, it is kept in the room of the man. Such expression indicates women’s dependency on men in the society. This femininity ideology makes it difficult for women to demand that their husbands use condom as it may show a sign of disrespect for the husband or dictatorship. As noted by UNAIDS (1999) and WHO (2003), women’s economic and social dependency on men greatly affects their ability to adhere to treatment and other medical services. They are encouraged and sometimes forced to ask for permission from their husbands or other family members to access services.

However, unlike women who are socialized to be dependent, the ideology of masculinity dictates that men are self-reliant and need not to seek assistance. They are therefore socialized to be independent and thus they grow with the feeling of supremacy over women. Such norm of masculinity and male supremacy encourage the men to engage in certain risky behaviours that make them and subsequently their wives susceptible to HIV. For instance the norm of masculinity encourages multiple partnerships as a means of a man demonstrating his manhood. However, the dominant ideal of femininity emphasizes uncompromising loyalty and fidelity in partnerships. It is this ideal that distinguishes a ‘good’ woman from a ‘woman of the street’ and defines sexual practices linked to reproduction as moral and those that are linked to pleasure as immoral (WHO 2003). To support this, one male interview respondent (aged 30 to 34) said:

“Men are considered as head of the family and that in every decision they should have the final say. They therefore take advantage of such supremacy to indulge in multiple relationships and hence expose their wives to HIV. However, our culture does not support that women marry more than one husband or engage in multiple relationship. Any woman who does that is considered as prostitute but the men are not.”

Traditional notion of masculinity and femininity seriously need to be addressed because they are associated with risk taking behaviour. Due to the ideology of masculinity, the feeling of male supremacy has been deeply rooted in men and it encourages them to indulge in certain risky behavioural practices like infidelity and sexual liaisons which exposes them and their wives or partners to the risk of contracting HIV. Similarly, the ideology of femininity has limited the self-confidence of many women and their ability to express their feelings. Thus they are unable to negotiate for safe sex and hence become vulnerable to HIV.

Although femininity and masculinity are dominant ideologies that mostly influence women's and men's attitude and behaviour in the study area, making both of them vulnerable to HIV/AIDS, there are multiples of masculinity and femininity as they vary by social class, ethnicity, sexuality and age (WHO 2003; Berg and Longlundt 2003). In an interview with the Kumasi Representative of Society for Women against AIDS in Africa (SWAA), an NGO operating in Ghana, she said:

“Generally women are considered to be subordinate to men. However, this varies according to class, groups and societies. Among the less privilege, women are considered subordinate to men or men are considered supreme to women. However, this isn't the case among the educated group. Women subordination to men makes them depend on the men financially and this exposes them to HIV/AIDS infection.”

As noted by the officer of SWAA, the fact that women are generally perceived to be subordinate to men in the study area, due to the influence of femininity and masculinity norms does not mean such ideology has influence on every woman and man. It varies by social class, ethnicity, age and

among various groups. In fact the financial and social status of a woman in society usually dictates whether she is considered inferior by her husband or not. Women with sound financial background and or good education who are mostly located in residential areas usually have the self-esteem and self-confidence and they are capable of expressing themselves when the need arise. Also such women are respected by their husbands or partners because they are less dependent on them.



Figure 6. 3: the researcher and an NGO representative having an interview
Source: own picture, Kumasi, 2005

However, poor women and women with low or no education who are usually located in the poor communities, especially the “Zongo” or shanty towns, which consisted of mostly Muslims but are not ethnically segregated, most often face the opposite since they are most of the time dependent on their husbands or partners. However, the ideology is dominant among the “northerners” (the ethnic groups from the northern parts of Ghana) who are usually located in the “zongo” areas or shanty towns in the study area than among the Asantes and other Akan groups. Among the Asantes for instances women are given some form of power due to the matrilineal system of inheritance. However, such power is usually limited to chieftaincy issues where the queen mother is empowered to chose the chief or King and also access to family resources. Yet it does not usually apply in the households where the men are hold in high esteem than the women. Also apart from the queen mothers who have absolute control over resources attached to her stool, although the Asante women have the right to access family resources like land, such resources are usually controlled by the head of the family or “abusua panyin” in Akan who is usually a man.

6.3.4. Motherhood

Being a mother is considered as a feminine ideal in many cultures (WHO 2003) and therefore motherhood is highly upheld in the study area. In the traditional Ghanaian society, there is the notion that marriage is for procreation. Marriage couples are therefore expected by both the nuclear and extended families as well as the community members as a whole to start having children as early as possible. Women who do not have children are considered barren and are despised by the society. Such women are usually referred to as “*bonyini*” in Akan which literally means an infertile woman. Similarly, the masculinity of a man is demonstrated by producing children which is a prove of his manhood. Thus a man might divorce a wife who prove to be



Figure 6. 4: A mother happy with her children, Kumasi
Source: own picture, Kumasi, 2005

barren or he might marry another woman to have children. Children therefore provide social identity for many women in the study area and guarantee them status in kinship groups (WHO 2003). Also they are source of social and economic security for their parents in their old age since the state does not take responsibility of caring for the aged in Ghana. These social and economic realities undermine women, particularly married women’s ability to negotiate safe sex. They pose a significant hurdle for women in HIV risk reduction because the use of barrier methods or non-penetrative sex prevents conception (WHO 2003) and most women if not all want to prove their fertility to avoid pressure, particularly, from her husband’s family.

6.4. Relations between Men and Women

One of the specific forms of oppression which women suffer, and which other oppressed social categories share, is the inability to be in social relationship and social situations in which gender is not present. Our experience as women is being always perceived and treated as members of a gender category about which there are all kinds of stereotyped beliefs, and which is inferior to the alternative gender category, that of men (Whitehead 2006). Male dominance and female subordination are important issues in the study area that needs to be critically addressed since they contribute greatly in making women vulnerable to HIV/AIDS. Male dominance and female subordination in the study area manifest through the unequal social, political and economic power relation between men and women which is present at different levels in the society: family, religion, and societal levels.

6.4.1. Family

In the family, men are perceived as having power over their wives, children and property. Male superiority over female starts at a tender age when both the girl and the boy are socialized to accept differentiated roles. The males are socialized to accept to be providers and heads of the family while women are socialized to be obedient and submissive housekeepers. The cause of such differentiation is the fact that the society view women as being more sexual beings instead of human beings (Charvet 1982; UNAIDS/01.24E; Kambarami 2006).

Apart from defining women in relation to men, women are also defined as subordinate and dependent on men (McDowell and Pringle 1992). In majority of marital homes, it is the man who financially supports the family while the woman stays home and cares for the children. Women as a whole have less control over the family's economic resources. Also they have less status relative to that of their husbands because they command a greater share of decision making and authority in the family. Relations between husbands and wives are marked by the behavioural components of inferiority and superiority, deference, and so on. The family based household is thus a hierarchical structure marked by the dependency of the wife and children on the husband, whose specific role in the household is marked by the bureaucratic definition of him as its head (Whitehead 2006).

Due to the male superiority relative to female, women usually lack the autonomy to make decision about sex since men make decisions so far as sexual matters are concern. This is because in most traditional societies in Ghana like that of the Asantes, the sexual gratification of the man is seen as paramount in any marital relationship. Hence any refusal on the part of a woman is seen as improper and sometimes outrageous. This lack of autonomy by the women to make decision concerning sex undermines their ability to negotiate for safe sex. Such male superiority was expressed by many of the interview respondents and in particular all the male respondents as a norm which is exposing women to HIV infection. To quote one man(aged 34 to 39) he said:

“It is believed that the men are the head of the house and thus the women are subordinate to them. Thus the man has the final say. This makes women submit to the wishes of their husbands or partners. The man can do certain things without the approval of the wife but the woman can not.”

The idea of male superiority over female critically needs to be reversed as it does not only undermines women’s negotiating power in sex but also hinder their progress which subsequently ensure the perpetuation of women subordination to men and hence their sexual subordination which makes them fall liable to HIV/AIDS. For a man to have the final say in decision making implies decisions taken would always be in favour of the man with the woman only suffering the consequence of irresponsible decisions taken.

The unequal power balance between men and women puts women at a greater risk of HIV infection. In the study area, social norms dictate that women remain monogamous, while men are allowed to engage in sex with multiple partners.

(<http://www.globalhealthreporting.org/diseaseinfo.asp?id=251>, 02 March 2007).

Men can have as many wives as they want and engage in sexual liaisons but women can not. Some men therefore exercise their superiority by marrying many wives or engaging in sexual liaisons and by so doing they make their wives and partners vulnerable to HIV/AIDS. However, many women are passive in sexuality and they are powerless in challenging male promiscuity. This is because due to their social and economic dependency on their husbands, any attempt by them to challenge them will



Figure 6. 5: A male respondent and the researcher in an interview, Kumasi, 2005
Source: Own picture, Kumasi, 2005

set them packing from the house. Thus women are unable to assert their right to refuse sex with their husbands when they find out that their sexual behaviour is risky to their health. In expressing his views on how the culture in the study area condones multiple partnerships by men one of the male interview respondent (aged 30-34) said:

“The culture in the society encourages polygamy and therefore engaging in multiple relationships by men is overlooked but women who engage in multiple relationships suffer criticism and stigma.”

Cultural distinction between men and women is very discriminating and it is an infringement upon the rights and freedom of women. To be lenient with men for establishing multiple partnerships while proscriptive with women for engaging in similar behaviour is an indication of a double standard of morality in society. What is even pathetic is that this male superiority and control is constructed and enforced not only through every day attitudes and behaviours but also through the legal system and social systems (McDowell 1999). The legal system which is supposed to protect human right of all people including women reinforces such male superiority by recognizing multiple partnerships under customary marriage or marriage which is not under ordinance. Many married women have therefore fall victim to HIV not because they have risky

sexual behaviour but rather it is a consequence of their husbands' irresponsible sexual behaviour. An example is an HIV/AIDS advertisement on the television which was used to educate the general public to accept people living with HIV. The advert showed an infected nurse who alleged she was infected by her husband. Similarly, an interview with the HIV positive women reveals that one of them was infected by her late husband and another was infected by her late partner.

6.4.2. Religion

Female subordination which is entrenched in our traditional system is encouraged by religion. This is because patriarchal attitude is rooted in religion and this has reinforced the traditional customs which men use to control women's sexuality (Human Rights Monitor, 2001; Kambarami 2006). Religions which believe the Bible or other religious text often follow it faithfully by its every word which puts the men in charge. For instance, the Bible, which most Christians live by states boldly that women should be submissive to men. Also it states that the woman was created from the rib of the man. With these in mind and those beliefs implanted in cultures, women don't stand a chance at gaining strength in their gender and its potential in our world. Many Ghanaian men and church leaders usually quote the Bible to justify men's control over women. Similarly, Islamic religion encourages Muslim men to marry four wives but it does not allow the Muslim women do similar thing.

6.4.3. Society

At the societal level, gender is a characteristic at the institutions or organisations and in politics. Female subordination manifests itself in the male domination of leadership positions and political power. Most of the leadership positions in the country are occupied by the men to the detriment of the women. Thus in most institutions or organisations as well as political leadership, gender difference is a characteristic of the situation. As explained by Whitehead (2006), in most organisations, there is a hierarchical relation, men and women are assigned to places within them so as not to contradict the 'fundamental' hierarchy of men above women which occurs in gender relational situations. Thus most of the influential positions in the various organisations are occupied by men while most women occupy low positions. This is because although gender is legally not a criterion for holding a particular job, there is gender selection. A good example is that usually men occupy managerial positions while women act as their assistants or secretaries.

So secretaries statistically are most often female, while their bosses are male. Correspondingly secretaries are usually thought of as female, and bosses are thought of as male.

Although women constitute more than 50 per cent of the 21.5 million population of Ghana, their share of political and public office appointments is a miserly eight per cent. And this is in spite of years of continuous public education by a host of non- governmental organizations and women groups. Measures such as affirmative action and nomination of women into public offices taken in recent times have only made minimal impact in redressing the trend. As at the end of 2004, there were only 19 women in Ghana's 200-member parliament and of the 230 members of parliament elected during the December 2004 parliamentary elections, there were only 23 women, representing 10 per cent in the national legislature.

(<http://www.ghanaweb.com/GhanaHomePage/NewsArchive/artikel.php?ID=73056>, 09.05.2005).

Apart from this, few women are nominated as Cabinet Ministers in the country. This subordination of women in politics and public offices makes it very difficult for women in the country to have a bearing on decision making which influence them and their children. For instance because the Ghana Parliament is dominated by male parliamentarians, the Domestic Violence Bill that was sent to parliament about 4 years ago was severely contested since most of the male parliamentarians were against the section which gives women control over sex. Thus the bill had to be sent to the local communities where it was debated before it was finally passed into a law this year, 2007. Also at the local levels, the bill was severely contested by the men and even the women themselves with the belief that giving women control over sex is not in accordance with our culture and thus may result in the breaking up of marriages. Thus at the end, the bill was pass with that section being reformed so that married men would not be convicted of marital rape.

In fact such political subordination of women and limited women's participation of women in legislation is actually undermining women's rights and their ability to control and protect their lives. Sometimes bills which usually emphasize women's needs and problems are either severely contested in parliament or delayed in passing into law because women representation in parliament is such that they have limited influence on decision and policy making. Few women are appointed as heads of public organizations and as cabinet ministers because it is always a man making such appointments and since they consider women are subordinate to them, they are

always appointing mostly their colleague men whom they think are more capable. What is pathetic is that due to the fact that women have been socialized to accept that men are superior to them and that the high female illiteracy has resulted in high ignorance among many women, the women in society who can help change their condition contribute to limiting the power of women in the society by voting mostly men into power. It is very critical that this trend is changed, especially by the women themselves since women outnumbered the men in terms of population. However, this would be difficult to achieve without mass social and economic reforms for women in the study area.

6.5. Chapter summary

The chapter explores the extent to which the subordinate position of women in society makes them vulnerable to HIV. It was found out that the biological disadvantage of women makes them more vulnerable to HIV infection than men. Male to female transmission is more likely to occur than female to male transmission. In addition, due to their relatively weaker immune system, women are also more prone to other sexually transmitted infections which further increase their vulnerability to HIV infection.

Furthermore, the study found out that due to gender inequality in income and access to economic resources women are financially constrained. They have no other option than to depend on men for survival. Some women intentionally or unintentionally resort to prostitution while others depend on men either as housewives or as a wife engaged in petty trading and also others depend on men as mere sexual partners. This economic subordination of women undermines their ability to negotiate safe sex and hence become more vulnerable to HIV.

Of equal importance are socio-cultural factors, such as the customs, norms and ideologies which undermine the social rights of women and prescribe what appropriate behaviour is for women and thereby limiting their power to negotiate for safe sex or resist unwanted sex. Such customs and norms ensure unequal distribution of domestic duties for males and females to the disadvantage of the women. They either hinder women's access to education or their academic progress, which is believed to be an important factor to provide livelihood opportunities and to enhance self-esteem. Violence against some women and particularly young girls in the study area also exposes

them to HIV. Also the dominate ideologies of feminity and masculinity make women passive when it comes to sexual matters whiles they encourages multiple partnership by men. In addition, the customs and norms in the study area encourage motherhood whiles barrenness is despised. Thus women in the study area find it difficult to use protective methods because of the desire to prove their fertility. The customs and norm therefore undermine women's ability to negotiate safe sex and subsequently they become vulnerable to HIV.

Finally, the study found out that the unequal power relation between men and women at the family and the societal levels plays an important role in making women vulnerable to HIV. The superiority of men in the family encourages multiple partnerships by men, makes women dependent on men and undermines women's autonomy to make decision on sex. Similarly, male domination of political power, parliament and public office appointments limits women's participation in decision and policy making in national affairs. Thus decision taken and national policies are usually not in favour of women. Such patriarchal attitude is also reinforced by religions such as Christianity and Islam in the study area. Thus unequal gender relation has made women politically subordinate to men, making it difficult for them to have bearing on decisions and policies that influence them and their children.

CHAPTER SEVEN: STIGMATISATION AND DISCRIMINATION OF WOMEN LIVING WITH HIV/AIDS

In this chapter I have tried to present how the subordinate position of women in society subject HIV/AIDS-Positive women to severe stigmatization and discrimination and what is being than about HIV/AIDS discrimination and stigmatisation. Specifically I have tried to do this by giving understanding of the sources of stigma, the dimensions of stigma ,how stigma and discrimination manifest themselves as well as by looking at institutional support for the women living with HIV/AIDS. The analysis and interpretation are done in the light of my objective and are based mainly on qualitative data collected from 10 females(do not know status), 10 males (do not know status), 3 HIV/AIDS Positive females, 2 elderly women, 5 female commercial sex worker, The Ministry of Women and Children’s Affairs, and 2 Non-Governmental Organisations(NGOs). In analysing and interpreting the views and opinions of the informants, effort is made to exploit ideas generated from the theoretical and conceptual frameworks selected for the study.

7.1. Sources of Stigmatization

7.1.2. Sexuality

HIV/AIDS-related stigma and discrimination are most closely related to sexual stigma. This is because HIV is mainly sexually transmitted and in most areas of the world, the epidemic initially affected populations whose sexual practices or identities are different from the “norm.” HIV/AIDS-related stigma and discrimination has therefore appropriated and reinforced pre-existing sexual stigma associated with sexually transmitted diseases, homosexuality, promiscuity, prostitution, and sexual “deviance” (Parker and Aggleton 2002). In Kumasi and most communities in Ghana, deviant behaviour and sexual promiscuity especially by prostitutes are commonly believed to be responsible for the heterosexual transmission of HIV. Due to this women who are infected with HIV/AIDS are frowned upon and are regarded as having caused their own woes. When asked why women living with HIV/AIDS are stigmatized and discriminated against, one female respondent (aged 20-25) said: “... *they (people in the society) feel they got infected as a result of a bad or indecent sexual behaviour.*” In an interview with another woman (aged 30-34), she also said:

“Once the people in the community see that a woman or any other person is always sick and growing lean, then they start pinpointing at her and also gossiping that she has HIV. People then start referring to her past sexual behaviour as having caused that.”

Some of the men in particular are of the view that women infected with HIV/AIDS indulged in indecent sexual behaviour. *“No, because I consider those with HIV/ AIDS as having indulge in immoral sexual behaviour,”* was the response of one male respondent (aged 25-29) when asked whether he will be willing to associate with women infected with HIV/AIDS apart from having sex, sharing razor and needles. Since heterosexual intercourse is seen as the fast and main mode of transmission in the study area, it has contributed to the silence surrounding HIV/AIDS, and the construction of HIV/AIDS as a “disease of the others”. This is because in the early years of the global epidemic, focus was mainly on people with so-called “high risk behaviour” such as prostitutes and male homosexuals etc. Thus some people exclude themselves and their family member as being at risk and consider HIV/AIDS as a disease of outsiders. However, it has become increasingly obvious that many others, who had false impression that the disease was not a threat to them, have been infected (UNFPA, 2000).

Heterosexual way as the main mode of transmission of HIV/AIDS has therefore compounded the already existing sexual stigma and fuel the stigmatization and discrimination against women living with HIV/AIDS. As suggested by Lawson(1997), given that the most common form of HIV transmission is through sexual intercourse, countries that have “conservative” attitudes to sex and sex education can have difficulties with open discussions on HIV/AIDS (Lawson, 1997). Moral and social norms connected to sex, and therefore also to HIV/AIDS, substantiate the taboo of sex, and create a fertile climate for stigma, silence, and the further spread of the disease. HIV/AIDS-related stigma can thus appropriate and reinforce pre-existing sexual stigma associated with sexually transmitted diseases (STDs), sexual practices and sexual identities that differ from the “norm” (Parker & Aggleton, 2002). The role of males in the stigmatization process will be discussed in the following section (that is gender).

7.1.3. Fear

Living with HIV/AIDS in a poor country like Ghana often means facing the fact of premature death. The fact that HIV/AIDS is a life threatening disease; it is an illness that people fear, and a

disease many equal to an automatic death sentence. The family and community perpetuate stigma and discrimination partly through fear, partly through ignorance and partly because it is convenient to blame those who have been affected first (UNAIDS 2002.43E; Aggleton and Parker 2003). Interaction with majority of the informants in the study area reveals that fear is entrenched in them and this fear of being infected with HIV forms the basis for stigma and discrimination. In an interview with one female informant (aged 20-24) about what make people stigmatize and discriminate against women who test positive to HIV she said:

“The fear of getting infected with HIV/AIDS disease is a major factor that makes people stigmatize against women who test positive to the disease. Even if you are a sister, mother or wife and you get infected with such a deadly disease, it is very difficult for even your close relatives to get closer to you because the disease is dangerous and people are afraid they may get infected if they get close to you”.

Also when the informants were asked whether they would be willing to associate with women living with HIV/AIDS apart from having sex, sharing razor and needles, one female informant (aged 20-24) said:

“I will be willing to serve the HIV/AIDS person if she is my family member, for example giving her water to drink, food to eat and other support. However, I will not be willing to have a close relation with her, for example eating together with her, sleeping on the same bed, having social chat with her because I’m afraid of the disease and her.”

From her response you can deduce that she is willing to associate with a woman living with HIV/AIDS only if she is a family member and even here there is a limit because of fear. She is willing to provide her with certain basic needs but excluding social interaction and closeness that will make the sick person feel accepted and manage to overcome the psychological trauma that the disease poses to her. Her response indicates that someone who has a misunderstanding of the risk of catching HIV. You can see that she is very worried and scared of the risk of getting blood contamination probably due to cut but she is not very knowledgeable about the disease. Furthermore, some of the respondents are of the view that people stigmatize and discriminate

against women living with HIV/AIDS because they are afraid if you get closer to or associate with such a person, you can mistakenly get infected if the person get a cut and you also have one (blood contagion). One woman (aged 35-39) said:

“People stigmatize and discriminate against women who test positive to HIV because they are afraid of the disease and believe that if you get closer to an infected person, you can mistakenly get infected. For example if a razor used by such person cut you or a needle used by her pinch you”.

However, as argued by Demoz (2003), these people are overstating the risk of contagion because of lack of Knowledge. If you are knowledgeable about the mode of transmission of the disease and how to reduce the risk of contracting it, a mere closeness to an infected person will not pose a threat to you.

Some of the informants particularly the men were of the view that once a person becomes infected with HIV she harbours ill-feeling against society and therefore her mind set changes with the intention to infect others and subsequently spread the disease. Due to this people are reluctant to associate or get closer to them because of the fear that they could be intentionally infected. In an interview, one man (30-34) said: *“They can cut their finger and eat with somebody so that the person is infected too.”* However, I believe a mere cutting of the finger and eating with somebody can not make the person get infected because HIV can not be transmitted through food or water unless you have a sore in the mouth. When asked whether he would be willing to associate with women living with HIV/AIDS, one man (aged 35-39) responded that:

“No, I will not. I won’t associate with you as a close friend or family member. I will just relate to you as an acquaintance. The reason is that many of the women and even the men who get infected with HIV become wicked. They have ill-feeling towards society. Some think they were infected by somebody so they would also infect others. Thus I won’t get much closer so that you intentionally infect me.”

He supported his statement with an example of an HIV positive woman who has decided to infect men with the disease. According to him she is very beautiful and looks plump so you will never imagine that she has the virus. According to him maybe the woman feels she was infected by a “burger” (People staying abroad who has return or visited home) so she has targeted only “burgers” whom she dress to attract and seduce during funerals. I (the author) will not doubt the view expressed by the respondent as I witnessed a documentary on the BBC where a young man who profess to be HIV positive said what makes him happy is to take alcoholic drink and to have sex with women. However, although HIV-positive people may infect others purposefully, it may be the consequence of how the society treats people living with HIV/AIDS. They feel unaccepted and are blamed for causing their own woes. They thus develop ill-feeling against society and they therefore take revenge for being stigmatized, excluded and want to draw other people into similar condition they find themselves. Also such ill-feeling is not develop by only women living with HIV but also men living with HIV(as the BBC documentary example given above) because of the way they may be treated by the society. Thus both HIV-positive men and women may revenge for not being treated well or fairly if stigmatized and discriminated in society.

My study also reveals that fear related ignorance about HIV/AIDS is a contributing factor to stigmatization and discrimination against women living with HIV/AIDS. People are ignorant about the mode of transmission of the disease and such ignorance causes stigma as it generates fear about the disease. One woman (aged 30-34) in an interview said: “

Earlier on I was afraid of people who have HIV/AIDS because the earlier information about the disease indicated that even when you touch the person or eat with her and do other things with her, you can get infected. Thus, ignorance makes people stigmatise and discriminate against them.”

Her statement shows that previously she lacked knowledge about the mode of transmission of HIV but this has changed. It has changed because now her knowledge about the mode of transmission of the disease has increased.

7.1.4. Gender

HIV/AIDS-related stigma and discrimination are also linked to gender-related stigma. The impact of HIV/AIDS-related stigma and discrimination on women reinforces pre-existing economic, educational, cultural, and social disadvantages and unequal access to information and services by gender (Aggleton and Warwick 1999, Parker and Aggleton 2002). HIV/AIDS related stigma and discrimination occur in larger systems such as patriarchal society like Kumasi and Ghana where men have the political and economic power in both the society and the private sphere, and where women usually do not participate in decision making. In such societies, women are considered inferior to men and are usually marginalized. According to Talja (2005), both men and women are discriminated but women are suffering more than men because of their inferior position. This is supported by my study as the majority of female and male informants interviewed said that both men and women living with HIV/AIDS equally suffer stigmatization and discrimination. However, there was a split female informants' perception. Some of them were of the view that although they believe both women and men suffers from discrimination, stigmatization and rejection; they think the men suffer more discrimination, stigmatization and rejection than the women. In an interview with one of them (aged 25-29) she said:

“Stigma doesn't choose, both women and men living with HIV/AIDS suffer discrimination, stigmatization and rejection. Although in reality you can't contract disease by eating with an infected person, people are afraid that by getting closer to an infected person they might get infected. However, I believe the men suffer more discrimination, stigmatization and rejection than the women. This is because men can easily influence women in order to have sex with them and therefore once people realize a man is infected they tend to avoid him.”

This is a person who is knowledgeable about the mode of transmission of HIV but purposefully want to stigmatise and discriminate against an HIV-Positive person, particularly infected males because of the fear that she can be seduced.

Some of the women and men were also of the stance that women living with HIV/AIDS suffer more discrimination and stigmatisation than the men. This is because it is considered more shameful if the woman contract the disease and that the weak immune system of the women makes them feel sick earlier and therefore they are blamed for contracting the disease or bringing

the disease into the family(UNAIDS 2000; UNAIDS 2002.43E; Parker & Aggleton2002; Aggleton & Parker 2003; Talja 2005; Centre for Reproductive Right, 2005). One of the women (aged 30-34) who are of this view in an interview said:

“...women with HIV/AIDS usually suffer more discrimination, stigmatization and rejection than the men. This is because it is considered more shameful if a woman contract the disease. As a result infected women feel shame to move closer to their colleagues and other members of the society. Also when the women become infected they feel the impact faster than the men as they grow lean faster and fall sick because of their relatively weaker immune system. Thus contracting the disease is attributed to the woman.”

Something is considered shameful in Ghanaian society if it is dishonourable and that it contradicts or is not in accordance with the set cultural values and norms in the society. Thus because heterosexual mode of transmission is considered as the main mode of contracting HIV, and that people who are infected are perceived as being promiscuous or having deviant behaviour, women who get infected with the HIV virus face more shame. This is because it is acceptable for men to be promiscuous in Ghanaian society but women are blamed for adopting similar attitude.

One of the men (aged 25-29) also confirmed that women suffer more discrimination and stigmatization than the men by saying that *“the women have weak immune system and therefore the disease manifest earlier in them than in the men. Thus people tend to shun them and blame them.”*

Although it is a fact that both men and women living with HIV/AIDS are stigmatize and discriminated, the women suffer more than the men as they usually feel more shame and rejection than the men. This is due to cultural values and norms, and double set of morals for men and women in the society. Men are usually forgiving for being promiscuous but women are not. This stigmatization and discrimination does not come from HIV/AIDS itself but rather HIV stigma is also often layered on pre-existing stigma toward marginal or powerless groups (Herek and Glunt 1988; Parker and Aggleton 2003) like women. The unequal power relation that exists makes the women living with HIV/AIDS more vulnerable to stigma and discrimination. Power relations in a society and the norms and values that are accepted there are all associated with stigma (Parker &

Aggleton, 2002). According to Parker and Aggleton (2000), in settings where heterosexual transmission is significant, the spread of HIV infection has been associated with female sexual behaviour that is not consistent with gender norms. Thus women are more likely to be blamed for their HIV-positive status, even when they have been infected by their husbands, in what for them have been monogamous relationships (UNAIDS, 2000). By blaming the woman for introducing the virus in the family the man can reproduce his power in relation to the woman (Talja 2003). In an interview with one of the HIV- positive female informants (aged 30-34) she said:

“When my husband and his family members got to know I have tested positive to HIV, they insulted me as having immoral life. They sacked me from his house and he later divorced me. I felt sick and was tested for the disease so I was blamed for it.”

The construction of women as the carriers of the infection may reflect entrenched asymmetrical patterns of power, where dominance and relative impunity are maintained over disempowered and “blameworthy” women (Lorentzen & Morris 2003). HIV/AIDS related stigma can therefore reinforce pre-existing disadvantages of women (Parker & Aggleton, 2002). Most often it is the women who are accused for introducing the disease into the family because by the nature of their relatively weak immune system, they quickly succumb to sickness, weight reduction and physical bodily diseases.

7.1.5. Poverty

There are socio-economic differences in the possibilities to cope and care with HIV/AIDS. Having HIV and AIDS is very different for people with money. Their money buy them more space to hide, allows them to live longer, helps cushion the impact, and allows them to more easily find support and love. People living with HIV/AIDS who are poor have less space to hide from stigma when they are sick. They do not have the possibilities to pay for anti retroviral therapy which requires partly payment from the user. They are sick more often, and they “die faster” or “when they are not supposed to” and occasionally alone (Bond et al. 2003). The study reveals that women are stigmatized and discriminated against partly because of their low socio-economic status. Some of the respondents argued that when you are not poor, you are capable of attracting many people to you and to get support and love when sick. Thus if a woman is able to meet her own needs and that of others, people would be still willing to come closer to take care

and show sympathy although she may be sick. However, to be poor means a burden on others and an inability to defend one's right when abused. This explains why women in the study area suffer more stigmatization and discrimination than men as majority of them are economically dependent. In an interview with one female respondent (aged 35-39) she said:

“Being poor means a burden on some one .The person would definitely become frustrated especially if the disease is HIV/AIDS because he knows definitely you will die. This is especially so because of the immoral means of getting the disease”.

Poverty and the low status of women are thus gender-related inequalities that subject women to stigmatization and discrimination. Poverty has made many women dependent on men and hence making them subordinate to them. According to Talja (2005), some women are so strongly economically dependent on men that they can not get divorced from their husbands. They do not cope without the income of the man. However, it is common that men can leave their wives if they find out that they are HIV-positive, sometimes without knowing if they are HIV positive themselves. For instance as already stated, one of the HIV positive women interviewed told me her husband sacked her from his house and later divorced her when he found out that she was HIV- Positive. Women are therefore less able to protect themselves from HIV/AIDS related stigma because they often have a disadvantaged position and limited right to express themselves due to economic dependency and social norms such as customs and traditions (UNAIDS, 2002.43E).

7.2. Dimension of Stigma in Kumasi

Goffman (1963) distinguished between three different types of stigma. The first type is Stigma as abomination of the body which refers to disfiguring conditions and physical handicaps. The second type is the blemishes of individual character which refers to individual traits and/or actions that are deemed unacceptable in the culture. For example, unaccepted sexual practices. The third one is “tribal” identity which refers to group membership in marginal groups, e.g. sex-workers, migrant workers, the poor and women (Lorentzen & Morris 2003). The study reveals that all of Goffman's three types of stigma are at work in Kumasi. However, by the nature of this study, tribal identity is associated with gender related stigma, where gender inequalities and the

marginalization of women has been discussed as factors that make women more vulnerable to stigmatization and discrimination.

7.2.1. Abomination of the body

The study reveals that the physical appearance of women living with HIV/AIDS makes them vulnerable to stigmatization and discrimination. According to Goffman (1963) someone that differs physically is more likely to be stigmatized. This is especially so if the stigmatizing attribute is not something the affected is born with, but rather appeared later in life. This is often the case of HIV/AIDS positive women. The progressive nature of HIV/AIDS and the fact that the individual ultimately will succumb to typical displayed physical signs or opportunistic infections is in itself stigmatizing, reflecting Goffman's stigma "abomination of the body" (Lorentzen & Morris 2003). According to many of the respondents, once a woman develops such physical signs as long sickness due to opportunistic diseases, rashes, TB, malaria, and typhoid, leanness, rashes and boils, then she is suspected of having the disease. Thus people begin to avoid her with the intention that she can infect them when they get closer to her. This is because many people that are HIV/AIDS-positive grow lean very quickly and this has become a sign that such people differ from the rest by having caught HIV/AIDS. One woman (aged 35-39) in an interview said:

"Once a woman become skinny or get boil or rashes, people suspect her to have the disease. This is because they say when you become infected you will start getting those signs and then later you develop chronic sickness and die. At times it may not be true the person has it, but because she has been sick for long, people begin to suspect her".

Stigmatizing and discriminating against someone on the basis of her physical appearance is however very inaccurate because other diseases such as Tuberculosis(TB), Typhoid Fever and Diabetes are all associated with some of these physical signs such as reducing in weight and developing skin diseases. Also in recent times where there is the presence of antiretroviral drugs for treating people living with the HIV/AIDS, it may at times be very difficult to distinguish an HIV/AIDS-Positive woman from a woman without the disease. Thus many women have been accused wrongly of carrying the virus where as in real terms they were sick from a different disease. A cousin of mine who was living in Kumasi, for instance was accused by her husband and his family members for having caught the virus when she started growing lean after suffering

from a long sickness for about ten months after giving birth. She was forced by them to have HIV/AIDS test and this affected her psychologically because she was of the view that “they (her accusers) say she has AIDS”. Although her test yielded negative result, she developed a high fever and later died. Yet five years after her death, her husband and her son who was about one year old when she died are still strong and healthy without any sign of the disease. Similarly, one elderly woman narrating her story said:

“My daughter died and people were claiming she died as a result of HIV/AIDS because she fell sick for a long time and became thin. However, we, her family members, knew she died as a result of developing TB which was not detected early and not AIDS”. When I’m going people point at me and say this is the mother of the lady who died from AIDS.

Women living with HIV/AIDS easily succumb to the physical features such as leanness and skin diseases and other opportunistic infections such as TB and typhoid fever because they are usually poor and therefore not well nourished. Thus their immune system which is relatively weak hastens the development of physical features which makes them fall victim to stigmatization and discrimination. Thus in order to avoid being discriminated and stigmatized, some HIV-Positive women hide behind opportunistic diseases such as TB and Typhoid fever as being the cause of their sickness while in reality HIV is the remote cause of the sickness. However, in Ghana TB is also associated with stigma because it is contagious and previously lacks cure. In recent times however, with the introduction of cure for TB, the associated stigma is being reduced. Thus, with the relatively low stigma associated with TB, people living with HIV usually prefer to claim it and other opportunistic diseases as the cause of their sickness rather than HIV which is highly stigmatized.

7.2.2. Weakness of individual character

The fact that the HIV virus is transmitted mainly through sex makes the disease especially vulnerable for stigmatization, although there are other ways to catch the virus such as through blood transfusion, mother to child, breast feeding and injections with needles with infected blood. The fact that the virus is sexually transmitted has probably led to a way of regarding an infected

individual as someone with a weakness of character (Talja 2005). When asked why women living with HIV/AIDS are stigmatized, one of the male respondents (aged 20-24) said:

“People are of the idea that people with AIDS had it through bad sexual behaviour”.

According to Talja (2005) this way of regarding a person that has HIV as someone with a bad behaviour is apparently linked with the assumption that the infected is a person who has several sex partners. A high amount of sex partners is regarded as a weakness of individual character, an over sexualized person that has to have sex with several partners (Talja 2005). One of the HIV/AIDS – Positive women in an interview said:

“You know this disease is associated with a lot of stigma. Once you get it you are considered as sexually immoral. People think you got it because you had several sex partners so they tend to look down on you. When you are walking along the street you see people pinpointing at you and gossiping about you”.

The sexual mode of transmission of HIV can in itself contribute to stigma, since sexuality is a sensitive subject and often surrounded by taboo in many contexts (Lawson, 1997) in the study area. HIV/AIDS can be understood as proof of sexual promiscuity and is often conceptualized as a “prostitutes disease” (Lorentzen & Morris 2003). Women who are infected with the disease are often perceived as having had several sex partners. In the study area, women who are perceived as having several sexual partners are usually called “*Ashawo*” or “*tutu ni*” in Akan, which when literally translated means prostitute. However, men who have several sexual partners are not called prostitutes. Thus there is asymmetry in norms for females and males in the society. Women already suffer sexual stigma as well as discrimination in terms of sexual accusation. Thus being an HIV/AIDS- Positive woman makes you more vulnerable to stigmatization and discrimination. One of the sexual workers interviewed said bitterly:

“It’s always the woman who is accused of “ashawo”, what about the men? Whom do we have sex with? Are they not men? Why we are the only people called “ashawo”.

To condemn women living with HIV/AIDS as having got the disease as a result of having several sex partners is unfortunate since there are innocent married and unmarried women as well as children who are currently living with the disease. Can we say that the estimated two million children currently living with HIV/AIDS in Sub-Saharan Africa (UNAIDS/WHO 2006) contracted the disease as a result of having many sexual partners? It seems although many people are becoming aware of the disease, knowledge about the mode of transmission has still not gone very deep. Consequently people are making hasty conclusions about infected women who fall victims to such ignorance. According to Talja (2005), Aggleton emphasizes the illusion that HIV/AIDS can never happen to us. Since we would never catch the disease, the others who are getting infected are abnormal and weird (Aggleton 2000; Talja 2005). There is this slogan that “all are at risk” but some people are of the view that catching the disease depend on risky sexual behaviour. Thus, if you practice safe sexual behaviour, you may not be at risk. However, being at risk of HIV does not depend solely on risky sexual behaviour but also other means such as transfusion of contaminated blood, breastfeeding, use of contaminated strings and razors. Talja (2005) also argued that the false impression of others as the bad ones and us as the good ones when the others are among us makes the life for HIV-Positive people hard.

7.3. Manifestation of Stigmatisation and Discrimination

Stigma is a complex and multifaceted phenomenon that can take many forms. HIV/AIDS-related stigma and discrimination are manifested at different levels; societal, community and individual; and can occur everywhere; in the family and in the community, in the education sector and the workplace, in the health care setting, in the religious sector, the media and in the political and judicial system, and in different contexts (UNAIDS 2000; UNAIDS, 2001; UNAIDS, 2002; UNAIDS/02.43E; Lorentzen & Morris 2003).

In societies with cultural systems that place greater emphasis on individualism, HIV/AIDS may be perceived as the result of personal irresponsibility, and thus individuals are blamed for contracting the infection. In contrast, in societies where cultural systems place greater emphasis on collectivism, HIV/AIDS may be perceived as bringing shame on the family and community (Parker & Aggleton 2002). In the study area, the cultural system is such that emphasis is placed on both individualism and collectivism. Thus contracting HIV/AIDS brings a broader shame shared

by the individual, his or her community and especially her family including the extended family. Consequently, this shared stigma tends to fuel the stigmatization and discrimination against people living with HIV/AIDS (PLWHA) in the community and family level as members are of the view that the affected has brought shame on the community or the family. The manifestation of stigmatization and discrimination against HIV-Positive women at the family level, community level, work place and the health institutions and religious institution as revealed by this study has been discussed below.

7.3.1. Family

The study reveals that in some families, there is low level of sympathy and empathy for women living with HIV/AIDS. Some HIV-positive women are sometimes rejected by the family members, while some are insulted and blamed for bringing shame on the family or becoming a burden on the family. Some are at times neglected by their family members or not given proper care because they consider them to be “rough” priorities. They think taking care of them and spending the limited family resources on them will yield no positive consequence since they would definitely die prematurely. Thus women living with HIV/AIDS are not shown brotherliness and compassion by some family members and they usually lack dignity as human beings. As already stated above, one of the HIV/AIDS- Positive women in an interviewed narrated how she was rejected by her husband and his family members when she tested positive to HIV after a chronic illness. Even though her husband was not aware of his status, he accused her of contracting the disease and after informing his family, they collectively sacked her from the house where they were both living and later divorced her. Another HIV-Positive woman (aged 35-39) also said:

“When my late husband got sick, I used all the money I had in taking care of him. I even sold all my belongings in order to take care of him. After the death of my husband, I was informed by the Doctor that my husband died as a result of AIDS, I was asked to take a voluntary test which yielded positive. When both my family and my husband’s family got to know that I am HIV – Positive, they have neglected me and my seven year old son. Now I go through a lot of hardship since I get no support from my family.”

The lack of sympathy and compassion within the families of some HIV/AIDS-positive women may be attributed to fear rather than punishment. This is because in Ghana, being infected with HIV is equalised to a death sentence since poverty, psychological stress and inadequate medical care or treatment, hasten the progression of the disease to AIDS and subsequently the premature death of the affected. Thus the disease is associated with great fear which in turn fuel stigmatisation and discrimination. During my visit to the house of one of the HIV/AIDS-Positive women, I observed that she was avoided by members of her family. She told me none of the family members was willing to share anything with her because they are afraid of her. Through personal observation I confirmed her complaints that they are reluctant to share meals with her, allow her to touch any of their things and they have even abandoned the use of the water closet in the house for her alone. However, this is some form of exaggerated fear because you can not get infected through mere touch, eating or by sharing water closet with an infected person. Since HIV/AIDS-related stigmatization and discrimination reinforce and interact with pre-existing stigmatization and discrimination, families may reject PLHA not only because of their HIV status but also because HIV/AIDS is associated with promiscuity (Parker & Aggleton 2002).

Although women living with HIV/AIDS usually suffer stigmatisation and discrimination at the family level, the study reveals that there are certain instances where families, especially the immediate families are willing to support by showing sympathy to their infected members, and giving them the necessary care, support and love. One of the HIV/AIDS -positive women (aged 25-29) said:

“I’m very grateful to my mother, she gives me all the love and necessary support I need. She cooks for me; help wash my clothes when I’m not feeling well; and always converse with me. She is a mother and a good friend too.”

This woman’s experience is not an unusual exception among women living with HIV/AIDS in Kumasi since the support and care that an HIV/AIDS infected person receives also depends on the nature of the relationship. Generally in Ghana, the immediate family, particularly mothers and children tend to show love, sympathy and compassion to their affected relatives.

In many cases, HIV/AIDS-related stigma and discrimination has been extended to families, neighbours and friends of PLHA. This ‘secondary’ stigmatization and discrimination has played an important role in creating and reinforcing social isolation of those affected by the epidemic, such as the children and partners of PLHA. The study reveals that when a woman become infected with HIV/AIDS in the family and it becomes visible to the community, people even become reluctant to marry from that family because they are afraid they may mistakenly contract HIV/AIDS. Also, having an HIV/AIDS person as a member of your family exposes the family to strong level of gossiping within the community. Thus HIV/AIDS brings shame upon the entire family, and in many cases the family rejects family-members with HIV/AIDS or even hide them from the public (UNAIDS 2002.43E, Lorentzen & Morris 2003).

7.3.2. Community

At the community level, HIV/AIDS related stigma and discrimination manifest itself in the form of avoidance and isolation. Community members often shun, mock, and gossip about those who have, or are perceived to have HIV/AIDS. This is especially so where the illness is believed to be the result of “immoral” or “improper” behaviour. Thus HIV/AIDS may reinforce pre-existing stigma of those whose behaviour is considered to be “deviant” (Parker & Aggleton, 2002; Lorentzen & Morris, 2003). One woman (aged 30-34) describing how members of the community treat HIV/AIDS- Positive women said:

“People tend to gossip and mock persons infected with HIV/AIDS the moment their status is disclosed. Even when they don’t know the status of a person but see that she is sick most often and that she is growing lean, they claim she has got HIV. They refer to her past behaviour and say she has got the disease because she has a bad behaviour. Her friends would then stop seeing her or moving with her.”

Living with HIV/AIDS thus results in social exclusion from the local community. Women who are HIV/AIDS- positive are usually squeezed out from the social networks and contacts especially where the community is integrated. This is because in local communities with strong ties and strong social networks, there is low level of anonymity of the residents. Thus community members and friends tend to avoid or neglect a person once her HIV positive status is known because they are afraid the community may extend the stigma and discrimination that the infected

person suffer to them. Most of the respondents argued that due to the sexual mode of transmission of the disease, those who are infected are considered immoral. Thus people tend to avoid an HIV/AIDS person because if you associate with such a person, you would be considered as immoral too. Due to this some of them substantiated their argument with the saying “*kyere me wo yonko na me nkyere wo wo suban*” which when literally translated mean “*show me your friend and I will show you your character.*”

The study also reveals that there are instances where PLWHA have been ejected from the house where they are living by their landlords when their HIV/AIDS status became visible. According to one woman, a woman who was an HIV- positive in her neighbourhood was ejected from the house she was living in by her landlord when the disease started progressing into AIDS and became visible.

7.3.3. Work Place, Health Services and Religion

During the studies, both the female and male respondents reported that such practices as pre-employment screening, denial of employment to individuals who test positive to HIV, termination of employment of PLWHA, and the reluctance of some workers to work next to PLWHA who have disclosed their status are all forms of discrimination and stigmatization that HIV/AIDS positive women in particular suffer. An interview with one of the women infected with HIV reveals that she was sacked by her boss when her HIV-positive status became known.

The studies also reveal that stigmatization and discrimination of PLWHA is evident in the health services where treatment occurs. As pointed out by Parker and Aggleton (2003) discrimination and stigmatization take the form of disclosure of one’s status to preferential treatment for the poor and the rich. Failure to respect confidentiality by clearly identifying patients with HIV/AIDS, revealing HIV-positive status to relatives and other people without prior consent, appear to be problems in some health services. One of the female respondent sighted an instance where some nurses in a hospital where she had her pre-natal care showed her a young woman who goes there for treatment as HIV-positive and said she is always dropped by a different car. Nurses and other health workers may give less care and psycho-social support to HIV-positive patients in comparison to other types of patients (Dvergsda 2005). Some of the respondents were of the view that the HIV/AIDS –positive people who are rich are given better treatment than the poor since

they are able to provide the health officers with gifts. Thus since majority of the HIV/AIDS-positive women are poor, they tend to suffer more than the men.

Furthermore, some religious leaders at times condemn women and also men living with HIV/AIDS as having contracted the disease as a punishment for immoral life. They support their pronouncement with a statement from the scripture that there will be a disease without any cure. However, it is wrong to assume the disease to be punishment for the affected and thus condemn them because there are currently a lot of innocent people, even infants and children, infected with HIV/AIDS.

7.3.4. Self- stigmatization

The study reveals that low self-esteem, low self-confidence and depression are more typical for women living with HIV/AIDS than men. Many of the HIV/AIDS –Positive women tend to stigmatize against themselves when they get to know their status. The feeling of uselessness and incapability seems to lead to that they turn to themselves in a destructive way. The tendency of blaming themselves for catching the disease appears to cause negative feelings (Talja, 2005). Most of the respondents were of the view that HIV/AIDS-positive women stigmatize themselves because they think the fact that they have the disease, they differ from other people in the society. They think they do not have the same rights as others and that they are not capable of doing what others can do since they are not accepted by other people who are not infected or know their status. Thus once a woman becomes aware of her status, she develops a feeling of worthlessness and most often chooses not to disclose her identity or status. Self stigmatization can therefore be seen as a way of discrediting oneself (Lorentzen & Morris 2003).

7.4. Isolation

In contexts where HIV/AIDS is highly stigmatized, fear of HIV/AIDS-related stigma and discrimination may cause individuals to disintegrate from the local community to the extent that they no longer feel part of civil society and are unable to gain access to the services and support they need (Parker & Aggleton 2003). According to Goffman (1963), someone that differs physically is more likely to be stigmatized and interaction with others can be more complicated and isolation may be the consequence. The affected herself probably has stigmatized and

regarded others who are HIV/AIDS-positive as less worthy and finds it now difficult to be in that situation. Interaction between the stigmatized and others can be stiff and uncomfortable and therefore a social contact may be avoided. Aggleton writes that Gilmore, Somerville and Hasan explains how a highly stigmatizing environment can lead to the withdrawal of an HIV-Positive Person from his company as a means of self-preservation, to prevent himself from being subject to bad treatment (Talja 2005). This study tried to uncover some of the reasons why HIV/AIDS-Positive women become isolated from the rest of the society when they become aware of their status.

According to some of the respondents (both men and women) HIV/AIDS-Positive women isolate themselves from the society because they become worried when they think of the stigma and discrimination they may go through as well as the inevitable premature death associated with HIV/AIDS in poor countries like Ghana. Consequently they go through psychological stress and tend to distance or disintegrate from others. Some were of the view that they think people have negative perception about the disease and therefore they believe they would be treated badly by people when they get closer to them. Also, some think that they isolate themselves due to lack of confidence in people whom they think when they get closer to them and disclose their status to them, they would in turn reveal it to others and consequently subject them to stigmatization and discrimination. Furthermore, some were of the view that they isolate themselves due to shame and guilt. One of the female respondents (status not known) made this statement:

“Some women become isolated because of the psychological stress: they know definitely they would die. Also it’s because of the stigma associated with the disease. It is believed HIV/AIDS is contracted through bad attitude and behaviour and that it is usually contracted by prostitutes. Thus once a woman get it, she develops the feeling that people will attribute it to bad attitude.”

Women living with HIV/AIDS thus isolate themselves, particularly from the local community in order to avoid massive confrontation with stigmatization by other people.

7.5. Effect of Stigmatization and Discrimination

Stigmatizing and discriminating against women who are HIV/AIDS-Positive have serious consequence on the affected, the family and the society. The study reveals that stigmatization and discrimination against HIV/AIDS- Positive women result in social exclusion whereby the stigmatized withdraw from the society in order to avoid such treatment. Since every individual has the need to belong, exclusion from companionship may eventually lead to emotional or psychological stress and probably consequent premature death. Empirical research supports the postulation that the need to belong is a fundamental human motivation. A motivation can only be fundamental if health, adjustment or well-being requires that it be satisfied. This implies that if the need to belong is not fulfilled, the individual can suffer severe psychological distress. (Lorentzen & Morris 2003). One woman (aged 25-29) explaining how stigmatization and discrimination affect the HIV/AIDS-Positive women said:

“She can become very sad and this can compel her to commit suicide. It can make her more sick, give her psychological stress and she can therefore die earlier than she is suppose to.”

To stigmatise against a woman living with HIV/AIDS is therefore a means of drawing her into severe emotional stress and consequent deterioration of her health condition because women are more susceptible to psychological stress than men. Since every human being has the need to belong, it is imperative for HIV/AIDS-positive women to feel acceptable and enjoy normal life.

The conceptualization of HIV/AIDS as a disease of shame, sexual promiscuity and immorality has consequences for disclosure and help-seeking behaviour. The fear of HIV/AIDS-related stigma and its negative impacts force many PLWHA to face the dilemma of whether to disclose their status or not (Lorentzen & Morris 2003). The study reveals that stigmatization and discrimination against women who are HIV/IDS-Positive compels others who test positive not to disclose their status for fear of being treated badly. Hence they lead their normal life in order not to attract suspicion and consequently they spread the disease. Similarly, people were of the view that such treatment give birth to ill-feeling and subsequently turn the affected against society by intentionally spreading the disease to other. Also the study reveals that stigmatization and discrimination would prevent infected persons with unique knowledge or idea that can be

beneficial to the society from utilizing it, making it useless. Such knowledge may include specialized form of skills, unique plan or opinion, special way of helping the community or initiating development and academic or professional experience.

The fear of being stigmatized and discriminated makes many women in the study area reluctant to take voluntary counselling and testing in order to know their HIV status. Thus it prevents individuals from seeking early treatment and hence exposing them to premature death. Also due to the lack of knowledge about one's status makes HIV carriers lead their normal lifestyle and subsequently spread the virus to others.

7.6. Institutional Support

Many institutions, Governmental and Non-Governmental Organisations (NGOs) as well as some government officials are actively working to provide care and support to PLWHA and to bring widespread stigmatization and discrimination against them under control. Although the fear of the disease and the negative perception about the mode of transmission remains an obstacle, many NGOs, the Ghana AIDS Commission, The Ministry of Women and Children's Affairs and some international organisations such as WHO, USAIDS are providing support to women and other people living with HIV/AIDS and sensitizing the public to accept them.

Currently, the Ghana AIDS Commission in collaboration with the Media is working to educate people not to discriminate and stigmatized people living with HIV/AIDS. This education is in the form of Mass Media advertisement that send message to the general public. The message send by the advertisement is that *“people who are infected with HIV/AIDS are humans like us and therefore they have to be accepted into the society.”*

Apart from the work of the Ghana AIDS Commission, interaction with some NGOs in Kumasi and the Ministry of Women's Affairs reveals that they are sensitizing the public about the various modes of transmission of the HIV/AIDS, how everybody is at risk and the need to accept women living with HIV/AIDS in order to help reduce the stigma and discrimination associated with the disease. The sensitization takes place in the form of community education, advertisement, education during women's meetings and speeches during public gatherings. The main aim is to

educate the public on how to handle women and other people living with HIV/AIDS. They argue that education is an important means of creating awareness on how to handle those infected with the disease. In an interview with one officer of an NGO, she said:

“Educating people on how to handle HIV/AIDS infected persons, particularly women and children can help prevent stigmatization and discrimination.”

The study reveals that there is the existence of HIV/AIDS policy under the HIV/AIDS programme that protect the right of HIV/AIDS-Positive women but the only problem is with implementation. Thus there is the need to rectify this problem of implementation in order to sustain the protected right of HIV/AIDS-Positive persons. During an interaction with one of the officers at the Ministry of Women and Children’s Affairs, she said:

“Under the HIV/AIDS Programme there is an ethical and legal aspect of the HIV/AIDS policy that states that you are not supposed to throw infected woman out of marriage or work. However, the only problem is implementation.”

Furthermore, models of home care essential to the needs of PLWHA to provide a basic minimum quality of care have been developed. Some adopted home care approaches are hospital outreach programmes, church based home care, community home care and persons living with HIV/AIDS networks. Such home care service such as community based home care can provide community leaders, families, volunteers and entire communities with information they need to gain confidence about their own ability to give safe, compassionate help and care to persons living with PLWHA, and orphans in their homes (GAC,2005).

Life Relief Foundation has organized an association of persons living with HIV/AIDS, known as Life Relief Support Group. Members meet monthly to share experience, receive nutritional support, and learn about HIV/AIDS prevention, “positive living” and their responsibilities towards the spread of HIV/AIDS. The organization believes that greater involvement of persons living with HIV/AIDS can help reduce stigma and discrimination and help decrease the spread of the disease. (GAC, 2005).

7.7. Chapter summary

This chapter presents how the subordinate position of women in society subjects HIV/AIDS-Positive women to severe stigmatization and discrimination and the support given to HIV/AIDS women. The study reveals that sexual stigma, fear, gender inequality and poverty have been the main sources of discrimination and stigmatization against women living with HIV/AIDS in the study area. HIV/AIDS positive women in the study area are discriminated and stigmatized because they are believed to be sexually immoral. People are afraid of the disease because it is life threatening, and living with it in a poor country like Ghana often means facing the fact of premature death. Gender inequality, has resulted in male domination of political and economic power in the study area and subjects the women to discrimination and stigmatization.

The fact that HIV/AIDS positive women easily succumb to physically displayed signs and opportunistic diseases, and the fact that HIV is transmitted mainly through sex and that women are marginalized and considered inferior to men subjects HIV-positive women to discrimination and stigmatization. Furthermore, the study revealed that discrimination and stigmatization against women in the study area manifest in the family, community, workplace, in the health care setting, and in the religious sector with the broader shame of the disease shared by the individual, her community and especially her family including the extended family.

Stigmatisation and discrimination have negative impact on both the infected women and the society by excluding them socially and preventing them from seeking help and support, and contributing to development process. They also contribute to the spreading of the disease. However, HIV women receives support from both government organisations and NGOs.

CHAPTER EIGHT: DISCUSSION, CONCLUSION, AND RECOMMENDATIONS

8.1. Discussion

This study mainly aimed at finding the factors that constrain women in the study area from negotiating safe sex and hence becoming vulnerable to HIV infection. In order to achieve this main objective, the study aimed at achieving some specific objectives, which were stated for the study. This chapter therefore discusses the results of the study in the light of the specific objectives formulated for the study.

Investigation on whether gender inequality in HIV, particularly, for specific age groups persist in the study area shows that a greater proportion of the people infected with HIV are women, confirming reports of many studies such as Crane (1991), UNAIDS (2004), and GDHS (2003) that there is gender inequality in HIV/AIDS with many women living with HIV/AIDS than men. The available data reveals that about 58 percent of the total number of 7744 adult HIV cases reported from 2000 to 2004 were women. This indicates that women are at greater risk of contracting the disease than men. However, due to the fact that data on the various age groups is unavailable on district and metropolitan basis, it was impossible for me (the researcher) to investigate whether gender inequality for specific age groups persist in the study area.

The exploring of women's perception about HIV risk, particularly, their worry for HIV risk, risk tolerance, risk taking behaviour and risk reduction; as well as their perception about their sexual right in the study area reveals that about 66 percent of the women in the study area are very much worried for contracting HIV/AIDS with worry being particularly higher among women in their thirties, especially those in their early thirties. The reason why most women show very much worry for contracting HIV/AIDS may be due to the shame associated with the disease and the fear of stigma which are consequence of the fact that women who are infected with the disease are considered as sexually immoral because in the study area the disease is transmitted mainly through heterosexual intercourse. Also women in their early thirties are more worried because most women are either married or in a sexual partnership around that age and usually spouses are more unfaithful after some years of marriage or being in partnership. The results further show that women who have had no sexual partner within the last 12 months are most worried for

contracting HIV/AIDS than women with one or more sexual partners. The reason for this is partly due to the fear of the premature death that most AIDS persons experience in Ghana and also due to the fear of being stigmatized and discriminated against. This is because women have suffered disproportionately from discrimination against people living with HIV/AIDS. Such treatment that women living with HIV/AIDS suffer may even explain why the women have chosen to remain single. Furthermore, the results indicate that about 95 percent of the women in the study area believe that AIDS is fatal. However, some of the respondents were of the view that there are some people who still believe that HIV/AIDS do not exist.

Furthermore, the results reveal that the majority of the women in the study area are of the view that they have a higher likelihood of contracting HIV. That is they believe they are either likely or more likely of contracting HIV within a period of 5 years. Also, relatively older women (women 30 years and above) believe they are at greater risk of contracting HIV than younger women. Older women think they are likely or more likely to contract HIV within a period of 5 years because they may have had more sexual experience due to their relatively older age than the relatively younger women (women below 30 years) and therefore they may be exposed to more risk. Also most of the women above 30 years are usually married, and since engaging in multiple partnership by men is condoned in the study area, these women's believe that they are at higher risk of contracting HIV may be attributed to the risky sexual behaviour of their husbands. In consistence with other theories of health behaviour, the results of the study show that it is women's perception of risk rather than the actual risk involved that influence their behaviour. Although women's HIV risk perception is generally high, women who usually have higher risky behaviour have relatively lower HIV risk perception than women who have lower risky behaviour. The results also show that the more likely a woman is to contract HIV within a period of 5 years, the more likely she is to contract other diseases like malaria, TB, typhoid, and other STDs. About 64 percent of the women in the study area believe they are most likely to be a victim of malaria than other diseases such as HIV/AIDS, TB, typhoid, and other STDs. This indicates that although malaria still remains the top killer in Ghana, it is more acceptable to be a victim of malaria than to be a victim of any of the diseases mentioned above, especially HIV/AIDS. It is more acceptable to be a victim of malaria because it has no stigma. Apart from malaria, the women believe they are likely to be a victim of is traffic accident because you can be

a victim of traffic accident even if you do not engage in risky behaviour. This is because you can be hit by a car or you can be a passenger in a car.

Generally, women's perception about HIV consequence is high, with most women (65%) perceiving the consequence for contracting HIV within a 5 year period as very large. Also there is a positive relationship between the age of a woman and the perception about consequence for HIV within a 5 year period. In accordance with Bernadi (2002), the women with no sexual partner and those with only one sexual partner perceive the magnitude of the potential loss in engaging in risky sexual behaviour as high and therefore they have chosen not to engage in a more risky behaviour. However, contrary to Bernardi's argument, the women with 2 to 5 sexual partners have still chosen to engage in risky sexual behaviour although they consider the magnitude of the potential loss in engaging in risky sexual behaviour as high. This is because the women are probably in despair or desperate for money. Also they perceive the benefits, for example, money, gifts, and protection as higher than the costs, that is risk of HIV. This is an indication that perception does not always have influence on behaviour.

The study further reveals that HIV risk tolerance (that is people's acceptance to live the risk level) is generally high, above 50%, at both the local (study area) and national level. Although HIV risk tolerance is high at both the local and national level, it is more highly tolerated at the national level than at the local level. This is an indication that there are variations in the HIV/AIDS prevalence in Ghana with some areas having higher prevalence than the study area. Also, the study reveals that the age of a woman is inversely related to the number of sexual partners within the last 12 months. That is younger women have more sexual partners while older women have fewer sexual partners. The reason why younger women have more sexual partners than older women is that they are usually unemployed and underemployed than the older women and they tend to follow more fashion which their own income can not afford. Furthermore, it shows that poorer women tend to have sex with a man for money or other forms of support than rich women. However, this is not always true for all poor women. There is an exceptional case where some women with no income have never had sex with a man for money or any form of support. This indicates that a women's sexual behaviour may not be determined by only financial constraint but also it is influenced by a combination of factors including moral

values and self discipline. In addition, the results of the qualitative analysis show that though some women are rich they still engage in prostitution or exchange sex for money. Nonetheless most of these women amassed their wealth through prostitution.

Caution was revealed as the most preferred measure for risk reduction by the women in the study area if they discover their partners' behaviour is a health risk to them and this is followed by the use of condom. The results of the study shows that married women in particular, about 60 percent of them, prefer to use cautioning of their spouse than any other measure for reducing the risk of contracting HIV. This is an indication that although women in the study area try to reduce the risk of contracting HIV, they are incapable of adopting effective measures. The reason behind this is that as Bernadi (2002) have stated, women's risk perception is affected by the degree of control they feel they have on their behaviour and that of their spouse or partner and also such control in turn influence their capability of reducing the risk. Thus women who do not have control over their spouses or partners behaviour as well as their own behaviour probably due to cultural values and norms such as the desire for children and male supremacy are usually incapable of adopting effective risk reduction measures to reduce their vulnerability to HIV infection. However, the results show that a greater proportion of the women(71%) have at least made some changes including abstinence, sticking to one sexual partner, and the use of condom, to their sexual behaviour to avoid HIV. In addition, majority of the women (61%) perceive it as very much important that the Ghanaian Health Authorities implement HIV/AIDS risk reduction measures.

Concerning perception about women's ability to negotiate safe sex and their sexual right, the results of the study show that low income or low economic status of women is the most important factor that undermines the capability of the women in the study area to negotiate safe sex. This is followed by the lack of social power, lack of self or sexual control, cultural constraints, lack of legal protection, and other factors such as low self-esteem and the fear of being criticized in order of their importance. Furthermore, low income or poverty, the fear of losing the man or divorce and the supremacy of men were ranked as the three most important reasons why women are unable to negotiate for safer sex. Low income or poverty was ranked by a greater proportion of the women (62%) as the first most important reason why women in the study area are unable to

negotiate for safe sex. This is an indication that poverty is the root causes of women's inability to negotiate for safe sex and hence their high vulnerability to HIV/AIDS. Apart from women's inability to negotiate for safe sex, unfaithful spouse or partner which is perceived by the women to be the next most important factor and other factors such as having multiple sexual partners, prostitution, cultural practices like educating the male child at the expense of the female child, as well as encouraging male supremacy and female submissiveness, untreated STDs, and weak immune system were perceived by the women to make them liable to HIV infection in the study area.

Most women in the study area (82%) are of the view that women should be given the right to make decision on sex. However, there was a divided view with some although relatively higher favouring full control over sex while others favour limited control. A slightly higher proportion of educated women (82%) than women with low or no education (78%) are of the view that women should be given the right to make decision over sex. Also a higher proportion of the educated women who are of the view that women should be given control over sex favour full control over sex while a greater proportion of the women with low or no education favour limited control. This indicates that education would play an important role in giving women the right over their sex. Thus in general women with different background have the desire that they are given some amount of autonomy over their body. Furthermore, the women were of the view that such factors as political and economic empowerment of women, breaking down of cultural barriers against women, balancing male and female power relations, introduction of women to sex education, organizing counselling for women, educating women on self-esteem, education on abstinence and particularly encouraging formal female education are important measures to give women control over sex.

Regarding the extent to which the subordinate position of women in society make them vulnerable to HIV, discrimination and stigmatization, the results show that gender inequality which is usually made evident through the biological, economic, socio-cultural, as well as political subordination of women in the study area makes them vulnerable to HIV. Women by the nature of their biological disposition have relatively weaker immune system than men and this makes them more vulnerable to HIV infection. Physiologically, women are more vulnerable to

HIV infection because of the anatomy of their sexual organ, greater area of mucous membrane exposed during sex, and the greater quantity of fluids transferred from men to women during sex. Male-to-female transmission is therefore much more likely to occur than female-to-male. Due to the relatively weaker immune system and the fact that they are usually poor and therefore not well nourished, women who are infected with HIV easily succumb to physical features such as leanness and skin diseases and other opportunistic infections such as TB, malaria and typhoid fever. Thus the weaker immune system of women places them at a disadvantage in terms of contracting HIV and also hastens the progression to AIDS. The progressive nature of HIV/AIDS and the fact that the woman ultimately succumb to typically displayed physical signs or opportunistic infections makes them suffer discrimination and stigmatization in the society. This is because once a woman develops such physical signs or opportunistic diseases, she is suspected of having the disease.

Gender inequality in income and access to economic resources makes them vulnerable to HIV infection. The low income of women and lack of access to resources including credit and technology leaves most women no option than to depend on men as a means of survival. This economic subordination of women in society undermines their ability to negotiate for safe sex. As noted by Conseil du statut de la femme (2002) there is a relation between the low economic status of women and their involvement in prostitution. Unemployment, poor education, few available jobs, inadequate salaries are some of the factors, which compounded, forces some women into prostitution. The worse thing is that because these women derive their livelihood from the exchange of sex for money, they are unable to control the circumstance under which sex take place. Due to desperation for money, some prostitutes usually succumb to the wishes of some men who offer them higher fee for unprotected sex. Thus the women's ability to negotiate for safe sex is compromised due to limited finances, making them vulnerable to HIV. The gender inequality in poverty in the study area is also fuel by social belief in the society that makes women dependent on men. Men are seen as having the responsibility of taking care of women and children. With such belief entrenched in the society, many women are constrain from securing alternative livelihoods than to depend on their spouses or partners. Due to dependency on men, women are unable to assert their right to refuse sex with their husbands or partners.

In addition, the results show that due to poverty women living with HIV/AIDS have relatively less space to hide from stigma when they are sick than the men. They do not have the possibilities to pay for anti retroviral therapy which requires partly payment from the user. They are sick more often, and they “die faster” or “when they are not supposed to” (Bond et al. 2003; Talja 2005). Due to poverty, such women are seen as burden and therefore they are unable to get support from family members when sick. Similarly, they are unable to defend their right when abused. Poverty is thus gender-related inequality that subject women to stigmatization and discrimination.

Social and cultural subordination of women were found to play an important role in making women in the study area vulnerable to HIV/AIDS. Customs, gender norms and ideologies such as femininity, masculinity, male superiority and female inferiority in the study area create unequal balance of power between women and men and they are rooted in the socio-cultural context of the society. Such societal and cultural norms and attitudes rigidly prescribe what is considered appropriate behaviour and thus limit women’s power to negotiate safer sex. Also they make it hard for women to opt out of abusive relationships, and promote expectations of dependence on men. Gender norms for instance have contributed to creating a culture of silence and shame that surrounds sexuality and an unequal balance of power between women and men. Also such norms as male superiority to female has in fact hindered many women from accessing school or progressing in their education which has been shown to reduce risk of infection, to enhance self-esteem and provide livelihood alternatives (IPPF, UNFPA, Young Positive, 2007).

Unequal power relation between men and women has been a common norm in the study area and it plays a major role in making women vulnerable to HIV/AIDS. It is revealed in the social, political and economic power of men as a group over women as a group. Men are constructed as superior to women and therefore they are assumed to have authority over them. The family based household is thus a hierarchical structure marked by the dependency of the wife and children on the husband, whose specific role in the household is a bureaucratic definition of him as its head. Such male superiority over female undermines women’s autonomy to make decision about sex. It also leads to double set of morals in the society because multiple partnerships by men is condone whiles it is intolerable for women. Patriarchal attitude is also rooted in religion, particularly Christian religion and this has reinforced the traditional customs which men use to control

women's sexuality. Further more, unequal power relation between men and women manifest itself in the male domination of leadership position and political power in Ghana. Most of the leadership positions in the country are occupied by the men to the detriment of the women. Although women constitute more than 50 per cent of the 21.5 million population of Ghana, their share of political and public office appointments is a miserly eight per cent. And this is in spite of years of continuous public education by a host of non- governmental organizations and women groups. This subordination of women in politics and public offices makes it very difficult for women in the country to have a bearing on decision making which influence them and their children. The idea of male superiority over female does not only undermines women's negotiating power in sex but also hinder their progress which subsequently ensure the perpetuation of women subordination to men and hence their sexual subordination which makes them fall liable to HIV/AIDS. Due to such cultural values and norms, and double set of morals for men and women in the society as discussed above, women living with HIV/AIDS tend to suffer more stigma and discrimination than their male colleagues. Men are usually forgiving for being promiscuous but women are not. The unequal power relation makes women living with HIV/AIDS more vulnerable to stigma and discrimination.

8.2. Conclusion: Limitations

Due to the fact the large sizes of the area and population in the selected suburbs and that data showing detail information such as names, house numbers, street numbers about the population is unavailable, I was compelled to conduct my own registration of the target women. Thus instead of the initial plan of giving all the women in the selected suburbs equal chance of being selected for the study, some houses were systematically sampled for females 20 to 29 years. After that 80 women were selected using quasi-random sampling. Furthermore, because I was working within a specific time frame, only women in the selected houses met at the time of registration were registered. Thus there was some form of bias in the registration because we could miss registering the poorest women and women at the highest risk. The study therefore concludes that the sampled population may not be a true representative of the population in the study area. Furthermore, during the field work it was clearly observed that interviewees, particularly HIV positive women and prostitutes, were unwilling or uncomfortable to share all the truth I hope to explore. Most of the interviewees were found to be embarrassed by the sensitive questions. Also most of them

were afraid to give true information about their income. The fact that doing a research on sensitive topics poses a substantial threat to the respondents have resulted in situations which may directly or indirectly affect the credibility of the study. Yet again it would have been interesting to explore at a large scale the males' or husbands' views, assessment and risk taking behaviours well.

Despite these limitations, the study was able to uncover the factors that undermine women's ability to negotiate safe sex and thus become vulnerable to HIV/AIDS, discrimination and stigmatization. Also it was able to at least achieve some degree of representativeness by selecting suburbs which has true reflection of the varied ethnic, religious, and social groups as well as using the triangulation method to overcome the major flaws that could have resulted from using a single method. The results of the study can therefore be trustworthy and relevant interpretations by researcher and to a certain degree be generalized for the entire population of Kumasi which is a mixture of cultures in Ghana. However, emphasis must also be given to other cultural practices such as female sexual mutilation and "*trokosi*" which are not in practice in the study area but yet has the potential of making women vulnerable to HIV/AIDS in other parts of Ghana.

8.3. Recommendations

This study revealed that women are highly vulnerable to HIV, discrimination, and stigmatisation due to economic, social, cultural and political factors that intertwine to undermine their ability to negotiate safe sex and also exposes them to more severe discrimination and stigmatization. Based on the findings of the study some suggestions and recommendations have been made.

There is the need to ensure that there is a universal access to sexual and reproductive health. It is therefore very necessary that both men and women are given access to sexual and reproductive health. By expanding access to sexual and reproductive health services, including family planning, contraceptive information and services, it will enable both men and women to get the information or care they need. Also in order to have bearing on HIV/AIDS, it is necessary to ensure that sexual and reproductive health programmes are part of Ghana's national AIDS plan as recommended by experts of United Nations Millennium Project. In addition to this, it is very important to promote responsible sexual behaviour.

Expanding public education and awareness raising campaign programmes is also a necessary step to take. Though most women know about HIV/AIDS, the study revealed that some people are still not knowledgeable enough about the modes of transmission of the disease. Due to this, some people either get infected or they discriminate and stigmatise against women living with HIV out of ignorance and misinformation. It is therefore very necessary that emphasis is given to the modes of transmission during public education and awareness campaign programmes. In addition, it is important to expand these campaigns to address issues like violence, early marriage, gender identity, patriarchy, stigmatisation and discrimination that make women more vulnerable. This is because silence on these issues can be very precarious.

Promoting and protecting the rights of women can also protect them from HIV/AIDS. There is the need to promote sexual right of women in order to give women control over their sex or bodies. Women should be allowed to make decision on sex in order to enable them control the circumstances under which sex occur. This can be done through protection of the sexual right of women by legal laws. Also there is the need to protect the human rights of women living with HIV/AIDS. This is because discrimination and stigmatization only fuel the spread of the virus. However, promoting and protecting the rights of women can not be effective without collaborating economic, social, and political empowerment.

It is very necessary that women are empowered in order to reduce their vulnerability to HIV. However, this empowerment must lead to change in the life of women, not only in terms of control over resources, but also greater autonomy and authority in decision making, self-expression, self-confidence, and assertiveness. In a nutshell, women's empowerment can be achieved by increasing women's access to economic resources like land and credit facilities, encouraging and promoting female education, addressing gender inequalities by balancing male and female power relations.

Also it is important to ensure the availability of female-controlled prevention options such as female condoms and also women's access to antiretroviral treatment and better nutrition to secure good health and prevent them from being exposed to discrimination and stigmatization. In

addition, HIV/AIDS programmes must be gender sensitive. Programmes should be designed in such a way that they address the specific needs of women and men instead of providing women and men the same interventions when their needs are different. Also they must be designed to provide similar interventions for women and men instead of different interventions when their needs are the same.

There should be the development of strategies that focus on increasing awareness, implementing and strengthening interventions, and expanding research related to HIV stigma and discrimination as well as sexual health and sexual right matters. In fact regarding HIV stigma and discrimination, and sexual rights of women, limited work has been done. It is therefore very necessary to encourage more research into that area.

Finally, to achieve all those recommendations mentioned above, there should be effective political commitment and good political will. It is necessary that government provide supportive environment and to ensure effective implementation of policies and laws enacted to reduce women's vulnerability to HIV infection, discrimination and stigmatization.

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APENDICES

Appendix I

Department of Geography
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Questionnaire No....

WOMEN, SEXUAL RIGHTS, AND HIV/AIDS IN THE KUMASI METROPOLIS OF GHANA

Questionnaire Survey

The main aim of this study is find out the factors that constrain women from negotiating safe sex and hence make them more vulnerable to HIV infection, discrimination and stigmatisation in Kumasi. The study is strictly academic exercise and its findings would be use for a Master Thesis in Geography at NTNU. It is guaranteed that responses provided will be treated as anonymous and cannot be traced to persons who provided them.

Section A: Background Characteristics

1. Age... <input type="text"/>	2. Size of household..... <input type="text"/>	
3. Marital status:	4. Level of education:	5. Religion:
Single <input type="checkbox"/>	No formal education... <input type="checkbox"/>	None..... <input type="checkbox"/>
Married..... <input type="checkbox"/>	Primary education..... <input type="checkbox"/>	Christian..... <input type="checkbox"/>
Separated... <input type="checkbox"/>	Secondary education... <input type="checkbox"/>	Muslim..... <input type="checkbox"/>
Widowed..... <input type="checkbox"/>	Tertiary education..... <input type="checkbox"/>	Traditional..... <input type="checkbox"/>
6. Work status:	7. Head of household:	
Formal sector <input type="checkbox"/>	Student/apprentice..... <input type="checkbox"/>	Male..... <input type="checkbox"/>
Informal sector paid.... <input type="checkbox"/>	Unemployed <input type="checkbox"/>	Female..... <input type="checkbox"/>
Self-employed..... <input type="checkbox"/>	Other (specify below)... <input type="checkbox"/> ↘	
	<input type="text"/>	
8. Average monthly personal income in Cedis... <input type="text"/>	9. Average monthly household income in Cedis <input type="text"/>	

Section B: Women’s HIV Risk Perception and Worry

10. Do you believe AIDS is a fatal disease? Yes to a strong degree... No.....
 Yes to a low degree..... Don’t know.....

11. How likely is it that you will contract HIV within a period of 5years? (Mark one of box only):

	Very unlikely				Very likely		
	1	2	3	4	5	6	7
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

12. Which one do you think you are most likely to be a victim of? Rank your alternatives from 1 to 3 with 3 being the highest rank.

HIV/AIDS..... <input type="checkbox"/>	Malaria..... <input type="checkbox"/>	Other STDs (eg.Gonorrhoea)..... <input type="checkbox"/>
Tuberculosis (TB)... <input type="checkbox"/>	Typhoid..... <input type="checkbox"/>	Traffic accident..... <input type="checkbox"/>

13. How would you consider the consequences if you contract HIV within a 5 year period?

Minimal consequences				Very large consequences		
1	2	3	4	5	6	7
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

14. How worried are you for contracting HIV/AIDS?

Least worried				very much worried		
1	2	3	4	5	6	7
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section C: Risk Tolerance, Behaviour and Need for Risk Reduction

15. To what extent do you tolerate (accept) the risk level for contracting HIV/AIDS:

	Tolerate to a very high degree				Tolerate to a very low degree		
	1	2	3	4	5	6	7
In Ghana in general.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In your local community.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

16. How many sexual partners have you had within the last 12 months?

Number of partners..... Don’t Know.....
 I prefer not to answer this question.....

17. In the past 12 months, have you had sex with anyone that you did not know anything about at that time (anonymous/ casual sex)?

Yes..... No..... I prefer not to answer.....
 If yes state the number of partners.....

18. Have you ever had sex with a man because you needed money or any other form of support from him? .

- No..... Yes, I had both protected and unprotected sex... Yes, I had protected sex...
Yes, I had unprotected sex..... I prefer not to answer this question.....

19. What measures can you take if you think your spouse/partner's behaviour is a health risk for you?

- I will demand the use of condom..... I will caution him..... I will divorce him...
I will abstain from having sex with him... I will just ignore it..... I don't know.....
Other, specify..... ↘

20. Have you made any changes in your sexual behaviour to avoid HIV?

- Yes..... No.....

21. If yes what changes have you made? Mark only one box.

- Abstain from sex..... Use condom during sex..... Have only one sexual partner ...
Other, specify.... →

22. How important do you find it that the Ghanaian Health Authorities implement counter measures to reduce HIV/AIDS risk?

- | | | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Least important | | | | | Very much important | |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Section D: Perception about women's ability to negotiate safe sex and their sexual right

23. What do you think is the most important factor that makes women incapable of negotiating safer sex?

- Low income/economic status... Lack of social power..... Cultural constraints...
Lack of self/sexual control..... Lack of legal protection... Other, Specify ↘

24. Can you rank the three most important reasons why women are unable to negotiate for safer sex? Please rank your answers from 1 to 3 with 3 being the highest ranking.

- | | |
|---|--|
| Low income/poverty..... <input type="checkbox"/> | Fear of losing the man/divorce..... <input type="checkbox"/> |
| Women's dependence on men.... <input type="checkbox"/> | Women's inability to control sexual desire... <input type="checkbox"/> |
| Low status of women in society.... <input type="checkbox"/> | Men's inability to control sexual desire..... <input type="checkbox"/> |
| Supremacy of men in society..... <input type="checkbox"/> | Other, Specify below..... <input type="checkbox"/> ↘ |

25. Apart from women's inability to negotiate safe sex, what other factor do you think is most important to make them liable to HIV infection? (Mark one box only)

- Prostitution..... Weak immune system... Cultural practices
Untreated STDs..... Unfaithful partner..... Having more than one sexual partner...
Other, specify..... →

26. Should women be given the right to make decision on sex?

- Yes, should be given full control over sex..... I'm indifferent.....
Yes, but should be given limited control..... Don't know.....
No, should not be given any control.....

27. What do you think can be done to give women control over their sex? (Mark only one box)

- Empowering them politically..... Balance male/female power relation..
Empowering them economically..... Encouraging female education.....
Breaking down cultural barriers against female... Other, specify..... ↘

28. What do you think are the most important measure that can be put in place to minimise women's vulnerability to HIV infection?

- Enactment of policy protecting women's sexual right... Increase access to resources....
Encouragement of female education..... Removal of cultural barriers...
Others, specify... →

Appendix II

INTERVIEW GUIDE FOR WOMEN AND MEN BETWEEN AGES 20 TO 39 TOPIC: WOMEN, SEXUAL RIGHTS AND HIV IN THE KUMASI METROPOLITAN AREA OF GHANA.

1. How old are you?
2. Are you married?
3. What level of education have you attained?
4. What is your religious denomination?
5. What work do you do?
6. How much are you earning per month?
7. Are you able to provide for your economic needs of your children (if a Mother) ? What economic needs are not covered?
8. If no who supports you with such needs?
9. What do you know about HIV/AIDS?
10. Do you believe that the disease exists?
11. Do you believe AIDS is a fatal disease? Give reason for your answer.
12. What do you think are the major reasons for the prevailing HIV infection level among women?
13. Which type of women do you think are most vulnerable to HIV infection in this Metropolis?
14. What kind of sexual partner do you have and how did you meet your partner?
15. Are you using any mechanism to avoid HIV infection? What are the reasons for your answer?
16. What in your view do you think makes it difficult for women to negotiate safe sex?
17. What measures can you take if you think your spouse/partner's behaviour is a HIV risk for you? Give reasons for your answer.
18. Can you insist that your spouse/partner use condom?
19. How common is sexual violence against women in this society? What are the Reasons for the violence?
20. Do most women depend on men in this society? To what extent do Women dependence on men make them vulnerable to HIV infection?
21. What in your view are some of the customs and norms in this society that make women subordinate to men? How do such customs and norms make them vulnerable to HIV?
22. Does the culture of this society give women the freedom to make decisions concerning their sexuality? Give reasons for your answer.
23. Do you believe women with HIV/AIDS usually suffer discrimination, stigmatization and rejection than the men? What are the reasons for discrimination and stigmatization against HIV/AIDS women?
24. Would you be willing to associate with women with HIV/AIDS apart from having sex, sharing razor and needles?
25. What do you think make people stigmatize and discriminate against women who test Positive to HIV.
26. What do you think make some women isolated when they test positive to HIV?
- 28 Do you believe discrimination is a violation against human right? Give reasons for

your answer.

29. What do you think can be the effect of discrimination and stigmatization on HIV/AIDS women themselves and furthermore the society as a whole?
30. Do you think it is necessary that women are given a protected right over sex? Give reasons for your answer regarding what kind of rights?.
31. What do you think could be done to prevent women from contracting HIV?

Appendix III

INTERVIEW GUIDE FOR KEY INFORMANTS

1. Age
2. Sex
3. Occupation
4. Institution/ Organisation
5. What is the status regarding legislation that gives women control over their sex in this country?
(For government key informants only)
6. What measures have been put in place by the government to protect the sexual right of women?
7. What is your organization doing to ensure that the sexual right of women is protecting them?
8. What programmes and activities is your organization undertaking to make women economically independent?
9. To what extent are such programmes making women economically independent in Kumasi?
10. What priority does your organization give to female education and why?
11. How is your organization addressing the issue of gender inequality, particularly in the areas of politics, decision making, and access to resources, culture and male /female power relations?
12. Do you have any programme and assistance for sex workers (eg.regular supply of affordable, quality condoms?)
13. How is rape issue being addressed by your organization?
14. Do you have any programme or assistance to HIV positive women?
15. Is there guideline on work practice for women living with HIV/AIDS? What Should the contents of this guideline be?
16. What is your organization doing to protect women with HIV/ AIDS from discrimination and stigmatization?

Appendix IV

INTERVIEW GUIDE FOR HIV/AIDS POSITIVE WOMEN (20-39 years)

1. How old are you?
2. Are you married?
3. What level of education have you attained?
4. What is your religious denomination?
5. What is your marital status?
6. How do you make a living?
7. How much are you earning per month if you work?
8. When was the first time you were diagnosed with HIV?
9. What was your reaction when you first got to know that you are HIV positive?
10. Before you became infected what measures you put in place to protect yourself from being infected.
11. What do you think were some of your previous attitudes that exposed you to the disease?
12. How did you get infected with HIV disease?
13. How have you been coping with the disease?
14. How do your family members and friends treat you?
15. Did you suffer any consequence after being tested positive(for example being sacked from work or school)?
16. Do you receive any assistance or support from the government and or any Organization (e.g.NGOs)
17. Do you feel you are discriminated and stigmatized? How?
16. What do you think can be done to prevent Stigmatization and discrimination against HIV/AIDS patients?

