



# **MALE ADOLESCENTS' KNOWLEDGE, PERCEPTIONS AND ATTITUDES TOWARDS HIV/AIDS PREVENTION**

*A case study of Elembelle District in Ghana*

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Abstract <p><b>Aim:</b> The aim of this study was to investigate the knowledge, perceptions, and attitudes of male adolescents towards HIV/AIDS in order to institute meaningful preventive measures for the control of HIV/AIDS in Elembelle community.</p> <p><b>Method:</b> the study employed Qualitative research approach to address HIV/AIDS prevention among male adolescents. Six male adolescents from six different villages in the Ellemebele District formed the study sample. The ages of the subjects range between 15 and 19 years. The method of collecting data was convenience sampling technique. One of the researchers obtained data through semi structured questions.</p> <p><b>Findings:</b> The results of the study clearly suggest general HIV/AIDS knowledge may be high but behavioural change is on the low side, the youth continue to practice risk behaviours. The adolescents see the disease as a threat to the society and are clearly aware of the transmission routes and prevention methods but the virus keeps on spreading among the adolescents.</p> <p><b>Conclusion:</b> Various policy makers and implementers should move beyond raising awareness to focusing on behavioural change because that is the only way to fight the spread of AIDS. Government, opinion leaders and religious bodies should show even stronger commitment in reducing the spread of HIV in the district.</p>		
Keywords Adolescent, sexual behaviour, perception, attitude, prevention, HIV/AIDS		
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## 1. INTRODUCTION

Since the first reported case of HIV/AIDS in 1981, the disease has had a devastating effect on all components of our society and has become the most deadly infectious disease epidemic in recent times. The disease is seen as a threat to the stability of entire nations and regions affecting the most productive members of the society. HIV/AIDS has become a global phenomenon, however the disease is most pronounced in developing countries particularly Sub-Saharan Africa. The spread of the disease has reached pandemic proportions in most parts of the African continent (Agyei-Mensah 2001).

The numbers of people infected with HIV keeps on increasing particularly among the young people. The estimated number of persons living with HIV worldwide in 2007 was 33.3 million. African continent alone had 22.5 million of the world's estimated 33.3 million people living with HIV/AIDS (UNSAID/WHO 2007). UNAIDS estimates showed that young people under 25 accounted for about 45% of all new HIV cases (over 6800 people become infected with HIV everyday) in adults in 2007. The disease continues to ravage Sub-Saharan Africa and it remains the most serious of infectious disease challenges in Africa. The leading cause of death in Sub-Saharan Africa is HIV/AIDS (Tanaka, Kunii, Hatano & Wakai 2007).

It is true HIV/AIDS continues to spread among the population of the outlying rural communities in Ghana, with its heavy toll on the 15 – 49 year age groups, who constitute the economically productive sector of the country's economy.

**Elembelle** community is one of the rural communities in the Western Region, Ghana which has seen increases in the spread of HIV/AIDS. The district has one of the worst HIV/AIDS prevalence in Ghana. As at 2006 it had prevalence rate of 15.5% far higher than the national average of 3.2 the same year. It is important to state that these were reported cases at the hospitals and therefore does not represent real magnitude of the problem. The high HIV/AIDS prevalence is attributed to number of factors including high influx of migrant fishermen, mining

workers, and stranded travelers at the boarder and farm laborers. ((Nzema East Municipal 2006).

Prevention supports of donor agencies and the government have been working assiduously to curb the HIV/AIDS epidemic but there has not been any considerable decrease in the prevalent rate within ellembele District. A critical question here is; what could have accounted for this? Prevalence in 15-19 years group shows an increase trend though efforts have been made to slow down the spread. Male adolescents are vulnerable and may be influenced into high-risk behaviours by cultural norms regarding alcohol use, plural or multiple partners and other aspects of social behaviour (Ministry of Health 2001, 37). The gap between male-female ratios regarding the spread of the HIV/AIDS in Ghana used to be wide but recent statistics suggests they are in close balance (Ghana Health Service, 2004). Despite this, few data exist on male adolescent involvement in contracting and transmitting the virus.

The aim of this study was to investigate the knowledge, perceptions, and attitudes of male adolescents towards HIV/AIDS in order to institute meaningful preventive measures for the control of HIV/AIDS in Elembelle community. The findings of this study can be added to the existing body of knowledge on HIV/AIDS in Ellembelle District and in Ghana as a whole. The findings of this study will help policymakers and healthcare professionals to develop adolescent-centered, all-round and intensive programs that will curtail the spread of HIV in the district.

## 2. LITERATURE REVIEW

### 2.1 HIV/AIDS – Definition

HIV is the short form of Human Immunodeficiency Virus, the virus that causes AIDS. (Levy . 1993). AIDS is an abbreviation for Acquired Immunodeficiency Syndrome. Simply put Acquired Immunodeficiency Syndrome (AIDS) is caused by the human immunodeficiency virus (HIV), which destroys the cells in the human body that combat infections. Dr. Samuel Border, formerly at the National Cancer Institute in the United States of America, reminds us the history of HIV/AIDS. He said “In June of 1981 we saw a young gay man with the most devastating immune deficiency we had ever seen. We said, we don’t know what this is, but we hope we don’t ever see another case like it again” (WHO 1994). On 5th June, 1981, AIDS was first reported in Los Angeles, California. (Centres for Disease Control 1981). According to Broder S 1984 cited by Katrak 2006, the Human Immunodeficiency Virus type 1 (HIV – 1) was discovered in 1983 as the root cause of Acquired Immunodeficiency Syndrome (Katrak 2006).

Kahende (2001), in his thesis viewed HIV/AIDS as a cause as well as a symptom of underdevelopment. Its long incubation period makes it hard to predict the social and economic effects it may have on households and national development as a whole (op.cit). The disease mostly affects individuals in their prime between the ages of 15 to 49 years and sizable number of those in this category will have major social and economic effects in the long run (World Bank 2007, International Development Committee (IDC) 2001). The United Nations International Labour Organization’s (ILO) report in Akukwe (2006), suggest that “a minimum of 26 million people worldwide living with HIV/AIDS are in the workforce with at least two-thirds of them living in Africa”. The consequence of this is that the labour force in Africa will be in jeopardy in the near future. The disease has an incubation period of about 8 years and someone infected with the virus could infect many other people (Kahende, 2001,). This means that a person infected with HIV may not show any noticeable symptoms until between 8years

to 10 years when the body's immune system can no longer withstand the HIV virus. During this time many more persons will have become infected [around 6800 new infections per day at present) USAIDS (2007)]. This creates continuing rolling burden and a vicious cycle of illness and deaths which effects could be perilous to the affected countries. This makes AIDS much more dangerous than other diseases since diseases without incubation periods can be easily identified and treated (Kahende, 2001). Cure for HIV/AIDS has not been found yet, however, anti-retroviral therapy can prolong the lives of individuals living with HIV/AIDS (Akukwe 2006). This therapy is however currently expensive and not available to majority of infected people in sub-Sahara Africa (Fry 2007).

## **2.2 Ghana in Brief**

Ghana, a country in West Africa is located bordering the Gulf of Guinea, between Cote d'Ivoire, Togo and Burkina Faso. (See figure1). According to the last census (2000), the population of Ghana is 18,912,079 and the country has an area of 239 460 square km. 31% of the total population are young people from aged 10-24 years. This percentage of young people has remained relatively the same for the last three decades. There are three main religious groups namely; Christians, Muslims and traditionalists. There are six major ethnic groups including Akan, Mole-Dagbon, Ewe, Ga-Dangme, Guan and Gurma. English is the official language, however there are over 49 local languages including Asante, Ewe, Fante, Boron (Brong), Dagomba, Dangme, Dagarte (Dagaba), Akyem, Ga, Akuapem , and others. The urban population (settlements with 5000 people or more) as at 2000 was 44%. The country is divided into ten political regions and 110 districts, with the district being the least political administration. (Ghana Statistical Service 2002). Life expectancy at birth is 59.85 (CIA world fact book, UNAIDS 2005). (See appendix 1)

Statistics show 76% of the youth is literate (UNICEF 2006). The 1992 constitution stipulates Free Compulsory Universal Basic Education (FCUBE) for all

(Government of Ghana 1992.) This constitutional right has caused increase in basic school enrollment tremendously in recent years. However, there is considerable decline in proportion after basic education. Majority of the students in secondary schools and tertiary institutions are in boarding schools which are owned by the government, private individuals or religious organizations (Ghana Statistical Service 2002).

Though Ghana is well endowed with natural resources, the country continues to depend on foreign financial and technical assistance. Agriculture is the mainstay of the economy and employs majority of the labor force. The main sources of foreign exchange include gold, cocoa production and individual remittances. (CIA world fact book.) Ghana lost her 'shining star' of Africa in 1983 as a result of microeconomic instability and unsteady growth (The World Bank 2008) yet she has approximately twice per capita output of the poorest countries in West Africa (CIA world fact book). The World Bank's country assessment places Ghana at the top of rankings in Africa and the government is making the effort to achieve the Millennium Development Goals (MDGs) and attain middle-income status by 2015 ( The World Bank 2008).

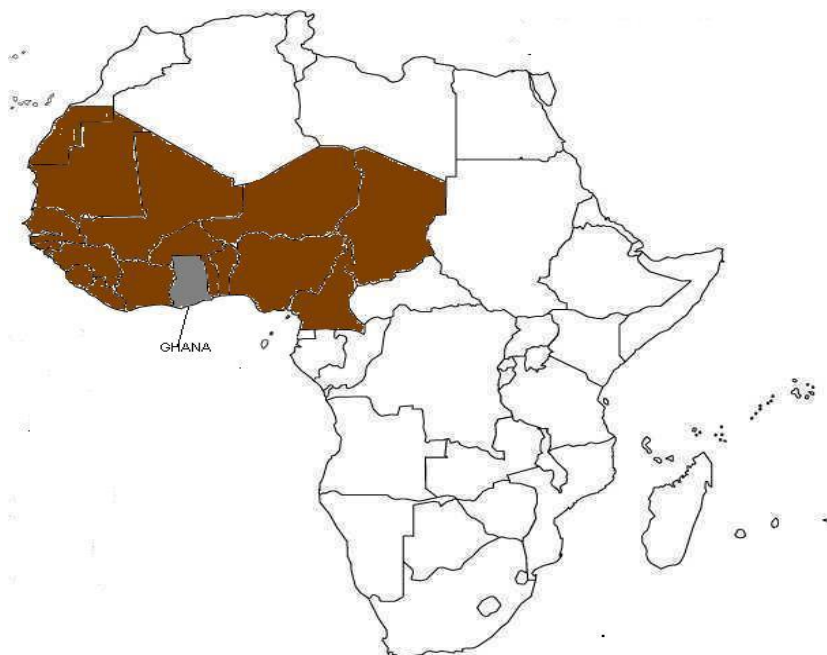




Fig1.

The illustrated map in figure 1 is Africa map and the area painted brown shows West Africa. The gray painted area within West Africa indicates Ghana.

### **2.3 HIV/AIDS in Ghana**

HIV/AIDS is increasingly becoming a major impediment to development. This has resulted in various responses particularly in developing countries to curb the spread of HIV/AIDS epidemic. The situation is not different in Ghana as the disease seems to spreading slowly but steadily since 1986 when first AIDS cases were reported (Ministry of Health 2001).

According to USAID/WHO definition, Ghana's HIV prevalence shows generalised epidemic as the disease has spread to all the ten regions as well as in all the age groups. The HIV prevalence rate has been fluctuating between 2.0% to 3.5%, from 1994 to 2004. (Ghana AIDS Commission 2004)

The number of adults and children living with HIV/AIDS in Ghana in 2004 was estimated by the government of Ghana to be 404 000 with nearly equal numbers of males and females. HIV is highest in the Eastern Region of Ghana and lowest in the northern regions of the country (MOH 2001, 15, UNAIDS 2005). In most studies which have surveyed the HIV/AIDS pandemic in Ghana, the total prevalence of HIV/AIDS is higher in urban areas, in mining and border towns, and along major transportation routes. HIV-1 is more common in West Africa and for that matter Ghana as compare to both HIV-2 and the combination of HIV-1 and HIV-2. (UNAIDS 2005.)

Heterosexual intercourse and mother-to-child transmission (MTCT) are the primary modes of transmission in Ghana. 80% of HIV cases are through heterosexual intercourse and mother-to-child transmission accounts for 15% (MOH 2001, 6-7, UNAIDS 2005, Ghana AIDS Commission 2004, 1). The connection between the prevalence of HIV/AIDS and the age is not quite

corresponding in many studies. 2003 Ghana Demographic and Health Survey (GDHS) suggest that HIV prevalence is very low among younger age groups with the exception of infants infected through their mothers (MOH 2001, 17). The infections are more common among men and women within 30-39 years and 25-34 years respectively, indicating that female are infected earlier than the males (MOH 2001, 17, UNAIDS 2005). In terms of social status, the HIV infection levels are highest in middle income and middle educated groups, with the poor and unemployed less affected. (UNAIDS 2005)

Knowledge of HIV/AIDS and modes of transmission are widespread. It is estimated that more than 95% of Ghanaians are aware of the HIV/AIDS epidemic. There are high fear and stigmatization towards and among people living with HIV/AIDS, however Ghanaians are still at risk of further HIV spread for diverse reasons including unsafe sexual practices, engaging in commercial sex, marriage and gender relations that make women more vulnerable to HIV, wrong perceptions about risky behaviours, and stigma and discrimination towards people living with HIV/AIDS. (PLWA). (UNAIDS 2005.)

HIV/AIDS is not just a medical problem; it has social, economical, security and developmental implications. The impact has a huge repercussion for development in Ghana. According to Commonwealth Rights Initiative Report (2001) "The HIV/AIDS epidemic adversely affect growth rate in complex ways not least by killing off the most productive in their prime". Life expectancy has fallen in the worst affected countries. UNAIDS and WHO have declared the pandemic to be Africa's worst killer. There is no cure yet, however, HIV/AIDS is treatable and preventable even in the poorest countries (Ayotte 2002).

#### **2.4 Impact of HIV/AIDS in Ghana**

There is no doubt Ghana already faces many serious health problems as a result of limited health resources available to care for the teeming population. With the spread of HIV/AIDS pandemic the health problems in Ghana are aggravated,

stretching the limited resources the more. With the increase in HIV/AIDS- related deaths among the adults, the number of orphans is bound to increase as well. According to MOH (2001) Reports on National AIDS and STD Control Programme “an orphan is a child under 15 who has lost either their mother or both parents to AIDS”. The number of orphans in Ghana is estimated to double by 2014 within high and low prevalence scenarios. There will be considerable pressure on social systems and families to cope with the increasing number of orphans. It is also estimated that AIDS will be responsible for 28% of deaths by 2014. (Ministry of Health 2001).

The population size and growth will be affected drastically. Without the AIDS epidemic the Ghanaian population is expected to grow to about 25 million people by 2014. However, with upsurge of AIDS-related deaths, there will be a short fall of 1.2 million persons by 2014 (Ministry of Health 2001). There will be decline in labour supply to every sector of the economy; agriculture, transport, education, health, civil service and business. The annual cost of treating the opportunistic infections resulting from AIDS patients is expected to triple by 2014. The economic implications are obvious; every aspect of the economy will suffer significantly (Ministry of Health 2001).

Ghana government has been using its available resources to contain the HIV/AIDS epidemic in the country. The contribution made by Ghana AIDS Commission as the coordinating body for all HIV/AIDS-related activities in the country is in the right direction. Its supervision on implementing National Strategy Framework (NSF) on HIV/AIDS with support of stakeholders, bilateral and multilateral partners has helped the situation. (UNAIDS 2005, Ministry of Health 2001.)

The government of Ghana aims at preventing new infections as well as mitigating the socioeconomic and psychological impacts of HIV/AIDS on the individual, families, communities and the nation at large. (op. cit.)

## 2.4 Adolescents and HIV/AIDS

Adolescence is one of the most captivating and complex transitions in the life span. It is a period of tremendous adjustment for children and parents. As children transition from childhood to adulthood, they undergo many physical, emotional and behavioral changes. These changes include; very fast physical growth, the rise of reproductive sexuality, new social roles, growth in thinking, feelings and morals. The sequence of pubertal changes is relatively predictable and consistent; however, their timing is extremely variable. (National Academies Press 1999, 1-2.)

The terms “adolescent”, “youth”, and “young people” are defined differently but these three terms are used interchangeably. According to WHO/UNICEF/UNFPA 1989 jointly refer to people between the ages of 10 and 19 as adolescents, those persons between 15 and 24 as youth and the larger group 10 to 24 as young people. These age transitions are not mutually exclusive.

Nearly 50% of the world’s population is under 25 (UNFPA 2003). The threat of HIV pandemic to young people cannot be over emphasized as UNAIDS estimates showed that young people under 25 accounted for about half of all new HIV cases in adults in 2007 and more than half of them still lack accurate and comprehensive information about how to avoid exposure to the virus(USAID 2008) . The indication that Less than 40% of young people globally have accurate and comprehensive knowledge about HIV (UNGASS indicator 13) is unacceptably low and consequently worrisome. Previous studies done in USA (DiClemente, Zorn, Temoshok, 1986; Bhattacharya, Cleland, Holland, 2000), Nepal (Mahat G & Scoloveno 2006) and Turkey ( Savaser 2003) where adolescents in those studies knew of only sexual route of transmission. There is the need to step up HIV/AIDS education among the youth particularly in Sub-Saharan Africa where various cultures frown at sex education among adolescents. Young People between the ages of 15 to 24 accounts for 30% of all people living with HIV/AIDS (UNSAIDS 2001). The disease keeps on spreading especially among young people making it even harder to control. The HIV/AIDS epidemic

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remain invisible to both young people and the society, people usually carry the disease for years without their knowledge. As a result, the epidemic is spreading among young people at an alarming rate.

In sub-Saharan Africa, the situation looks gloomier. More than half of sub-Saharan Africa have generalized HIV/AIDS epidemic, this means 5% or more of the young people are infected (UNSAIDS 2000). The youth constitute one-fifth of the world's population and nearly two-fifths in the developing countries' populations (Population Reference Bureau (PRB) 2000). All hands must be on deck to reverse the trend in order to salvage our youth from the scourge of HIV pandemic, the future looks bleak if current situation must be allowed to continue.

Young people have been designated as a group at high risk of acquiring HIV/AIDS due to their involvement in sexual experimentation and the use of recreational drugs. Vulnerability of young people to HIV/AIDS can be attributed to physical, social, economical and psychological features of adolescents (Offer, Ostrov, Howard, & Atkinson, 1988, 270 & Senderowitz, 1995). Socially and economically, most adolescents are dependent and inexperienced therefore, they are unable to protect themselves from infections, and have less access to health care than adults. Again, young people's vulnerability to HIV/AIDS increases as result of cultural practices that shape their behaviors. Adolescence is a stage where young people establish their sexual identities, in doing so they are faced with pressures from society as well as their peers. Men's sexual behavior which is usually influenced by harmful cultural beliefs about masculinity makes them not only the prime casualties of the epidemic but transmitters as well. They contribute to HIV infections in women, who often have less power to determine where, when, and how sex takes place. For example, by traditions and customs, males are allowed to have multiple partners therefore; they are more likely to spread the disease than anything else (Ministry of Health 2001).

Young people may be ridiculed by their peers for not being sexually active with multiple partners. In Nicaragua, recent studies suggest that virginity is highly

treasured among young women, however having multiple sexual partners is viewed as sign of masculinity in young men (Zelaya, Marin, Garcia, Berglund, Liljestrand & Persson 1997). Similarly, studies conducted in South Africa and Zimbabwe revealed similar results. Abdool Karim & Morar's (1995) study cited in the work of Rivers and Angleton 1999 shows that In South Africa, popularity and importance among young men are derived from having multiple sexual partners. Masculinity among young men is a commonplace in sub-Saharan Africa; girls are usually pressured to give in to sex by young people as a proof of love and obedience. Reports of sexual coercion suffered by young women in the hands of young men have been presented in many studies. Studies in Ghana (Glover, Bannerman, Pence, Jones, Miller , Weiss and Nerquaye-Tetteh J 2003) and Uganda (Koenig, Zablotska, Lutalo, Nalugoda, Wagman & Gray 2004; Polis, Lutalo, Wawer, Serwadda, Kigozj, Nalugoda, Kiwanuka and Ronald Gray R. 2009) for example, revealed sizable number of girls reported sexual coercion during their first sexual experience.

Heterosexual sex, especially with multiple sexual partners, homosexuality (Coates A 1988), intravenous drug use, cultural practices (Hrdy 1987), blood transfusion and blood products are regarded as risk factors in the transmission of HIV/AIDS (Chin J 1990). Adolescence is a period of life that can be regarded as a period of intense sexual drive, sexual and drug experimentation. Nicolosi, Leite, Musico, Anici, Gauazzeni and Lazzarin (1994) reported in their studies that the efficiency of HIV transmission from an infected male to his female partner is greater than the efficiency of transmission from an infected female to her male partner. Therefore, male adolescents are a vulnerable group at risk of contracting and transmitting HIV/AIDS. Available data on HIV/AIDS prevalence corroborates the work of Chin (1990) which estimated that during 1990s, more than half of the AIDS cases in Africa would consist of women and children. With no specific cure for AIDS and no developed vaccines, preventive measures base on information and education programmes remain the mainstay for tackling HIV/AIDS and its associated problems. Awareness programs need to be intensified to enhance

adolescents', particularly male adolescent's knowledge, perceptions, and attitudes towards HIV/AIDS.

In Ghana, the youth keeps on recording increased rate of infection. The annual report by Ghana health Service (2007) indicates prevalence in 15-19 years group is still the lowest, however it is showing an increase trend. The increase is a cause for concern because prevalence among this age group is a proxy for new infections. Again, the report indicated that prevalence in the 20-24 increased whereas prevalence in the 25-29 and 30-34 years age group showed decreasing trend (Ghana Health Service 2007. 16). This suggests that the youth are at high risk of contracting HIV apart from commercial sex workers whose vulnerability is uncomparable. The comprehensive communication program implemented by Ghana Aids commission in 2006 did not reflect in the behavioral change among the general population. Higher risk sex increased slightly in both men and women. However there was significant increase in condom use in both men and women (Ghana statistical Survey and UNICEF 2007, Ghana Aids Commission 2008, 7-8).

## **2.5 Adolescents' knowledge, attitudes, perceptions and prevention of HIV/AIDS**

HIV/AIDS has caused indescribable suffering to millions of people world wide. The fight against the scourge and epidemic of HIV/AIDS is and continue to be one of the biggest challenges facing the world today. The impact of the disease touches on the lives of the global community in different predictable and unpredictable ways. Though the severity of the crisis is obvious, biochemical and pharmaceutical development of vaccines continue to have limited success; current drugs available can suppress the virus but they do not cure HIV infections or AIDS (The National Institute of Allergy and Infectious Diseases (NIAID), 2009). Therefore, promotion of prevention strategies needs to be intensified in order to halt the spread of HIV.

It is now a common knowledge as reported in many studies that Transmission of human immunodeficiency virus (HIV) via sexual contact is the most common (UNAIDS 2002) and accounts for 75 to 85 percent of all infections (Royce, Seña, Cates, & Cohen, 1997). Over the past two decades, rates of infection with sexually transmitted diseases have continued to increase among teenagers. Roscoe and Kruger (1990) in their article titled 'Late adolescents' knowledge and its influence' concluded that although adolescents' knowledge of HIV transmission might have improved over the past few years, their risk-related behaviors remain unchanged. This, no doubt can be linked to Adolescents' sexual behavior and knowledge, attitudes, perceptions towards HIV/AIDS. Numerous studies have been done on adolescents' sexuality, knowledge, attitudes, and/or behaviors relevant to AIDS in order to improve the over all sexual behavior of adolescents. It is important at this point to consider such surveys of adolescents. A random-sample surveyed by Strunin and Hingson (1987) of 860 adolescents, 16 to 19 years of age, concerning their knowledge, beliefs, attitudes, and behaviors regarding AIDS indicated 70% were sexually active (having sexual intercourse or other sexual contact) but only 15% of them reported changing their sexual behavior because of concern about contracting AIDS, and only 20% of those who changed their behavior used effective methods.

Several prominent studies showed high engagement in unsafe sexual behaviors such as sex with multiple partners, sex with unknown persons, as well as negative views about condom use, and a low rate of behavior change even after learning about HIV/AIDS (Buysse, 1996, Gray & Saracino, 1989). This corroborates the suggestion that a moderate to high knowledge level of AIDS may not be a predictor of safe sexual behavior practices (Gray & Saracino, 1989). However, a study conducted by Roscoe & Kruger, (1990) of 300 late adolescents suggests that one-third had altered their sexual behavior as a result of fear of the disease. Available Research on the effects of beliefs of susceptibility to AIDS indicates that adolescents and adults who report high perceived risk for AIDS practice safer sexual behaviors, whereas those who perceive low risk for contracting AIDS report practicing unsafe sexual behaviors



(Gray & Saracino, 1989 Villarruel, A.M., Jemmolt, Howard, Taylor, & Bush, 1998).

Youth Education and prevention programmes have been used as the primary means of decreasing rate of HIV infections among adolescents, it can be summed up in three letters ABC(A=Abstinence, B=Be Faithful, C=Condoms). Barnett and Parkhurst (2005) have described abstinence as the best followed by faithfulness to one partner and condom use as last. Anytime ABC is mentioned Ugandan situation comes to mind, in 1991, the government, opinion leaders and the people of Uganda had the courage to change the attitudes and behaviors that were spreading the HIV. A Harvard study in Uganda finds HIV rates drop 50% within eight years. The study credits abstinence education in reducing HIV/AIDS in Uganda (Trafford 2002). Again, it has been argued that condoms have about 10-13% failure rate in preventing pregnancy and 10-20% failure rate in preventing HIV for several reasons. Museveni (2004) in his commentary on HIV titled 'Behavioral Change Is the Only Way To Fight AIDS' cited Uganda as being excellent in this direction; it has successfully managed to bring the sero-prevalence rate from 18.6% to 6.1% using just social vaccine (behavior change), approximately 70% reduction. Molomo 2008, National coordinator of NACA (National Action Committee on AIDS) said "behavioral change is the responsibility of the individual and not the community". He explained the latter could provide enabling environment within which the former can effect behavioral change. Attitudes, beliefs, and/or intentions have been described by many theories as proximal determinants of behavior. Consequently, changes in attitudes toward abstinence and condoms, and Perceptions of personal risk or susceptibility to HIV should be the main goals in any HIV/AIDS prevention programme.

### **3. AIMS AND OBJECTIVES OF THE STUDY**

The aim of this study was to investigate the knowledge, perceptions, and attitudes of male adolescents towards HIV/AIDS in order to institute meaningful preventive measures for the control of HIV/AIDS in Elembelle community. Ultimately, the study sought to provide information on appropriate intervention methods necessary for preventing HIV/AIDS among male adolescents in the community.

#### **3.1 Research Questions**

With respect to the theme of our research, the following research questions shall be addressed;

1. What knowledge do male adolescents in Elembelle district have about HIV/AIDS?
2. What are the perceptions and attitudes by male adolescents towards HIV/AIDS preventions?
3. Which preventive method(s) do they use?
4. Do they perceive any risk of contracting/getting HIV/AIDS?

## **4. RESEARCH METHODS AND DATA SOURCES**

Qualitative research approach was used to address HIV/AIDS prevention among male adolescents. Qualitative methodology or deductive approach according to Pope and Mays (1995) is used to explore, interpret or illustrate the actions and/or subjective experiences of research participants. In other words qualitative research tends to give a comprehensive data about human observations, thoughts and feelings; it tries to establish meaning from human life experiences. As the focus of our study was to investigate the knowledge, perceptions, and attitudes of male adolescents towards HIV/AIDS and its prevention, a qualitative approach allowed the participants to express their feelings and experiences genuinely(Punch 1998).

### **4.1 Setting**

The data for this research came from Ellembele which until February 2008 was part of Nzema East District. The district is located in the Western part of Ghana, about 84 kilometers from Sekondi-Takoradi, the regional capital. It is close to Ghana's borders with Cote d'Ivoire. The District is made up of 56 towns and villages with Nkroful being her capital where governance and administrative operations are undertaken (see appendix 2). As at 2000 census, it had a total population of about 52,000. The major occupations in the area are mainly Farming and Fishing. Illiteracy is one of the major problems confronting the area. Statistics proved that about 60% of the residences, particularly, the youth are illiterate, (Ellembele District Assembly). The participants were drawn from six towns and villages in the district.

### **4.2 Sampling**

Six male adolescents from six different towns and villages in the Ellembele District formed the study sample. Convenience sample technique was used to select subjects whose ages range between 15 and 19 years. The inclusion  
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criteria were male adolescents and young people aged 15 to 24 years who have lived in the district for at least five years. Excluded criteria were; males who have either high or higher education, males who speak neither English language nor Nzema. Permission was sought from the district assembly to carry out the research (appendix 3). All participants were fully informed of the expectation and time commitment involved (appendix 4) and signed a contract that guarantees anonymity and confidentiality (appendix 5). Participation was strictly voluntary.

#### **4.3 Data collection**

One of the researchers obtained data through a semi structured open questions (such as “please, tell me your beliefs and feelings about HIV/AIDS and its Preventions”) followed by probes. This method allowed the researcher to explore themes as they arise and for the participants to influence the research content of the interview (Punch 1998). All the interviewees were given information sheets each prior to the interview that spell out the purpose of the study, protection of confidentiality and storage of the data. Informed consent was obtained from all participants. The interview covered various topics including **Knowledge on HIV/AIDS, Male adolescents’ attitudes and perceptions of HIV/AIDS, HIV/AIDS prevention methods and Self-perceived risk of contracting HIV.** The length of each interview varied between 15 minutes to 35 minutes depending on the response of the participant. All the recorded interactions between the researcher and the participants were recorded and transcribed verbatim.

#### **4.4 Data analysis**

The recorded interviews were initially transcribed in the original language (Nzema) and verified for accuracy and completeness after which they were translated to English by the researcher. All the written interviews generated 15 pages, an average of two and half pages per participant. Content analysis was carried out by the researchers to analyze the data. Content analysis has been defined by several authors as a systematic research method for analyzing textual

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information in standardized way that allow evaluators to make inferences about that information (Weber 1990, 9-12 & Krippendorff 1980 21-27). This systematic, replicable technique is used to compress many words of the text into fewer content categories based on explicit rules of coding (Stemler 2001, Weber 1990, 12).

The researchers developed operational definitions of the four predetermined themes. These themes were set prior to the interviews purposely to guide the interviewer. However, the researchers were not limited to the four guided themes. Inductive qualitative content analysis was used in an attempt to produce a detailed and systematic list of categories arising from the interviews (Miles & Huberman, 1994). The researchers reviewed all transcripts carefully, highlighting all text that appeared to describe each category. All the highlighted text was coded accordingly using the predetermined themes wherever possible. Text that could not be coded into one of the categories was coded with another label that was relevant to the studies. The researchers examined the data again for each category, after coding, to determine whether sub-categories were needed for a theme. Data that could not be coded into one of the four themes were reexamined to describe different category.

The researchers used guidelines identified by Atkinson (1998) to prepare the quotations in the result. These guidelines include the use of participant's own words while using correct sentence structure and paragraph form, using standard spelling for words rather than how they sound, deleting unnecessary words, and editing for readability while maintaining the original meaning. Also this procedure allows omission of the researcher's questions and reorganization of certain words so that related subject matter remains together.

#### **4.5 Ethical considerations**

Ethical considerations were carefully and systematically adhered to before, during and after the study. Permission to carry out the research was obtained from the district assembly. All participants provided written consent prior to being involved in this study and all results were made unidentifiable prior to reporting. The interview data were not available to anybody other than the first authors. Participation was strictly voluntary.

## 5. RESULTS

After analyzing the transcript, preliminary codes were united into categories and then themes (see appendices 6 and 7. The various themes were put together in a manner that gives meaning to the entire body of data (Polit & Hungler 1993, 331-332).

### 5.1 Themes

#### Knowledge on HIV/AIDS

The results of the interviews suggest that the interviewees have basic knowledge on the HIV/AIDS. They know the meaning, courses and mode of transmission of the disease.

Half of the interviewees defined HIV as the abbreviation for Human Immunodeficiency Virus. Majority of the informants went further to explain that HIV is a virus, it attacks and destroys the immune system (the white blood cells) that fights against diseases or infections thereby making the body weak and prone to many infections. These are called “opportunistic infections (OLs)” because they take advantage of the body’s weakened defenses and develop into AIDS. All of them mentioned the causes and mode of transmission as through unprotected sexual intercourse and blood transfusion. Also sharing used blades and unsterilised equipments especially at barbering shops and multiple use of syringes and needles at the hospitals. Some of them mentioned another cause called Mother-to-Child Transmission (MTCT)

*“Some affected mothers transfer the disease to their unborn babies and other babies acquire HIV through mothers’ breastfeeding”*

They argued that unless one is diagnosed by a doctor(s), it is difficult to detect a person(s) with the disease yet recent research reveals that persistent diarrhoea,

rashes, tuberculosis, cholera, fatigue, loss of appetite cancer and many other diseases experience by a person(s) give indication that he/she has contracted the disease.

The informants also believed that HIV/AIDS is not curable but treatable. There are drugs such as anti-retroviral drugs that are used for its treatment but not all patients have access to them.

*“The drugs are very expensive so poor patients cannot afford to buy them therefore die before the 15 years period maximum allocated from the day of infection”*

### **Male Adolescent attitude and perception of HIV/AIDS**

The interviewees perceived that HIV/AIDS is real and is claiming a lot of lives particularly the energetic and working population in our society so a lot more should be done about the campaign to create more awareness and wake up the youth to believe it, particularly those who know of its existence but ignore. A number of the informants said a common slogan among the youth.

*“despite the AIDS we go fuck!”*

Literally, it means we know there is HIV/AIDS but we will still engage in sexual intercourse.

### **Prevention methods**

The interviewees mentioned the same methods of prevention of HIV/AIDS as abstinence, be faithful to your partner, condoms use, avoid using used blades and unsterilised equipment at barbering shops. However, they emphasized that, the commonly used method in Ghana is condom which the informants condemned it as the worse means of preventing the epidemic.

*“Guys like to exhibit their youthful exuberances therefore moving from one girl to the other so they go with condoms but that is not safe because the*



*condom can burst during sex which can make you catch the disease” so said two of the informants.*

Some of the interviewees stated that blood must be examined at the laboratory to ensure that it does not contain any form of disease before transfusion.

### **Self perceived risk of contracting HIV/AIDS**

This was categorized under risk and non- risk behavior of contracting the epidemic. Under the risk behavior the interviewees explained that they can contract the disease if they continue to exhibit their youthful exuberances by having sex with numerous girls without protection. Others also argued that uncontrollable alcohol drinking habit of most youth of these days is a contributory factor to contracting the epidemic. This is because once you are drunk you cannot control your emotions.

*“Whenever I am drunk, I may act abnormally and do anything stupid on bed with a woman I don’t know which can let me contract the disease.”*

The non risky behavior mentioned by the informants included being faithful to your partner, use of condom, use of sterilized instruments and above all abstinence from sex if not married which is the best among ways of avoiding the disease.

*“In Ghana, the on going campaign to create awareness of the existence of the disease and means of preventing it from the youth and all catching HIV is named ‘ABC’ meaning: Abstinence, Be faithful to your partner and Use of condom if you can not do the first two.”*

### **Stigmatization attached to the HIV/AIDS**

Another interesting theme derived during the interview was stigmatization attached to the HIV/ AIDS epidemic. The interviewees’ attitude and perception about the disease was genuine and threw more light on stigmatization of the disease. Most of the interviewees believed that people with HIV/AIDS

should not be isolated since socializing with them will not lead to infection. However they emphasized that one should be conscious of blood contact when relating with HIV/AIDS patient as it is the easiest means to contract the disease.

### **Community participation in preventing the HIV/AIDS**

Some of the interviewees suggested that another means of combating the epidemic among the adolescents and all categories of people is to encourage the youth and others to attend church or join other social clubs; this will prevent them from engaging themselves in sexual affairs. Two said churches speak against premarital sex.

*“We believe the male adolescents should be encouraged to attend church since all churches preach against fornication so that the youth will not involve themselves in sexual activities”*

## 6. DISCUSSION

### 6.1 Assessment of the research

Personal and individual nature of qualitative research usually hampers attainment of objectivity (Patton & Westby 1992). However, several techniques can be employed by researchers during and after data collection to enhance the validity and trustworthiness of research findings. Qualitative research results can be evaluated for accuracy through various means. Reliability and validity are often seen as the main standards for judging research findings. Reliability and validity of qualitative research have been discussed by several researchers but the most often quoted concept or criterion for evaluating qualitative findings and establishing trustworthiness was developed mainly by Lincoln and Guba(1985, 290). The idea of trustworthiness has four components: credibility, transferability, dependability and confirmability. In conventional criteria, they are analogous to internal validity, external validity, reliability, and objectivity. However, these criteria are not applicable to all the qualitative research methods.

Credibility is similar to “internal validity” in conventional criteria. It assesses the believability of the research findings regarding members or study participants. Lincoln and Guba (1985) argue that qualitative work consist of ensuring that the findings are reflective of the data collected. The researchers used several methods to increase credibility; all interviews were initially taped-recorded and then transcribed verbatim. Member-checking technique as advised by Kuzel and Like (1991) was continuously used during and after the interviews. Member-checking involves the researcher restating, summarizing or paraphrasing the information received from participants and making sure that what was heard or written is, in fact, correct( Kuzel & Like 1991). The recordings and the notes jotted during the interviews support the credibility of the study.

Transferability also known as generalizability is analogous to external validity. It refers to the possibility of transferring qualitative findings of one context to another. Lincoln and Guba(1985) note ; in the case of transferability, the burden of proof is placed not on the original researcher but the person seeking to make an application elsewhere. The responsibility of the original researcher ends in providing sufficient descriptive data to make such similarity judgment possible. The data generated from this study is sufficient and the researchers provided enough descriptions about the subjects, setting, procedures and the interviews.

## **6.2 General findings of the research**

The data obtained from the research signified that the male adolescents in Ellemebele District have basic knowledge and are aware of the existence of the HIV/AIDS epidemic. The informants provided enough information regarding the meaning, causes and mode of transmission and preventing methods of the disease. All the respondents believe HIV can be contracted through various ways such as; unprotected sexual intercourse, unscreened blood transfusion, sharing used blades and unsterilised instruments especially at barbering shops, multiple use of syringes and needles at the hospitals, Mother-to-Child Transmission (MTCT) is a clear confirmation of their basic knowledge on the disease. This is inconsistent with previous studies done in USA, Nepal and Turkey ( DiClemente et al. 1986; Bhattacharya et al. 2000;, Savaser 2003) where adolescents in those studies knew of only sexual route of transmission. The increase in knowledge may be attributed to several reasons; the questions asked may be different in the surveys; there has been greater awareness of AIDS today; more education programs; unprecedented reports on HIV/AIDS in the mass media; and the recency of this study (Roscoe & Kruger 1990). It is also true that HIV/AIDS is preventable and treatable but incurable (Ayotte 2002). Drugs such as anti-retroviral drugs are available for treating HIV/AIDS patients but not all patients have access to them (Fry 2007).

The analysis revealed that they know ways to avoid the HIV/AIDS including the use of condom, having one partner and abstaining from sex. Respondents' believe of condom use as the worst means is well supported by Barnett and Parkhurst (2005) describing abstinence as best followed by faithfulness to one partner and condom use as last. This can also be supported by the Ugandan situation, where A Harvard study in Uganda found HIV rates drop 50% within eight years. The study credits abstinence education in reducing HIV/AIDS in Uganda (Trafford 2002). Again, it has been argued in medical literature that condoms use is not 100% safe for preventing HIV infection for several reasons.

Another interesting revelation from the analysis is, they all perceived that HIV/AIDS is real and is claiming a lot of lives particularly the energetic and working population in our society. They described non risky behaviors as abstinence, being faithful to one partner and not sharing sharp equipment. Risk behaviors included, being infected by a partner, receiving infected blood by transfusion, hair cut or an accident. The respondents know all these yet almost all of them mentioned the common slogan among the youth "*despite the AIDS we go fuck*". It sums up the attitudes and sexual behaviour of the adolescents. This means that having adequate knowledge about HIV/AIDS may not necessarily result in an equivalent behavioral change (Roscoe & Kruger 1990).

There is the need to educate barbering shops' keepers and closely monitor them to use sterilized instruments in their shops. Single-use equipments regulations must be adhered to by health workers at the hospitals. The best protection against HIV/AIDS and future epidemics is individual and collective responsibility base on knowledge. The youth must refrain from negative attitudes and sexual behaviours that put them at high risk of getting infected. This cannot be achieved in isolation, the community can provide enabling environment within which youth can effect the change (Molomo, National coordinator of NACA). Uganda has been excellent in this direction; lessons can be learnt from it. Museveni (2004) describes behaviour change adopted by Uganda as social vaccine.

The respondents mentioned two significant aspects of HIV epidemic; community participation in preventing the spread of HIV and stigmatization which is the social impact. Half of the informants believed that people with HIV/AIDS should not be isolated since socializing with them will not lead to infection. This suggests adolescents may have poor attitude towards people living with HIV/AIDS (UNAIDS 2005). Stigmatization and discrimination affect victims of the disease culturally, socially and psychologically. The respondents' idea of encouraging the youth to attend church or join other social clubs to discourage them from engaging in indiscriminate sexual affairs is understandable. They pointed out churches speak against premarital sexual affairs. The use of popular opinion leaders and trendsetters, for example pastors, chiefs etc. within the community social networks can articulate openly the need to decrease or avoid risk behaviors among the youth.

### **6.3 Implication for practice and future research**

Revelations of this study have implications in clinical practice particularly for those working with the adolescents. Health practitioners working with the adolescents and HIV/AIDS prevention should concentrate not only on giving detailed information regarding the disease but also implement strategies that can effect significant behavioral change. Short HIV/AIDS education and counseling may increase clients' knowledge about the disease but this alone is not sufficient to promote noticeable change in risk behaviors particularly for clients with well rooted high-risk behavior habits. For example, drinking habits, use of recreational drugs and sexual behaviour practices are difficult to change. Therefore, HIV prevention programs that are likely to yield meaningful result must be intensive and all-round.

Though the study has reveal adolescents' basic knowledge about HIV/AIDS, we still think more studies can be done on the subject. For example, HIV/AIDS prevention among adolescents usually involves the implementation of programs intended to encourage abstinence and discourage early or premarital sex. Such

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approach has merit; we think research is needed to evaluate the effectiveness of abstinence intervention as compare to other approaches like condom use.

## **CONCLUSION**

The prevention of HIV/AIDS disease among the adolescent is an important contribution to reduce the spread of HIV/AIDS in Ellembelle and Ghana. The results of this study clearly suggest general HIV/AIDS knowledge may be high but behavioural change is on the low side, the youth continue to practice risk behaviours. The adolescents see the disease as a threat to the society and are clearly aware of the transmission routes and prevention methods but the virus keeps on spreading among the adolescents. Various policy makers and implementers should move beyond raising awareness to focusing on behavioural change because that is the only way to fight the AIDS. Governments, opinion leaders, religious bodies must show even a stronger commitment in reducing the spread of HIV in the district.



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## APPENDICES

### Appendix 1: Ghana at a glance

<b>Languages</b>	Asante 14.8%, Ewe 12.7%, Fante 9.9%, Boron (Brong) 4.6%, Dagomba 4.3%, Dangme 4.3%, Dagarte (Dagaba) 3.7%, Akyem 3.4%, Ga 3.4%, Akuapem 2.9%, other 36.1%
<b>Ethnic Group</b>	Akan 45.3%, Mole-Dagbon 15.2%, Ewe 11.7%, Ga-Dangme 7.3%, Guan 4%, Gurma 3.6%, Grusi 2.6%, Mande-Busanga 1%, other tribes 1.4%.
<b>Religion</b>	Christian 67%, Islam 17%, Traditional 9%
Main Exports	Cocoa, Gold, Timber
Education	Youth (15-24 years) literacy rate, 2000-2006, male - 76% Youth (15-24 years) literacy rate, 2000-2006, female - 66% Total adult literacy rate, 2000-2005 - 58% Primary school net enrolment/ attendance (%), 2000-2006 - 75
Life Expectancy	Life expectancy at birth (years), 2006 - 59
Population	Total population (thousands), 2006 - 23008



## Appendix 2: Study Area-Ellembelle



The illustrated map above is Ghanaian map and the area painted brown shows Western region. The gray painted area within Western region indicates Ellembelle District.

**Appendix 3: Permission to undertake research**

Loukkukorventie 6d A 12,  
40640 Jyvaskyla Finland.  
Tel +358440577875  
Email D1258@jamk.fi,  
2nd November, 20008.

The District Chief Executive,  
Elembelle District.

Dear sir/madam,

**PERMISSION TO UNDERTAKE RESEARCH STUDY IN YOUR DISTRICT**

We are students of Jyvaskyla University of Applied Sciences studying degree programme in Nursing. We are writing our Bachelor's thesis on the topic *"Prevention of HIV/AIDS among male adolescents in Ghana- A case study of Elembelle District"*

The purpose of the study is to investigate the knowledge, perceptions, and attitudes of male adolescents towards HIV/AIDS prevention in Elembelle District. We are therefore requesting your kind permission to collect research data in your District between the month of November and December. The research data is to be collected through interviewing, at least 5 people in your District. The selection criteria specified for this study include

- male adolescents from age 15 to 24
- male adolescents who are residents of the District for at least five years
- male adolescents who can speak either English or Nzima
- male adolescents who have neither high nor higher education.

The data is collected and used for research purposes only and will be dealt with anonymously. We are with firm conviction that this request will meet your kind consideration and approval. Thank you.

Yours faithfully,

Yaw Danso and William Ocran.

.....  
District Chief Executive  
.....

Bachelor's Thesis

#### **Appendix 4: Letter of information**

Jyvaskyla University of Applied Sciences,  
School of Health and Social Studies,  
Jyvaskyla, Finland.

Dear Participant,

#### **LETTER OF INFORMATION**

We are students of Jyvaskyla University of Applied Sciences studying degree programme in Nursing. We are writing our Bachelor's thesis on the topic "*Prevention of HIV/AIDS among male adolescents in Ghana- A case study of Elembelle District*"

The purpose of the study is to investigate the knowledge, perceptions, and attitudes of male adolescents towards HIV/AIDS prevention in Elembelle District. We shall conduct interviews for this study between the month of November and December 2008. Participation is strictly voluntary and there are no known risks to participate in the study. Participants are free to withdraw anytime and they are not obliged to answer any questions they find objectionable or which make them feel uncomfortable. The interview will last for 30minutes to 1 hour and there are no remunerations for taking part in the study. Information obtained from participants will be used purposely for this study and your confidentiality or anonymity is guaranteed.

Each participant is asked to sign a consent form to confirm their consent to the interview before commencement. Participants may contact the researchers or the district assembly if they have any questions, concerns or complaints about the research procedures.

Thank you for your participation

Yours truly,

Yaw Danso and William Ocran

Tel. +358445984277, +358440577875

Email D1258@jamk.fi and D1256@jamk.fi

**Appendix 5: Consent Form**

**CONSENT FORM**

**Title; *Prevention of HIV/AIDS among male adolescents in Ghana- A case study of Elembelle District.***

The participant's name;

I am signing this consent form to give permission to researchers undertaking this study to interview me and use tape recording equipment for research purposes. I am aware that my participation is voluntary and I can contact (researchers or the district assembly) with any question, concern or complaint that I may have. I am aware of my right to withdraw from the interview at anytime or request the researcher to switch off the recorder during the interview.

I have been assured that I cannot be identified from the results of the research data analysis and my response will not affect my status.

Date and place

signature of participant

.....

.....

Signature of student

.....  
William Ocran

## **Appendix 6: Themes**

### **THEMES**

#### **Knowledge on HIV/AIDS**

- meaning of HIV/AIDS
- Causes and transmission of HIV/AIDS
- Symptoms and treatment

#### **Male adolescents' attitudes and perceptions of HIV/AIDS**

- perceptions, experiences and attitudes about HIV/AIDS prevention

#### **HIV/AIDS preventions**

- HIV/AIDS prevention methods
- Commonly used method

#### **Self-perceived risk of contracting HIV**

- Risky behaviors
- Non-risky behaviors

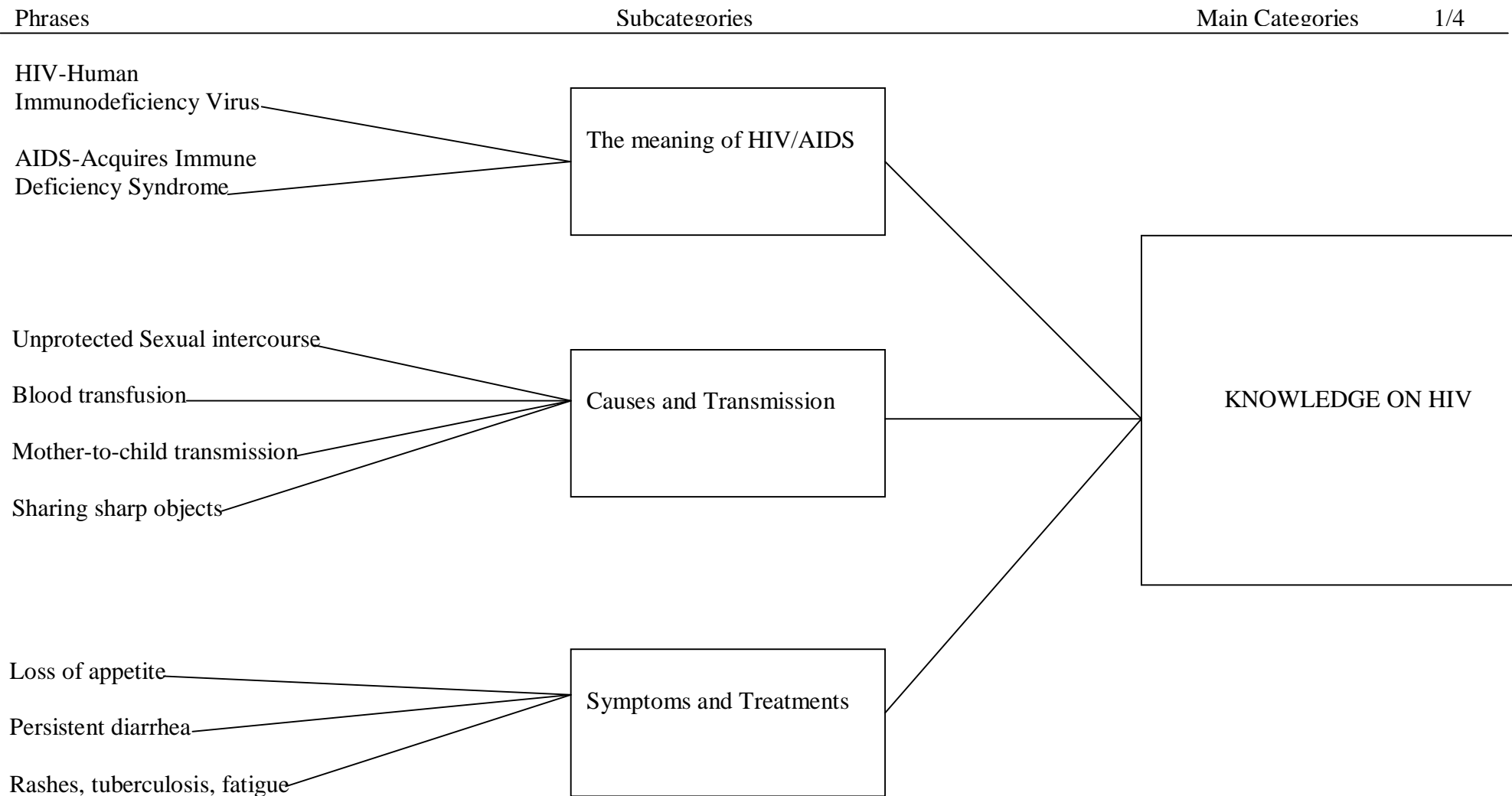
#### **Stigmatization attached to the HIV/AIDS**

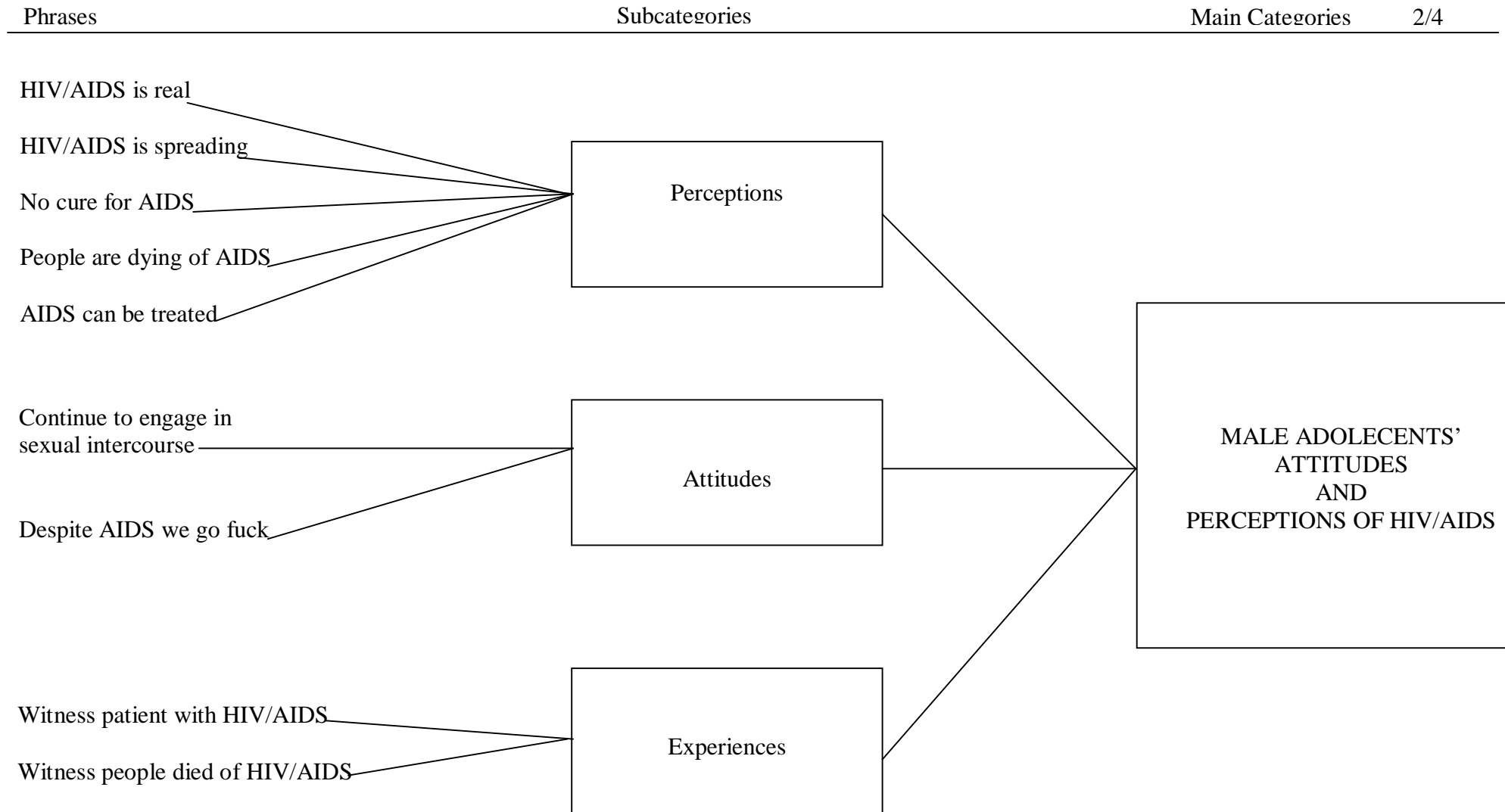
Discrimination and rejection towards HIV/AIDS victims  
Poor attitude and wrong perception about HIV/AIDS victims

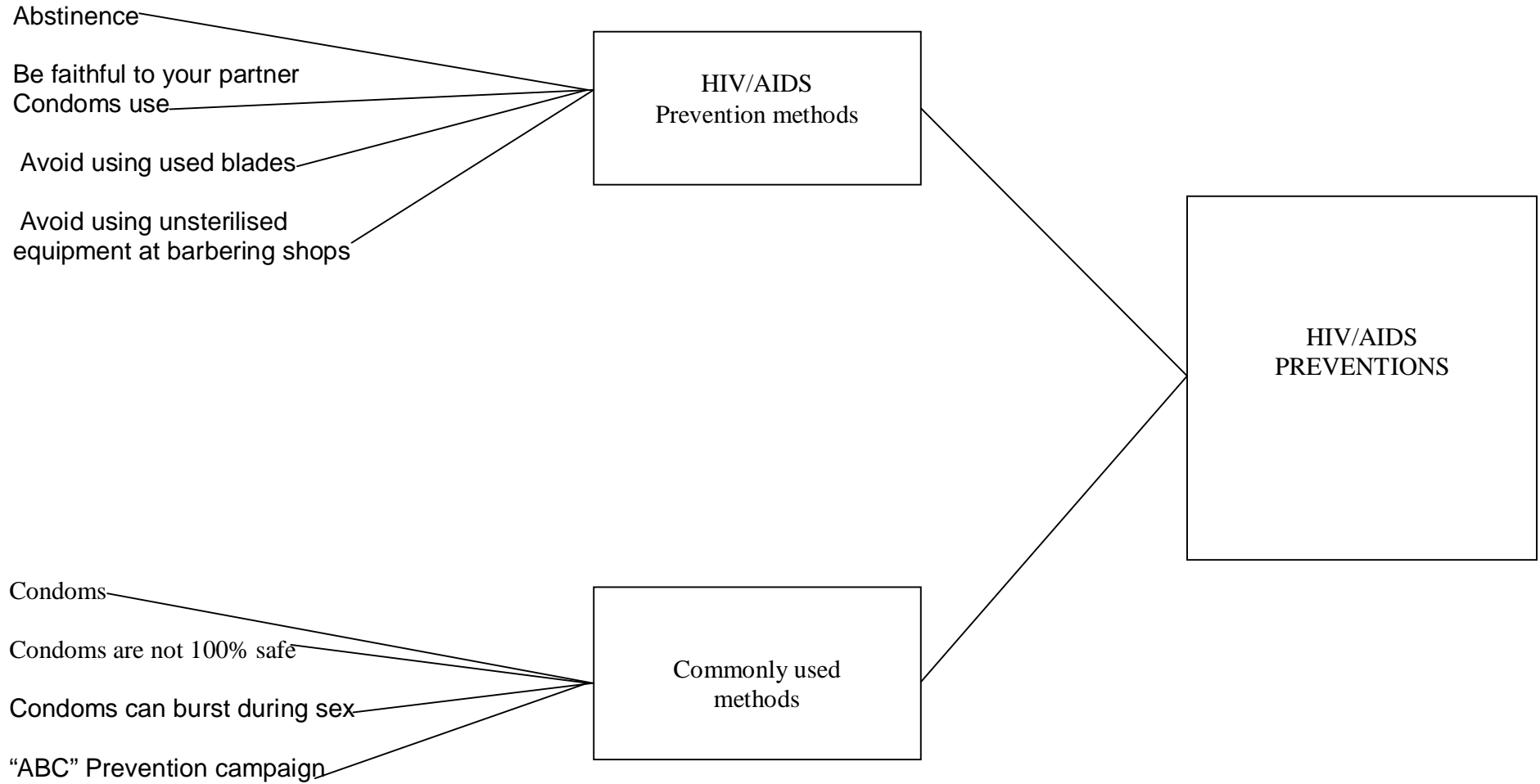
#### **Community participation in preventing the HIV/AIDS**

Youth involvement in religious and social activities in the community

## Appendix 7: Abstract of the material









Phrases

Subcategories

Main Categories

4/4

Having sex with numerous girls without protection

Uncontrollable alcohol drinking habit

Uncontrolled sexual behaviors

Risky behaviors

Being faithful to your partner

Use of condom

Use of sterilized instruments

Abstinence from sex

Non risky behaviors

SELF-PERCEIVED RISK OF CONTRACTING HIV

