

**MITIGATING THE IMPACT OF HIV/AIDS IN GHANA:  
THE ROLE OF EDUCATION**

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## **1.0 Introduction**

Since the first clinical evidence of HIV/AIDS was reported in 1981, the epidemic continues to escalate at an alarming rate and has now become a full-blown developmental crisis in the world. Africa is the most affected continent and at the end of the year 2002 she had 28.1 million of the world's estimated 42 million people living with HIV. Since the beginning of the epidemic and by the end of 2001 a cumulative 19 million Africans had already died of AIDS.

Although just 10% of the world's youth live in Sub-Saharan Africa, the region contained almost three-quarters of all youth living with HIV/AIDS in 2001 – a total of 8.6 million. That is certainly a threat to the future generation of Africa and calls for refocusing of efforts on strategies that have the potential of registering a strong impact in efforts at reducing further spread of the disease.

This paper identifies education as a strategy that can be used to mitigate the impact of HIV/AIDS in Ghana. It focuses on both formal school education and general education on HIV/AIDS.

## **2.0 HIV/AIDS Situation in Ghana**

Ghana was among the first countries in the West African sub-region that recognised the danger posed by HIV/AIDS and took a decisive step to control its spread. By December 2002, the Ministry of Health (MOH) had recorded a total of 64,316 AIDS cases since the first official case was recorded in Ghana in 1986. This means that on the average, the country has been recording about 3,783 AIDS cases annually since 1986.

Until about the year 2000, HIV/AIDS in Ghana was managed as a disease rather than a development issue. The national response has, consequently, been medically oriented and directed by the Ministry of Health. The earliest national response was the establishment of the National Advisory Commission on AIDS (NACA) in 1985 to advise government on HIV/AIDS issues. In 1987, a year after the first case was diagnosed in the country the government established the National STDs/AIDS Control Programme (NACP) under the Ministry of Health's Diseases Control Unit to be responsible for issues relating to HIV/AIDS. NACP was charged with the responsibility of reducing the transmission of HIV infection, and to mitigate the impact of the disease on human suffering. This they do through planning and managing, monitoring and evaluating all co-ordinated HIV/AIDS prevention and control activities in the country, setting up sentinel surveillance systems to monitor the transmission of the AIDS virus. Also, they provide HIV screening and counselling facilities in all Teaching, Regional and District hospitals, develop educational programmes to create awareness and increase knowledge of the disease to enhance positive behaviour change. In the year 2000 a National HIV/AIDS and STI Policy was developed backed by an HIV/AIDS Strategic Framework.

In the absence of a multi-sectoral arrangement, the NACP has not been able to reach its goals due to the extensive demands on it. It became obvious that the complexity of the HIV/AIDS epidemic requires a developmental, holistic, co-ordinated, and multi-sectoral approach to address the multi-faceted and multi-dimensional nature of the epidemic. This led to the formation of a Ghana AIDS Commission under the office of the President. Another factor identified was lack of clearly defined budget line by the

Ministry of Health to address the HIV/AIDS epidemic. Due to this handicap on the part of the Ministry of Health, sponsorship for HIV/AIDS control and prevention programmes in Ghana has largely come from Bilateral and Multilateral sources. Among the donors are the Canadian International Development Agency (CIDA), German Technical Co-operation/Regional AIDS Programme (GTZ), United States Agency for International Development (USAID), the European Union (EU), UNAIDS and Japanese Fund.

A number of NGOs and CBOs have also been working in partnership with the donors to bring HIV/AIDS control and prevention programmes closer to the people. These include Christian Health Association of Ghana (CHAG) comprising the Catholic Secretariat, Salvation Army and the Presbyterian Church. Others are Ghana Red Cross, Save the Children Fund (SCF) UK, Centre for Development of People (CEDEP), CARE International, Action AID and Stop the Killer AIDS.

In spite of these attempts, currently the MOH and NACP estimate that about 600,000 (4.6%) of the entire Ghanaian population are infected with HIV and, over 200 persons are estimated to be infected every single day. The basis for the estimates is from sentinel surveillance systems set up by the Ministry of Health in some designated hospitals and health centres in the country. Findings from the sentinel surveillance for antenatal women show that by 1994, 2.7 per cent of all pregnant women who visited these designated hospitals and health centres were tested HIV positive. The figure increased to 4.6 per cent in 1998 and is expected to increase to 6.4 per cent in 2004, 8.2 per cent in 2009 and 9.5 per cent in 2014.

The distribution of number of HIV/AIDS cases in the country varies from region to region. Currently Ashanti Region leads with 30.1 per cent of all cases followed by Greater Accra Region with 17.3 per cent and Eastern region with 14.6 per cent (Table 1). Thus, these three regions alone contain 62 per cent of all AIDS cases in the country. Table 2 also shows HIV prevalence levels by geographical belt and by regions. The table shows that prevalence is highest in the southern belt (mean of 4.5 per cent) and decreases steadily through the middle belt (3.6 per cent) to the northern belt (3.0 per cent). The pattern of distribution indicates that HIV prevalence is highest in the best-developed and economically endowed regions of Ghana.

**Table 1: Reported Cumulative Aids Cases by Region**

1986-2002		
REGION	No.	%
ASHANTI	19330	30.1
BRONG AHAFO	5262	8.2
CENTRAL	4249	6.6
EASTERN	9420	14.6
GT. ACCRA	11106	17.3
NORTHERN	3200	5.0
UPPER EAST	2836	4.4
UPPER WEST	1249	1.9
VOLTA	2423	3.8
WESTERN	5155	8.0
NOT STATED	86	0.1
TOTAL	64316	100.0

**Table 2: HIV Prevalence by geographical belt by region by site – 2002**

Belt	Mean Belt Prevalence	Median Belt Prevalence	Region	Mean Regional Prevalence	Median Belt Prevalence	Site			
Middle	3.6%	3.1%	Ashanti	3.9%	4.2%	Kumasi			
						Mampong			
						Obuasi			
			Brong Ahafo	3.3%	3.3%	Sunyani			
						Wenchi			
			Volta	3.2%	3.2%	Hohoe			
Southern	4.5%	4.1%	Central	2.6%	2.6%	Assin Faso			
						Cape Coast			
						Eastern	7.9%	7.8%	Agomanya
						Koforidua			
						Greater Accra	4.1%	4.1%	Adabraka
									Korle-bu
									Maamobi
									Tema
						Western	5.0%	2.0%	Eikwa
									Sekondi-Takoradi
Northern	3.0%	2.9%	Northern	2.0%	2.0%	Nalerigu			
						Tamale			
			Upper East	3.9%	3.8%	Bawku			
						Bolgatanga			
						Navrongo			
			Upper West	2.7%	2.6%	Jirapa			
Wa									
<b>Total</b>	<b>3.8%</b>			<b>3.8%</b>					

The Ministry of Health and National AIDS Control Programme have projected that if the present rates continue, the current estimate of 600,000 PLWHA will rise to 720,000 in 2004, and 1.36 million in 2014. It is also estimated that within the periods the number of persons infected daily will be 300 by the year 2004, 380 by 2009 and about 510 by 2014. As with the present pattern about 90 per cent of the infected persons, according to the official records with MOH/NACP, will be within the 15-49 year age group. This is the theoretical age group from which every country derives its workforce. The concentration will continue to be within the 24-39 years accounting for 59 per cent of PLWHA in Ghana. Only about 1.0 per cent of all HIV/AIDS cases

recorded are below 15 years, with the older persons (49 years and above) constituting 8.0 per cent. That is an indication that, given the long incubation period of the disease, most of the people got infected in their teen ages. We may therefore conclude that HIV/AIDS is basically a problem of the youth and as such, is a major developmental issue.

With regard to sex distribution, females are in the majority, accounting for 63 per cent of the recorded HIV/AIDS cases while males account for 36 per cent. The peak ages for females and males also differ. That is, whereas females have a concentration of infected persons in the 25-29 years age group, males are concentrated in the 30-34 years age group, implying that more young females are infected with HIV than their male counterparts.

Since its first appearance on the scene in the mid 1980s, HIV/AIDS has claimed many lives and rendered a number of children orphans. Official records show that as at 1994 7,000 persons within 15-49 years age group had died from AIDS-related diseases in Ghana. By 1999 the number of deaths resulting from AIDS increased to over 20,000 persons, and it is projected that by the year 2014 more than 1 million persons in Ghana will have died from AIDS-related diseases. As the most affected group are people in their reproductive age, more children keep on becoming orphans as parents continue to die from HIV/AIDS. As at June 1999, the MOH had recorded as many as 126,000 orphans resulting from the AIDS epidemic. This is expected to increase to 252,000 by the year 2004 and further increase to 603,000 by the year 2014.

Considering the modes of transmission of HIV in Ghana, data establish that at least 80 per cent of all PLWHA get it through sexual contact; about 15 per cent is mother-to-child transmission, while 5 per cent get it through blood contamination/transfusion.

To ensure that these projected increases do not become a reality, the government is now taking a more serious approach to combating the disease. As a first step, HIV/AIDS advocacy has been lifted to the highest political level with the formation of a National AIDS Commission chaired by the President. All sector Ministries have been instructed to incorporate HIV/AIDS activities into their programmes and to draw a budget line for such activities. A cabinet retreat was concluded towards the end of the year 2000 devoted solely to HIV/AIDS. Even more welcoming is the MOH's sponsored collaborative effort between the NMIMR and the Centre for Scientific Research into Plant Medicine (CSRPM) at trying to develop herbal medicine that could be used to combat the disease. Preliminary results that have come out are encouraging. It thus appears that Ghana's serious effort at curbing the spread of HIV/AIDS has just begun and the best perhaps lies in the future. One pointer to this is that government has noted in the Ghana Poverty Reduction Strategy (GPRS) that there is a direct relationship between good health and poverty reduction. HIV/AIDS has been singled out as a real threat to the country's development and has been given special attention in the GPRS.

### **3.0 General Linkages Between Poverty and HIV/AIDS**

The discussion on linkages between poverty and HIV/AIDS, though debatable, poses two valid and mutually reinforcing issues that suggest that the relationship between AIDS and poverty is bi-directional:

- Poverty is a factor in HIV transmission and exacerbating the impact of HIV/AIDS
- The experience of HIV/AIDS by individuals, households and even communities that are poor can readily lead to an intensification of poverty and even push some non-poor into poverty. Thus HIV can impoverish or further impoverish people in such a way as to intensify the epidemic itself. (Collins and Rau, 2000). We suggest here that the combined effect of poverty and income inequalities on social transactions – including sex, patterns of vulnerability and patterns of risky behaviour in relation to HIV infection and AIDS (See Fig. 1).

### **3.1 Does AIDS induce or deepen Poverty?**

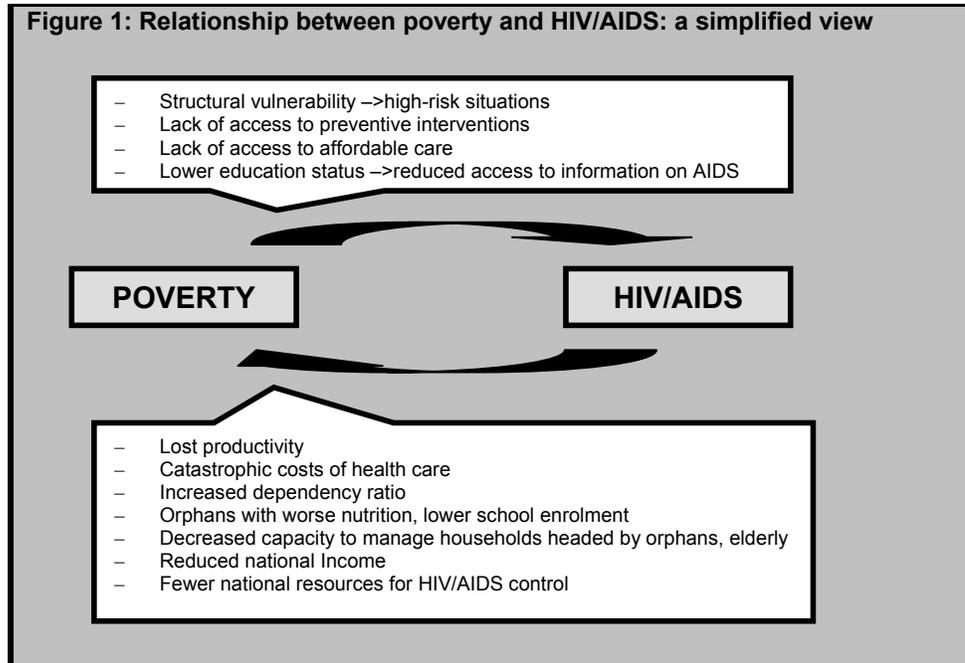
It is not debatable that AIDS is condemning millions to misery and poverty. As a clear example, for instance, AIDS has left behind 13.2 million orphans – children who before the age of 15 lost either their mother or both parents to AIDS. Many of these children have died, but many more survive (UNAIDS, 2000a). In Ghana, at the end of 2001, an estimated 200,000 children who were alive and who were below the age of 15 were reported to have lost their mother or father or both parents to AIDS. (Ghana Country Profile 2001)

Surveys of the impact of having a family member with AIDS show that households suffer a significant decrease in income and huge rises in medical care spending. Decreased income leads to fewer purchases and diminished savings. In a study in Thailand, one-third of rural families affected by AIDS experienced a halving of their

agricultural output, which threatened their food security. Another 15% had to take their children out of school and over half of the elderly people were left to take care of themselves. Families spent an average UD\$1,000 for medical care during the last year of an AIDS patient's life – the equivalent of an average annual income

In urban areas in Cote d'Ivoire, the outlay on school education was halved; food consumption went down by 41% per capita and expenditure on health more than quadrupled.

In Ghana the relatively low prevalence rate has probably not elicited impact assessment studies that clearly establishes the link between HIV/AIDS and poverty. However, Anarfi (2004) suggests that the situation of the rapid increase of orphans has led to affected family structures no longer able to cope with the needed care and support challenges. It is known that when family members in urban areas fall ill, they often return to their villages to be cared for by their families, thus adding to the pressure on scarce resources and increasing the probability that a spouse or other in the rural communities will be affected.



The foregoing is only portraying the picture of what happens at one end of a continuum; that is, when HIV/AIDS has already struck. It is also important to take a critical look at whether or not poverty either directly or indirectly, increases the likelihood of HIV infection and AIDS.

### 3.2 Does Poverty increase the Likelihood of HIV Infection and AIDS?

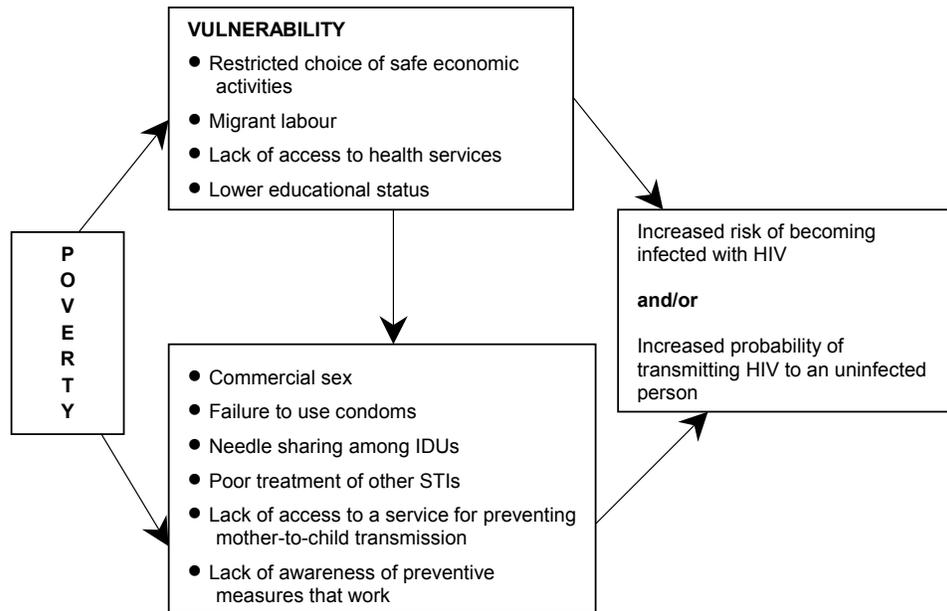
In the early years of the HIV/AIDS epidemic, it was observed that persons of higher socio-economic status were more likely than others to become infected with HIV. In the first decade of the HIV/AIDS epidemic a number of studies showed a positive correlation between HIV infection and socio-economic status, measured by schooling, income or occupation (Ainsworth and Semali, 1998) Indeed some of these studies showed that the probability of having a non-regular or commercial sexual partner rose with education, potentially increasing exposure to contracting STIs, including HIV (Filmer 1998; Deheneffe et al., 1998). Also, persons with higher education and

higher incomes have more disposable cash and are more likely to travel – thus having more opportunities for sex.

As HIV/AIDS becomes endemic in most African countries, the positive correlation between socio-economic status and HIV infection disappears. Poverty and illiteracy might be expected to raise the probability of infection with sexually transmitted diseases, including HIV/AIDS, since people with low incomes may be less able than those with higher incomes to afford condoms or STI treatment. Secondly those with little education may have less access to information about the danger of high-risk behaviour or may be less able to understand prevention messages. This explains why, for most STIs the poor and uneducated have higher infection rates (Lacy et al, 1997). It also appears to be the case for the spread of HIV in industrialized countries (Cowan et al., 1994; Krueger et al., 1990; McCoy et al., 1996). Subsequently among the issues needing attention is the combined effect of poverty and income inequalities in social transactions – including sex, patterns of vulnerability and patterns of risky behaviour in relation to HIV infection (See Fig. 2).

Controlling the disease, therefore, calls for a holistic and sustained approach aimed at influencing acceptable behavioural change in people, particularly the youth, the future generation.

Figure 2: Poverty increases the likelihood of HIV infection and AIDS



#### 4.0 The Consequences of Inaction

If levels of HIV prevalence rise in Ghana, not only will the health consequences be serious but also the demographic, social and economic consequences. On the demographic side for example, life expectancy is expected to be 57 years by 2005 because of AIDS instead of 62 years. Under low prevalence scenario, the number of total infections in Ghana would rise to 470,000 in 2009 and 568,000 by 2014. This excludes the numbers who will have died from AIDS over these periods. It is also estimated that if HIV prevalence is 4 percent in 2014 (low prevalence scenario) the annual number of deaths in age group 15-49 will reach 96,000 by 2014 an increase of 27,000 over what it would have been without AIDS.

On the social side we note that one serious consequence of AIDS deaths among adults is an increase in the number of orphans. Given the predominance of heterosexual transmission in spreading the virus, many children will lose both parents. On a low

prevalence scenario, the number of AIDS orphans would rise to 236,000 in 2014. We can expect a tremendous strain on the social systems to cope with large number of orphans and provide them with needed care and supervision. At the family level there will be increased burden and stress for the extended family as grandparents are left to care for young children with attendant inadequate health care and schooling. The number of street children will rise and child labour will become more common as orphans look for ways to survive.

Cost of health care as a result of AIDS-related opportunistic infections is expensive and can put significant pressure on the delivery of health care in Ghana. For instance Nabila, Antwi et al (2001) suggest that treatment of opportunistic infections experienced by a person living with AIDS was close to 4.2 million cedis. They indicate further that if 50 percent of all PLWA were to go for health care in a given year, the expenditure to treat opportunistic infections would rise to 167 billion cedis in 2014 and that the cost of anti-retroviral treatment for one person would cost about 45 million cedis per year.

There seems to be no data on the impact of HIV/AIDS on the various sectors of the economy. However one can infer the serious impact of the disease if infections should continue to spread. In education for instance AIDS among teachers may result in increasing absenteeism and disruption in the schools. Training cost for teachers could rise as we try to replace those lost to the disease.

On the general labour front, overall economic output can be affected through the loss of people in their most productive years. Cost of replacement of trained and skilled

workers would also be high. AIDS can also have significant impact on industries as expenditures on cost of health care increase as a result of infections, burial costs and loss of work hours due to funerals. The aggregates of these affect macroeconomic performances.

In the agricultural sector, decline in labour supply due to morbidity and mortality from HIV/AIDS will have a negative impact on production and on food supply

### **5.0 Addressing the epidemic – Education as Social Vaccination**

There is yet no cure for HIV/AIDS; that leaves education as the only social vaccination against the disease. Education here includes everything done to increase and sustain people's awareness and knowledge of HIV/AIDS towards staying away from risk behaviours. The succeeding sections focus on the need for both formal and informal education as tools for fighting the epidemic.

Given the predominant heterosexual nature of transmissions in Ghana it is important that educational efforts aim at achieving the following:

- Promoting abstinence and faithfulness
- Reducing the overall number of sexual partners
- Delaying the onset of sexual activity among adolescents
- Encouraging voluntary counselling and testing

### **5.1 The Role of Formal Education**

In 2000/2001, there were 2,955,228 pupils/students in primary, Junior and Senior Secondary Schools in the public sector alone. (MOE 2002a) This represents

significant portion of the segment of the population that offers us a window of hope. The school environment presents us opportunities to reach out to this window of hope and to get them to know about HIV/AIDS before they form their sexual habits.

The Ministry of Education (MOE) has established a secretariat for HIV/AIDS education within the Ministry and has developed a Workplace Manual for implementation of its activities involving 240,000 strong workforces. This includes 174,445 teachers and supporting staff located throughout the country. (MOE 2002b) USAID for instance has supported NGOs in developing programmes to establish HIV/AIDS clubs in schools and sensitise teachers and parents about HIV/AIDS. In addition to this, a nationwide HIV/AIDS prevention-training programme has been established in 34 teacher-training colleges and all teacher trainees are required to undergo HIV/AIDS training as part of their teacher preparation programme. (USAID Mission in Ghana: Programme Overview – Education)

These initiatives follow a USAID Mission study that assessed the knowledge, attitudes and practices of students, teachers and parents about HIV/AIDS. The results of the study showed that students in JSS were much more sexually active than expected and there were also many misconceptions about HIV/AIDS.

HIV/AIDS has been integrated in some of the subjects in the school curricular for primary, Junior and Senior Secondary Schools. It is crucial that these focus on providing skills for healthy living after school and this in itself provides us the challenge to keep these children in school for as long as possible preferably to the end of the educational ladder.

At the tertiary level, where students can be expected to be very sexually active, it is crucial that HIV/AIDS educational programmes and activities become a sustained feature on campuses especially during Hall Week celebrations and SRC activities. Training of Hall HIV/AIDS Focal persons and SRC HIV/AIDS Desk Officers can be essential tools for sustaining and coordination of activities and to provide the needed focus. In the broader perspective tertiary institutions must develop HIV/AIDS Policies that would give direction and support to initiatives and activities on the various campuses.

The serious impact HIV/AIDS can have on the education sector and the acceptance that the sector is an effective environment for the fight against the disease is recognised by the Association for the Development of Education in Africa. The ECOWAS sub-regional level of the Association held a conference on HIV/AIDS and Education at Elmina, Ghana in March 2001 for Senior Experts of the ministries of Education, other ministries, educational Institutions and International and local organisations. The Conference noted that:

*“The terrifying impact of HIV/AIDS on education demands, supply and quality requires explicit and immediate attention in national policy-making and planning. Programmes to control and reduce the threat of the virus must make maximum use of education’s potential to transmit messages on prevention and to change attitudes and behaviours”*

The action plan issued at the Conference included directives on prevention and control of spread of HIV/AIDS (See Box 1)

**Box 1****Prevention and Controlling the Spread of HIV/AIDS****It must be ensured that:**

1. Life Skills curricula (including HIV/AIDS issues appropriate to each age group) are in place in all learning institutions and that they are made examinable
2. Learner-friendly and gender sensitive life skill materials are developed and distributed, and are used
3. Young people are full participants in the response through peer education and other child-to-child or youth-to-youth activities
4. Teachers, teacher educators, school counsellors, and managers receive pre-service and in-service education and training on HIV/AIDS
5. Information, education and communication (IEC) campaigns on HIV/AIDS are implemented to reach young people in and out of school
6. Youth-friendly health education and counselling services are available locally which address problems related to HIV/AIDS, STDs and reproductive health
7. A range of partners are included in the education system's prevention work (including parents, persons living with HIV/AIDS, religious leaders, the media, local community groups, local and other NGOs, the private sector). Volunteer AIDS patients should be closely associated with the process

**Source: Association for the Development of Education in Africa: ECOWAS Experts Conference**

The action plan as noted above provides a panacea for reaching out to the window of hope before they form their sexual behaviour because once behaviours are formed, they become difficult to change. The challenge now lies in the effective implementation of these noble goals and this calls for the provision of governmental support in the provision of needed resources.

## **5.2 The Role of Non-formal Education**

Non-formal education on HIV/AIDS presents enormous challenges due its spread-out nature. This section looks at 5 areas which are seen as very crucial in the campaign

against the spread of the disease. These include the mass media, Religious Bodies, workplace activities, outside school youth centres and community-based education.

### **5.2.1 The Mass Media**

The radio, television and the print media have been the main mass communication avenues in the campaign on HIV/AIDS information, education and communication. On radio various spots as *stop AIDS love life, show compassion*, etc have been regular features in both English and in 4 local languages. Also key in radio presentations are talks, interviews and phone-in interactions and these have been regular on several FM stations across the country. These initiatives have made significant contributions in dissemination of information and education on HIV/AIDS.

Similar to radio, television spots have featured campaign programmes as indicated above for radio. However television has an added picture appeal and extremely useful especially in the urban areas where the service is available. Discussion programmes as, *Talking point on GTV, Agenda on TV 3 and Good Evening Ghana* have also been used to reach out to many people. Local Drama as *cantata* on GTV and several music videos carrying campaign messages on several TV stations have been a regular feature.

Articles from print media are used frequently in the various newspapers to reach the literate population to provide and sustain campaign messages in addition to coverage of several HIV/AIDS educational activities and programmes throughout the country.

The significant efforts of the Media in the fight against the HIV/AIDS epidemic as noted above is indeed highly commendable. These efforts have contributed in large measure in creating the high HIV/AIDS awareness levels. However, the new challenge that we are confronted with is the urgent need for the nation to translate awareness into behaviour change. It is for the media to identify the missing link in our campaign approaches that would elicit change from risk behaviours especially hanging on to multiple sexual partners and non-use of condoms. We also need to repackage our campaign efforts to enable us break through the high self-efficacy perceptions of Ghanaians. The Media need to rethink the following:

- Campaign needs to be sustained rather than start and stop approach
- Media inputs should be internally initiated rather than sponsored packages
- Programmes should be more in the local languages especially on TV
- De-emphasise the symptomatic features of AIDS and emphasise more on non-symptomatic nature of HIV

### **5.2.2 Religious Bodies and Faith-Based NGO Initiatives**

The religious bodies and faith-based organisations are key advocacy group that can play a major role in helping the society fight HIV/AIDS. Indeed Ghana is predominantly religious and this places religious bodies in good stead to be part of the national response against the disease. Religious bodies have good structures for effective education, they are easy to mobilize, their leaders elicit high compliance to directives and they have the capacity to sustain activities and to elicit behaviour change. In addition to general education to its members, one key area that religious bodies can help is care support for PLWHA. The effort here should include getting adherents to change from negative attitudes towards PLWHA.

It is acknowledged that several religious and faith-based organisations have responded to Ghana's national call and have mainstreamed HIV/AIDS into their programmes.

HIV/AIDS counselling including encouragement for voluntary testing is now provided in several religious groupings especially for prospective marriage couples. Towards effective implementation of HIV/AIDS campaign efforts, the PPAG with sponsorship from UNFPA and some collaboration from Johns Hopkins University has helped in building the capacity of Religious Bodies and faith-based organisations at various levels. These have resulted in compassion messages in churches and mosques towards positive reception of PLWHA.

As we court along with efforts to reduce the spread of the disease the role of the religious bodies remains a valuable part that should be sustained and even improved. However whilst religious admonishing on chastity and abstinence receives national endorsement, religious bodies are faced with the religiously perceived “unedifying” issue of condom use as an acceptable and effective protection against HIV/AIDS infection during sexual intercourse. This challenge remains. (See Boxes 2 and 3)

**Box 2**

*“How can I ask my members to use condoms? For what activities would I be asking them to use the condoms? Is it not sex outside marriage, which we strongly speak against? If we ask them to use condoms, are we not invariably giving encouragement and approval to the behaviour for which the condom is to be used? Knowing that some of our members engage in illicit sex is one problem, asking them to use condom is another.”*

**Box 3**

*“It is our duty to say that there are better means than the condom to protect oneself against AIDS – conjugal fidelity, that fact of having only one partner, to respect him/her, the fact of learning to be capable of expressing true love. We are in favour of the means that respect human dignity and honour the society. We therefore refuse, given our mission, to enter that logic according to which, the immediate answer to the dramatic question about AIDS is the condom.”*

**Catholic Bishops of Chad, 2002**

### 5.2.3 The Role of the Workplace

HIV/AIDS poses a major threat to the world of work because the disease largely affects the most productive segment of the labour force. In other respect the workplace becomes an avenue for effective education on HIV/AIDS. The impact of HIV/AIDS manifest in the following specific ways:

- Increased absenteeism and labour turnover
- Loss of productivity
- Loss of experienced personnel, particularly at the middle management and skilled workers levels
- Need for increased resources to hire and retrain replacements
- Increased health care and funeral costs to industries

Ghana's Workplace HIV/AIDS policy recognises that there is a strong linkage between the rate of the nation's human capital formation and its socio-economic development and that the HIV/AIDS epidemic has the potential of reversing the human capital gains made so far.

Many private companies such as Unilever, Standard Chartered Bank, Ashanti Goldfields and Bank of Ghana, Guinness and GBL/Heineken, few of the large national companies, SMEs etc have developed HIV/AIDS workplace policies and are implementing HIV/AIDS prevention, care and support programmes. Several informal groupings as Tailors and Seamstresses have been mobilising their members for HIV/AIDS sensitisation programmes.

Participation of the Public Sector comprising Ministries, Departments and Agencies appears to be now taking off. Overall, programmes have been more on awareness creation and prevention of new infections and capacity building through training of Desk Officers/Focal Persons and peer educators. The Trade Union Congress, which serves as an umbrella body for several workers in both the Private and the Public Sector, has mainstreamed HIV/AIDS into its activities.

We suggest that the workplace offers us unique opportunities for effective educational campaign due to easy access to employees and good avenue it provides for sharing information.

#### **5.2.4 Youth Centres and Community-Based Education**

Planned Parenthood Association of Ghana (PPAG) Youth Centres known as Young and Wise Centres offer a good example of how young people who constitute the window of hope can be reached. The Centres create opportunities for the youth to meet, interact and be provided with information on HIV/AIDS and reproductive health through youth-friendly approaches. The Centres have the potential to register significant impact in HIV/AIDS behaviour change advocacy and sensitisation. Serious efforts should therefore be made to replicate the approach in all Regional and District capitals in the country.

Community-based educational approaches work quite effectively. It creates opportunities for community members to ask questions and get answers that give better understanding into issues. It also enables misconceptions to be cleared. (Appiah and Afranie, 2000). It is acknowledged that several NGOs and CBOs are working in many communities in Ghana and it is important that the efforts be sustained.

#### **6.0 Strategies that do not work and those that work**

As we forge towards effective educational approaches it is important for us note that several factors can diminish AIDS educational efforts whilst other can enhance them.

(See Box 4)

**Box 4****Strategies that do not work**

- Focusing narrowly on health aspects of the epidemic without also considering other aspects as living standards
- Failing to reach secondary audiences, such as parents, as well as people at risk of HIV infection and transmission
- Denying information to young people that would help them protect themselves from HIV Infection.
- Failing to Address the Root Causes of Vulnerability
- Stigmatising People Infected with HIV/AIDS
- Designing Programmes for youth without involving youth themselves

**Strategies that Work**

- Advocacy and enabling environment
- Peer education
- Access to Condom and other Safe Sex Practices
- Voluntary Counselling, testing and referrals
- Livelihood approaches
- Involving Parents and Families Reaching Youth At Special Risk
- Building partnership with youth

**7.0 Summary and Conclusions**

Although HIV/AIDS is threatening every part of the world, Africa is the hardest hit since it carries 70 percent of the World's 42 million people living with the disease. The situation is made worse by the realisation that the most productive segment of the population is affected.

In Ghana it is estimated that about 600,000 (4.6%) of the population are currently infected and not less than 200 persons are infected everyday with heterosexual transmission accounting for 80 percent of infections.

Though Ghana's prevalence rate can be said to be comparatively low, a comprehensive national response strategies and programmes have been put in place and spearheaded by the National AIDS Commission with the President as Chairman. Indeed Ghana recognises that HIV/AIDS is a developmental issue just as it a health problem.

Subsequent to that, the Government of Ghana has acknowledged in the Ghana Poverty Reduction Strategy that there is a direct relationship between good health and poverty and that HIV/AIDS is seen as a real threat to the country's development.

Ghana's HIV/AIDS-development linkage finds context within general discussions on causal linkages between poverty and HIV/AIDS and HIV/AIDS and poverty. Though such discussions tend to be inconclusive, there are lines of agreement that poverty is a factor in HIV transmission and also that the incidence of HIV/AIDS can lead to an intensification of poverty or predisposition to poverty.

Whilst the discussions go on, the devastating impact of the disease is acknowledged and the consequences of inaction could be severely damaging. For instance Ghana's life expectancy could be lowered to 57 years by 2005 instead of expected 62 years and the number of orphans would rise to 236,000 in 2014 even on low prevalence scenario. HIV/AIDS infections can put sever pressure on the health delivery system and education, labour in general and agricultural output would be affected through the loss of people in their most productive years.

Halting the spread of the disease remains very urgent and this paper identifies education (both formal and non-formal) as one effective social vaccination by which HIV/AIDS can be addressed. Efforts here should aim at promoting abstinence and faithfulness, reducing the overall number of sexual partners, delaying the onset of sexual activity among adolescents and encouraging voluntary counselling and testing.

**Formal education** can draw on the 7 million learners and 240,000 workforce in the education sector. The learners especially are the window of hope and the school environment, which is a cycle, offers opportunities for us to reach out to especially the very young ones before they form their sexual habits.

The Education sector has already integrated HIV/AIDS into the school curricular for teacher-training institutions and primary, junior and senior secondary schools and this need to be strengthened to ensure that the desired behaviour formation and or change is impacted. USAID sponsored HIV/AIDS clubs in schools and prevention programmes in teacher training institutions are noteworthy and compliments education sector efforts which includes workplace education for teachers and support staff.

At the tertiary level HIV/AIDS programmes can become key in JCR and SRC activities and the Universities can formulate HIV/AIDS policies that can guide both student and worker initiatives.

The challenge then lies in our ability to keep the children in school and to show commitment in implementing and evaluating the programmes that have been put in

place. The ultimate goal is to get the children to carry into life what they have learnt in school with regard to safe sexual habit.

**Non-formal education** offers a broad environment within which to carry out HIV/AIDS education as well as diverse challenges. These include the mass media, religious environment, workplace environment, youth centres and community-based education.

The **mass media** covering radio, television and print have been in the forefront in the campaign against HIV/AIDS. Programmes have been diverse and included talk shows, interviews, phone-ins, drama, feature articles and music videos carrying messages.

These efforts have been instrumental in helping us to achieve significant HIV/AIDS awareness. The challenge now lies in re-focusing and re-packaging programmes to elicit desired behaviour change currently seen as not correlating high awareness levels. In refocusing and repackaging, the media should look at running more programmes in the local languages and limit emphasis on the symptoms of AIDS and raise more awareness on the deceptive non-symptomatic nature of HIV.

**Religious bodies and faith-based** organisations have good structures for effective education. Their membership is easy to mobilise and the leaders enjoy respect and compliance. They also have the capacity - financial and physical structures - to sustain programmes and to elicit behaviour change. Educational efforts should

therefore make good use of these bodies given the strength in their numbers and cohesiveness.

We note however that condom use is a key campaign point in efforts at reducing the spread of infections. Religious bodies do not favour use of condoms and this constitutes a challenge that confronts the use religious platforms for HIV/AIDS education.

**The workplace** is another avenue that offers a ready platform for effective HIV/AIDS education. Already many workplaces in the formal sector are developing workplace policies and implementing programmes. We will achieve significant results in behaviour change by using the workplace platform because of easy access to employees and opportunities for sharing information among themselves.

The emergence of associations of persons engaged in private/individual enterprises as tailors, seamstress, hairdressers, etc also makes it easy for such groupings to be mobilised for education and sharing. The importance of such groupings lies in their ability to reach out to many others who are their clients.

Outside the school environment there must be other opportunities to reach out to the **youth** for education and sharing of information. PPAGs young and wise centres offer a model for replication in all Districts in Ghana. Such centres appeal to the youth and gives them opportunities to learn and share in styles that are friendly to them.

Several educational efforts, especially through the mass media appear detached from communities. We suggest that **community-based education** work better because it gives person-to-person opportunities to share information and to clear misconceptions.

HIV/AIDS education with the environments discussed would be enhanced within the following framework:

- Advocacy and enabling environment
- Peer education
- Access to Condom and other Safe Sex Practices
- Voluntary Counselling, testing and referrals
- Livelihood approaches
- Involving Parents and Families in Reaching Youth at Special Risk
- Building partnership with youth

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