



All communications
should be addressed to the
General Secretary

**AWARENESS AND USE
OF HIV/AIDS PREVENTION
METHODS AMONG
TEACHERS AND EDUCATIONAL
WORKERS IN GHANA**



**SURVEY REPORT
DECEMBER 2008**



All communications
should be addressed to the
General Secretary

Ghana National Association of Teachers (GNAT) &
Teachers and Educational Workers' Union (TEWU)
of Ghana Trades Union Congress



**Ghana National Association of Teachers (GNAT) &
Teachers and Educational Workers' Union (TEWU)
of Ghana Trades Union Congress**

**AWARENESS AND USE OF HIV/AIDS
PREVENTION METHODS AMONG
TEACHERS AND EDUCATIONAL WORKERS
IN GHANA**

SURVEY REPORT

2008

Contributors

Research Team

Dr. Yaw Baah (Deputy Secretary-General, formerly the Director of Labour Research & Policy Institute, Ghana Trades Union Congress), **Edward Fokuoh Ampratwum** (Researcher), **Kennedy Atong Achakoma** (Researcher) and **Harriet Botchway** (Research Assistant) all of the Labour Research & Policy Institute of the Ghana Trades Union Congress

Planning & Coordinating Team

Helena Awurusa (Gender and HIV Desk, Ghana National Association of Teachers)

M.S. Bogobiri, Deputy General Secretary, Teachers and Educational Workers' Union of Ghana Trades Union Congress

John Nyoagbe (Deputy General Secretary, GNAT)

James Fokuoh, Deputy General Secretary, GNAT)

Haruna Ibn Hassan (District Education Office, Amasaman)

Leticia Hammond (National Treasurer, GNAT)

Supervisory Team

Irene Duncan-Adanusa (General Secretary, Ghana National Association of Teachers)

Dan Ayim Antwi (General Secretary, Teachers and Educational Workers' Union of Ghana Trades Union Congress)

Table of Contents

Summary.....	4
Part 1:	
Introduction.....	6
Data.....	7
Structure of Report	9
Part 2: HIV/AIDS in the Education Sector:	
A Review of the Literature.....	10
2.1 HIV/AIDS in Africa	10
2.2 HIV/AIDS Epidemic in Ghana	10
2.3 HIV/AIDS and the education sector in Ghana	12
Part 3: Analysis of Survey Results	17
3.1 HIV/AIDS awareness among teachers and educational workers in Ghana.....	17
3.1.1. HIV/AIDS Awareness.....	17
3.1.2 Sources of Information about HIV/AIDS.....	18
3.2 Direct Experience with HIV/AIDS.....	20
3.3 Access to HIV Education, Testing and Counselling.....	23
3.4 The Use of HIV Prevention Methods.....	27
4.0 Conclusion	30
References.....	31

SUMMARY

This is a report of a survey conducted to reassess the level of awareness of HIV/AIDS and the use of HIV/AIDS prevention methods among teachers and other workers in the education sector in Ghana. The present survey is a follow-up to a similar survey conducted in 2007 to assess the level of awareness of the disease in the education sector and the needs of teachers and educational workers living with HIV or AIDS.

These surveys are the results of efforts of Ghana National Association of Teachers (GNAT) and Teachers and Educational Workers Union (TEWU) of the Ghana Trades Union Congress to provide the necessary information which can serve as basis for unions' policies to support their members infected or affected by HIV or AIDS.

The 2007 and 2008 surveys have revealed that, generally, the level of awareness of HIV among

teachers and educational workers is very high.

The majority of survey participants (over 80%) rely on television or radio for information on HIV/AIDS. Newspapers and information from other people are also important sources of information of the pandemic.

In terms of direct experience with the disease, about a third of the respondents indicated that they knew someone living with the HIV virus in the general population but just about one in ten people knew a teacher or educational worker living with the virus. A relatively high percentage (57.9%) of the respondents in the present survey knew someone who had died of AIDS. This represents a rise of about five percentage points over the corresponding figure in the 2007 survey. A small fraction (less than 2% in the 2008 survey and 0.8% in the 2007 survey) knew someone living with the virus in their places of work. A higher proportion of those known to be living with HIV or died of AIDS were females (63.8%) compared to males (36.3%) in the 2008 survey.

Nearly 46% of the sample (in the 2008 survey) said they got information about the people they knew to be living with HIV or died of AIDS “through rumours” and 13.5% got their information directly from HIV victims. This is an indication that still a relatively small fraction of those suffering from the disease have the courage to disclose their status.

In terms of access to HIV-related education, the results are very encouraging. Over three quarters of the samples for both the 2007 and 2008 surveys said they have had access to HIV awareness programmes. But testing and counselling are still problematic (less than a third of the sample had tested for HIV or attended counselling) although the results show some improvement between 2007 and 2008. Our results show a more positive response to testing and counselling from females compared to their male counterparts. The rate of increase of the proportions of females that attended counselling and tested of HIV was much higher compared to the rate for their male counterparts.

The results further suggest that abstinence from casual sex is the most popular method of prevention among teachers and educational workers. This is followed by the use of condom. The response pattern is not very different when the data are analysed by sex, by age group, and by marital status. Among all these sub-groups of the sample, abstinence from casual sex seems to be very popular.

PART 1: INTRODUCTION

This is a report of a survey conducted to reassess awareness of HIV/AIDS and the use of HIV/AIDS prevention methods among teachers and other workers in the education sector in Ghana. This survey is a follow-up to a similar survey conducted in 2007 which focused on the assessment of the needs of teachers and educational workers living with HIV or AIDS to provide the basis for planning and developing union policies to support them¹. The 2007 study also covered, to some extent, the awareness and use of HIV prevention methods among teachers and educational workers. This allows us to compare the results over time.

The study is one component of a broader *Education for All and HIV/AIDS* (EFAIDS) programme being implemented by the Ghana National Association of Teachers (GNAT) in collaboration with the Teachers and Educational Workers' Union (TEWU) of Ghana TUC to:

- Create consensus views of union members on EFAIDS issues;
- Increase awareness of the role of unions toward the achievement of the Education for All (EFA);
- Eradicate HIV/AIDS-related stigma and discrimination within the education sector in particular and in the Ghanaian society in general;
- Develop a national policy agenda concerning EFA and teachers;
- Improve care and support for infected and affected teachers and educational workers; and to
- Mobilise membership of GNAT and TEWU around EFA.

A number of activities have been planned under the EFAIDS programme. They include:

- Drafting a union policy on EFA that seeks to motivate teachers to remain in the classroom;
- Publish and distribute the union policy on EFA within the education sector;

¹ The results of the 2007 survey were compiled by Dr. Yaw Baah, Kwabena Otoo and Luise Jarl of the Labour Research & Policy Institute of the Ghana Trades Union Congress. It was entitled "An Assessment of the Awareness of HIV/AIDS and the Needs of Teachers and Education Workers Living with HIV/AIDS in Ghana: Survey Results". The survey was coordinated by Helena Awurusa, The Gender and HIV/AIDS Coordinator of the Ghana National Association of Teachers (GNAT).

- Develop union's workplace HIV policy with emphasis on the elimination of stigma and discrimination;
- Implement the GNAT EFAIDS Workplace Policy;
- Disseminate information within union structures on issues involving care and support for the infected and affected members of GNAT and TEWU;
- Conduct a survey to determine the number of teachers leaving the classroom for other jobs within Ghana and the reasons for their exit;
- Conduct research on supply and demand of education;
- Organise training workshops for members to support EFA; and
- Organise training workshops for teachers on HIV and STI Prevention using the EI Exercise Book

The present survey is part of the activities planned within the broader EFAIDS programme with the overall objective of making education accessible to all and stopping the spread of HIV.

Data

Like the 2007 study, a questionnaire survey approach was adopted for the present study. This survey was designed to cover 500 teachers and educational workers in the ten regions in Ghana compared with the coverage of 681 in the 2007 survey. Out of the 500 questionnaires that were distributed among teachers and educational workers 420 completed questionnaires were returned. The distribution of the 420 respondents by region, sex and age are shown in Tables 1.1, 1.2 and 1.3 respectively. The mean and median ages of the sample were 40.6 and 40 years respectively. Seventy-eight percent of the respondents were aged between 18 and 49 years (the more vulnerable age group); and 22% were between 50 and 60 years. Seventy-four percent were married and 26% were either single or widowed. Among the males 81% were married and among the females 66% were married.

Table 1.1: Distribution of Survey Respondents by Region

Region	Frequency	Percent
Western Region	4	1.0
Central Region	48	11.4
Greater Accra Region	96	22.9
Eastern Region	91	21.7
Volta Region	11	2.6
Ashanti Region	55	13.1
Brong Ahafo Region	28	6.7
Upper West Region	72	17.1
Upper East Region	15	3.6
Total	420	100.0

Source: Survey Data

Table 1.2: Distribution Survey Respondents by Sex

SEX	Percent
Male	53.0
Female	47.0
Total	100.0

Source: Survey data

Table 1.3: Distribution of Survey Sample by Age

Age Group	Percent
Between 18 and 49 years	78
50 years and above	22
Total	100%

Source: Survey data (2008)

Information collected from the survey (i.e., the primary data/information) was complemented with further (secondary) information obtained from extensive review of the literature on HIV/AIDS in the education sector not only in Ghana but in the West African sub-region. These two sources of information therefore provide the basis for this report. Where appropriate or necessary, the analysis of the data is done by sex, by age group and by marital status to highlight the differences or similarities between males and females, between those in the more and less vulnerable age groups (i.e., 18-49 year group and those who are 50 years or above) and between those who are married and those who are single. As noted above, the availability of the results from the 2007 survey allows us to do a comparative analysis with the results of the present survey as and when necessary.

Structure of the Report

The report is structured as follows: The next part (Part 2) presents the results of a review of the literature on HIV/AIDS focusing on the education sector. Part 3 discusses the findings of this survey. Where appropriate the results of the present survey have been compared with the results of the 2007 survey (mentioned above). Part 4 is the conclusion.

PART 2: HIV/AIDS in the Education Sector: A Review of the Literature

2.1 HIV/AIDS in Africa

HIV and AIDS is unprecedented in the history of Sub-Saharan Africa in terms of its impact on the social and economic wellbeing of the people in the region. Millions of Africans are infected with the virus. AIDS has become a leading cause of death among individuals between the ages of 15 and 49 years in the sub-region along with malaria and other communicable diseases (Stone, 2002).

The UNAIDS (2008) estimates that 67% of the global total of 32.9 million people living with HIV lives in sub-Saharan Africa. Three quarters of all AIDS deaths in 2007 occurred in the region while an estimated 1.9 million new HIV infections were recorded in 2007 alone. Currently, it is estimated that 22 million are living with the HIV virus in the sub-Saharan African region.

The prevalence of HIV however varies across countries within the sub-region. Adult HIV prevalence is below 2 percent in several countries in West and Central Africa and in the horn of Africa. But HIV prevalence exceeded 15% in seven southern African countries namely Botswana, Lesotho, Namibia, South Africa, Swaziland, Zambia, and Zimbabwe and was above 5% in seven other countries including Cameroon, the Central African Republic, Gabon, Malawi, Mozambique, Uganda, and the United Republic of Tanzania in 2007 (USAID,2008).

2.2 HIV/AIDS Epidemic in Ghana

The HIV pandemic continues to challenge the health and development of Ghana. Between 1986 (when the first case of HIV was recorded in Ghana) and 2006, 121,050 cases of AIDS were reported by the Ministry of Health. In 2007 it was estimated that 312,030 Ghanaians (290,202 adults and 21,828 children) were living with HIV (Djokoto, 2008). In 2006 18,535 people died of AIDS. The corresponding figure for 2007 was 16,000 (representing nearly 14 percent reduction of the 2006 figure).

HIV/AIDS prevalence in Ghana was estimated at 1.9 percent in 2007 representing a decline from the 3.6 percent in 2004 and 2.22 percent in 2006. HIV prevalence among pregnant women, according to the 2007 HIV Sentinel Survey Report, also decreased from 3.6 percent in 2006 to 2.6 percent in 2007. Those who are most vulnerable to the disease include sex workers, transport workers, prisoners, sexual partners of people living with HIV/AIDS, and men who have sex with men and their female sexual partners (Fobil and Soyiri, 2006).

HIV prevalence in Ghana varies considerably across geographic regions, gender, age, occupation, and to some degree, urban-rural localities (Djokoto, 2008). In southern Ghana, prevalence rates vary from 3.0 to 6.5 percent while in the northern regions it averages 1.8 percent (IRIN, 2008). In the urban, mining and border towns, and along main transportation routes, prevalence is generally higher. In Ho, the capital of the Volta region, for instance, 5.8 percent of the people tested HIV positive and in Tema, Ghana's main harbour city, 6.4 percent of the people tested HIV positive (IRIN, 2008). The relatively high prevalence rate in the southern part of the country compared to the rate in the northern parts has been attributed partly to the relatively high urbanization rate in the south and to migration. Southern Ghana receives most of Ghana's foreigners and migrants from other parts of the country. Sex tourism has also been an issue of concern in these areas. Eastern region has the highest prevalence rate (7.9%) followed by the Western Region (5%) while the Northern (1.4%) and Upper West (1.3 %) have the lowest rates (see Djokoto, 2008; Fobil and Soyiri, 2006).

In terms of HIV prevalence among the age groups, those aged between 15 and 49 have a prevalence rate of 4.5%. Those in the 15 -19 year age group had 0.8 % prevalence rate in 2005 and 1.4% in 2006 while those in 20 and 24 year group had 2.4% in 2005 and 2.9% in 2006) (see Djokoto, 2008). incidence of new infections in 15 to 49 year age group is due to high sexual activity.

The declining trend of HIV prevalence in Ghana has been attributed to a number of factors. The Institute of Statistical, Social and Economic Research (ISSER) of the University of Ghana attributes it to the increase

in funding for HIV/AIDS-related activities in the country and the government's response to the HIV epidemic. A national AIDS spending assessment carried out by the Ghana AIDS Commission with the support of USAID showed that the total expenditure on HIV/AIDS-related activities increased from US\$28,414,708 in 2005 to US\$32,067,635 in 2006 (representing a 11.4 percent increase during the one year period). The total spending on people living with HIV (PLWHIV) increased from 17 percent of total expenditure in 2005 to 30 percent of total expenditure in 2006 (ISSER, 2008). Djokoto (2008) agreed with ISSER but placed more emphasis on the effectiveness of specifically targeted interventions in higher prevalence areas by the Ghana AIDS Commission. Fobil and Soyiri (2006) attributed the declining trend of HIV prevalence rates to the political commitment and government's effort to operationalise the National Strategic Framework through multi-sector collaborations.

Other reports have, however, contested the claim that HIV prevalence in Ghana is on a decline. According to the USAIDS, the availability of new methodologies for estimating HIV prevalence, in particular the application of the UNAIDS/WHO Epidemic Projection Package may account for the change in the figures. This, in their view, does not represent a reduction in HIV prevalence but rather it is due to the change in methodology (USAID, 2005).

2.3 HIV/AIDS and the education sector in Ghana

All sectors of society have been affected by HIV but its impact on the education sector in particular has been the focus of attention (Fobil and Soyiri, 2006). The impact of HIV/AIDS on education in sub-Saharan Africa is particularly alarming compared to other sectors because of its negative effects on human development (Tamukong, 2004). In spite of the obvious unanimity on the gravity of the situation and the urgent need to seek mitigation strategies and solutions the lack of comprehensive and reliable data constraints the effective evaluation of the impact of HIV/AIDS on education systems in countries in the sub-region (Fall, 2002); Kelly, 2000).

Some estimates suggest that HIV prevalence rates in the education sector in the sub- region is twice as high as the national average despite a high rate of awareness in the sector (Boler, 2003). In a study of six West African countries in 2004, Tumokong (2004) reports that HIV/ AIDS infection rates in the education sector in some countries were not significantly different from the national averages in Senegal (0.5%); Nigeria (5.8%); and Cameroon (11.8%). However, this was not the case in Ghana where, according to Tumokong (*op cit.*) the education sector has a prevalence rate of 9.2 % while the national prevalence rate was 3.0 in 2004.

Summarizing the HIV/ AIDS situation in West Africa, Baku (2001) identified four factors that facilitate infection among teachers: (i) The frequent transfer of teachers from school to school and village to village; (ii) the higher social prestige of teachers; (iii) higher disposable incomes compared to other social groups and; (iv) the 'promiscuous nature' of a good number of them. In Burkina Faso, for instance, Catraye et al. (2001) and Dakuyo et al. (2002) identified two main causes: (i) male teachers are forced to leave their wives behind when they are sent to work in remote areas and; (ii) young unmarried teachers tend to engage in unsafe sex. CILUS (2002) in trying to identify the causes of such a situation in Cote d' Ivoire reported that young male teachers engage in risky sexual behaviour with multiple partners claiming to be "living their youth". The young unmarried female teachers also say they are looking for "self-discovery" and claim that experiencing sexual intercourse with multiple partners is one way of discovering the self. In both situations described by CILUS, male and female teachers reported low rate of condom use.

Statistics on HIV/ AIDS prevalence among teachers in the sub-Saharan African region are not available. Dakuyo et al. (2002), however, gave some indication of rates among teachers in Burkina Faso when they reported that 1,578 teachers were living with HIV/ AIDS in 1998. Martin et al (2001) also reported that in 2001 alone, 500 teachers in Burkina Faso were infected. In Ghana, although some studies have reported an estimated prevalence rate of 9.2% in the education sector (about three times the national prevalence rate), the absolute number of teachers infected with the virus were not reported.

HIV/AIDS has led to increased mortality among teachers in many parts of sub-Saharan Africa. In East Africa, Kelly (2000) reports that death among teachers rose from 450 in 1995 to about 1,500 in 1999 in Kenya. This situation was not different from cases in Uganda and Zambia where 948 (1997) and 1300 (1999) deaths due to AIDS were recorded (Congressional Research Services Report, 2002; Amenyah, 2005). In West and Central Africa, Dakuyo et al (2002) estimate that in 1996, 14.8% of teachers living with HIV/AIDS died in Burkina Faso. In Cote d'Ivoire, Kanga (1999) found that 64.86% of teacher deaths in 1999 were attributable to HIV/AIDS and that five to eight teachers die every week from HIV/AIDS (Yaro, 2002) and (Cohen, 2000). Tamukong (2004) drawing on Nkwenti (2002) estimated that between 5 and 10 teachers die every week of HIV/AIDS in Cameroon. In Ghana, Baku (2004) reported that 893 teachers died of AIDS between 1996 and 2002 representing an average of 128 per annum in the seven year period. This may be an underestimation because it is considered shameful to die of AIDS and sometimes such deaths are attributed to witchcraft or a curse.

HIV/AIDS profoundly affects the professional lives of teachers (Tamukong (2004). It results in higher mortality rates, increase in early retirement and lower productivity. All these factors could compromise the effective delivery of education and worsen the problems of lack of access, equity, efficiency and management (Kelly, 2000). If this situation continues to go unchecked then education targets such as Education for All (EFA) will never be attained (Tamukong, 2004).

One of the main effects of HIV/AIDS in the education sector is the absenteeism among teachers infected with the virus. Casely-Hayford (2001) reported that teacher absenteeism was on the rise across the Economic Community of West African States (ECOWAS). Catraye et al. (2001) reported that in Burkina Faso teacher absenteeism due to HIV/AIDS was on the rise either because the teacher is ill or he/she has to take a sick family member to the hospital or attend a funeral. In Côte d'Ivoire, Azoh (2004) reported that as a result of HIV/AIDS teachers are absent for 6.8 months out of the nine months that make up a school year (2004).

The long and frequent absence from school among teachers living with HIV could lead to low enrolment or absenteeism among pupils. Dakuyo et al. (2002) and Catraye et al. (2001) argued that in Burkina Faso teacher morbidity encourages drop-out and absenteeism among pupil/students because when pupils and students do not see their teachers for a long time they tend to stay away from school and may eventually drop out completely. In Cameroon, Matchinda (2004) reported a drop in the enrolment rate from almost 100% in the 1980s to 71 % in 1996 due partly to HIV/AIDS. Some students withdrew from school when they did not see their teachers for a long period of time due to illness.

Absenteeism among teachers infected with HIV could also lead to increased workloads for those who are not infected. Where a teacher is ill and does not return to school and the administration has yet to recruit a replacement, the load of the sick teacher is usually shared among those who are healthy. The heavier workloads invariably reduce effectiveness in the classroom. Another problem is related to the difficulties of finding replacements for specialist teachers who fall victim to HIV. When a general educator is absent there is some possibility of others moving to cover him or her but this is not possible when the loss is that of a highly specialized educator such as an A-level mathematics or science teacher or a college lecturer in infant teaching methods (Kelly, 2000). Training such specialised teachers requires huge investments and their early deaths or incapacitation due to HIV/AIDS means a huge loss of state funds because they need to be replaced at a faster rate than it would have been without the HIV. In addition, the invaluable experience gained by some of these teachers cannot be obtained through training. Education systems in sub-Saharan Africa are therefore overburdened as trained professionals and ancillary staffs fall victim to this dreadful disease (Stone, 2002).

HIV infection among teachers also results in low productivity and sometimes non-completion of curricula. Infected teachers become weak and are unable to concentrate on their work. Casely-Hayford (2001) argues that such teachers are unproductive given the little effort and time they put in preparing their lessons. Infected and/or affected teachers often do not have time and energy to complete programmes on time.

Pupils receive a lower quality of education because teachers are weak, traumatized, absent and are dying (Tamukong, 2004).

The disease further compounds the already heavy financial burden on teachers. Anti-Retroviral drugs (ARVs) are expensive and in some cases teachers infected with the virus have to sell their property to be able to afford medication. When this happens, they may not be able to afford decent clothes or the means of living comfortably enough to prepare their lessons. Those already advancing towards AIDS need to buy antibiotics and other medicines and this further compounds their already deteriorating conditions making it very difficult for them to function properly as teachers (UNDP, 2001).

Furthermore, teachers living with HIV/AIDS suffer from overwhelming stress and psycho-social trauma for fear of social stigma and discrimination (Kelly, 2000). They are also deeply affected by the incidence of HIV/AIDS among their relatives and colleagues, and by fear and uncertainty about their personal infection status. Relations with colleagues, students and parents become strained making it extremely difficult for a teacher living with the virus to report to duty regularly. Kelly (2000) reports in his study referred to earlier that less than one-third of his sample of teachers who had experienced AIDS sickness or death among their relatives had talked about the problem with friends or relatives. The remaining two-thirds felt either unable or unwilling to do so because of the stigma attached to the disease and the attendant discrimination that one can experience when they are known to be living with the HIV.

The foregoing shows the effects of HIV and AIDS on the education sector. It is an undeniable fact that the HIV/AIDS epidemic is perpetuated primarily through sexual transmission. To stop the spread it is important to create awareness of how HIV is transmitted, the methods for prevention and the appropriate sexual behaviour.

It was against this background that this survey was conducted to reassess the awareness and use of HIV prevention methods among teachers and educational workers in Ghana. The next section of the report presents the findings from the survey.

Part 3: ANALYSIS OF SURVEY RESULTS

3.1 HIV/AIDS Awareness among Teachers and Educational Workers in Ghana

3.1.1 HIV/AIDS Awareness

Awareness creation is the beginning of all interventions that seek to stop the spread of HIV. Teachers and educational workers are well-placed to serve as important sources of vital information about HIV for young people under their care or leadership. In many communities in Ghana, teachers serve as *de facto* opinion leaders. In this capacity they could lead the efforts towards HIV prevention. High level of awareness of HIV/AIDS among teachers may lead to change in their sexual behaviour that is needed to stop the spread of HIV not only among teachers and educational workers themselves but also for others who come under their care and/or leadership and see teachers as models in society.

A number of related questions were posed in this and the previous survey to find out the degree of HIV/AIDS awareness among teachers and educational workers in Ghana. The first question was “*Are you Aware of HIV/AIDS?*” Out of the 407 respondents who responded to this question in the present survey 98.5 % said they were aware of HIV/AIDS compared to 99.5% in the 2007 survey. The results are shown in Table 3.1 below. Further analysis of the responses to this question by sex and by age showed a similar level of awareness among males and females and across age cohorts in the sample. Again the results of the 2008 survey are comparable to the 2007 survey and are largely consistent with results of more nationally representative surveys.

Table 3.1: Awareness about HIV/AIDS among Teachers and Educa

Are you aware of HIV/AIDS?	Percent [2008 Survey]	Percent [2007 Survey]
Yes	98.5	99.5
No	1.5	0.5
Total	100%	100%

Source: Survey data

3.1.2 Sources of Information about HIV/AIDS

With regard to sources of information on HIV/AIDS, television was mentioned as the most popular source. As shown in Table 3.2, 90% of our sample of teachers and educational workers in the present survey mentioned television as one of their most popular source of information about HIV/AIDS; 85% mentioned radio; 77% mentioned newspapers and 65% said they received information about HIV/AIDS from other persons. The corresponding proportions in the 2007 survey were 89% for TV; 86% for radio; 78% for newspapers; and 72% received information from other persons.

It is important to note the lower proportion of respondents who received information from other persons. This is an indication that people still find it difficult to discuss HIV/AIDS among themselves. The results of both 2008 and 2007 surveys suggest that television and radio continue to be the most popular sources of information about HIV/AIDS in Ghana (see Table 3.2). It is also interesting to note that males are more likely to receive information on HIV/AIDS from radio, newspapers and even from other persons (in the 2008 survey) while females are more likely to rely on television for information on the disease.

Table 3.2: Sources of Information about HIV/AIDS

Source of Information on HIV/AIDS	2008 Survey Results			2007 Survey Results		
	Total Sample [%]	Male [%]	Female [%]	Total Sample [%]	Male [%]	Female [%]
86	Radio	85	89	82	86	91
Television	90	90	90	89	87	93
From another person	65	69	60	72	72	72
From Newspapers	77	79	76	78	79	76

Source: Survey Data

A comparison of the age groups in terms of their source of information on HIV/AIDS showed similar patterns in both the 2007 and 2008 surveys. In the 2007 survey the sample was divided between those below 30 years and those 30 years old or above to highlight the differences between youth and adults. In the present survey the sample is divided between those in the vulnerable group (18 – 49 years) and those 50 years or older. The analyses by age group in the two studies are therefore not directly comparable. However, in both surveys the results showed that there are some slight differences between the age groups in terms of their sources of information on HIV/AIDS. The 2008 survey shows that older people are more likely to rely on TV, radio and newspaper for information of HIV/AIDS but younger people are more likely to rely on other persons for information. The 2007 results also show that younger people in the education sector are more likely to learn about HIV/AIDS from other people compared to their senior colleagues (see Table 3.3).

Table 3.3: Sources of information by age

	Age Bracket	TV	Radio	Other persons	Newspapers
2008 Survey	Between 18 and 49 years	89%	85%	66%	76%
	50 years or above	92%	90%	63%	83%
2007 Survey	Below 30 years	90%	91%	73%	79%
	30 years or above	90%	84%	70%	76%

Source: Survey data (2008)

3.2 Direct Experience with HIV/AIDS

Direct experience with HIV/AIDS may create a higher level of awareness of the disease and may have a stronger impact in terms of changes in people's sexual behaviour. In other words, people who have lost a close relative or a colleague to AIDS or who have relatives or colleagues living with the virus are likely to be more conscious of the devastating impact of the virus compared to those who have not had direct experience with the disease.

In both surveys, respondents were asked if they know someone living with HIV or died of AIDS. Table 3.4 shows the results of the analysis of the questions related to direct experiences with the disease. Over a third (37%) of the respondents in the 2008 survey said they knew someone who is living with the virus and 58% knew someone who has died of AIDS. In the 2007 survey, approximately 30% said they knew someone living with HIV and 53% said they knew someone who had died of AIDS. Just about 10% of the sample knew any teacher or educational worker living with HIV (in 2008 survey) compared to 5.7% in the 2007 survey and only 1.8% of the respondents said they knew a teacher or educational worker in their workplace/school who is living with HIV or died of AIDS.

It is worthy of note that the corresponding proportions of the sample who experienced HIV/AIDS increased as shown by the differences between the 2007 and 2008 survey results shown in Table 3.4. For example, the proportion of the sample who knew someone living with HIV increased from 29.7% to 37.4%. The percentage who knew **anyone** in the general population who has died of AIDS was 53.2% in 2007 compared to 57.9% in 2008. The proportion of the sample who knew **a teacher or educational worker** living with HIV was 5.7% in 2007 compared to 9.9% of the 2008 sample. In 2008 the proportion of the survey sample who knew a teacher or educational worker living with HIV or died of AIDS **at their workplace** was 1.8% compared to 0.8% in 2007. It is not clear why the proportion of teachers and educational workers having direct experience with HIV/AIDS is increasing in all cases especially when evidence suggests that HIV prevalence in Ghana is declining. It may be the case that more information on people's HIV status

is leaking to the public as more people avail themselves of testing and counselling services being provided by government.

Table 3.4: Experience with HIV/AIDS

Do you know anybody living with HIV	Percent [2008 Survey]	Percent [2007 Survey]
Yes	37.4	29.7
No	62.6	70.3
Total	100.0	100
Do you know anybody who has died of HIV/AIDS?		
Yes	57.9	53.2
No	42.1	46.8
Total	100.0	100
Do you know any teacher or any education worker living with HIV/AIDS		
Yes	9.9	5.7
No	90.1	94.3
Total	100.0	100
Do you know if any of the teachers or workers <u>in your school</u> is living with HIV/AIDS		
Yes	1.8	0.8
No	98.2	99.2
Total	100.0	100

Source: GNAT Survey data (2008 and 2007)

As in the 2007 survey, the 2008 survey went further to find out the sex of those who are known to have died of AIDS or living with the virus. The majority (about two-thirds) of the respondents said the person they knew to be living with HIV or died of AIDS was a female (see Table 3.4).

Table 3.6 shows the age of those known to be living with HIV or known to have died of AIDS. Our results are consistent with the known fact that HIV/AIDS mostly affect people in the 18 to 49 year group. Nearly 90% of all those known to be living with HIV or known to have died of HIV are in the 18 to 49 age group.

Table 3.5: Sex of person known to be living with HIV or died of AIDS

Sex of the person known to have died of AIDS or living with HIV	2008 Survey Results		2007 Survey Results	
	The sex of a person you know living with HIV/AIDS	Sex of the person you know who died of HIV/AIDS	Sex of the person you know who died of HIV/AIDS	Sex of the person you know who died of HIV/AIDS
Male	36.3	33.0	43.1	35.7
Female	63.8	67	56.9	64.3
Total	100.0	100	100	100

Source: Survey data (2007 & 2008)

Table 3.6: Age of persons known to be living with HIV or have died of HIV

Age of the persons you know to be living with HIV/AIDS	Percentage
18 - 49 years	89.8%
50 +	10.2
Total	100%
Age of the persons known to have died of AIDS	Percentage
18 - 49 years	89.9%
50+	10.1%
Age of teachers or educational worker living with HIV/AIDS	Percentage
18-49 Years	84.8%
50-60	15.2%

Source: Survey data (2008)

The respondents were further asked to indicate the source of their information about those they knew to be living with HIV or have died of AIDS. Our analysis suggests that the majority heard about it through “rumours” or “other sources”. As shown in Table 3.7, only 13.5% of the

sample reported that they received information directly from the people living with HIV or died of AIDS. These results are an accurate reflection of the situation in Ghana where, like many other African countries, people still find it very difficult to disclose their HIV status to other people including even their close relatives for fear of stigmatisation and/or discrimination. These results confirm the findings in an earlier study by Kelly (2000) in which he found that less than one-third of his sample of teachers who had experienced AIDS or death among their relatives had discussed the problem with friends or relatives. According to Kelly, the remaining two-thirds of the teachers in his sample felt either unable or unwilling to do so because of the stigma attached to the disease and the attendant discrimination that one can experience when they are known to be living with HIV. Like other parts of Africa, people's HIV status is a top secret in Ghana.

Table 3.7: How did you know that someone is living with HIV or died of AIDS?

Source of Information	Valid Percent
Through rumours	45.8
I was told by the person directly	13.5
Other sources of information	40.6
Total	100.0

Source: Survey data (2008)

3.3 Access to HIV Education, Testing and Counselling

Access to HIV-related education, testing and counselling are extremely important for a successful fight against the spread of the virus. Government of Ghana (GoG) through the AIDS Commission and in collaboration with international agencies, in particular USAID, has made some efforts to increase access to these services in the country. The declining trend in HIV prevalence in Ghana in recent times has been attributed largely to government's positive response to the pandemic and the significant increase in funding for HIV/AIDS-related activities across the country.

The results of both the 2007 and 2008 surveys show very encouraging results. As shown in Table 3.8, over three quarters of teachers and educational workers in both samples reported that they had attended HIV awareness programme. The results also suggest that teachers and educational workers are responding quite positively to the campaign for mass counselling. In 2007 less than 10% of the sample had attended counselling. But in 2008 over a quarter of the sample said they had used counselling services. This may be an indication that more teachers and educational workers are using counselling services (including the services provided by GNAT as part of the union's initiative towards HIV prevention). But it should be emphasised that a successful fight against this deadly virus requires that a higher percentage of the population should have access to and be encouraged to use counselling and testing services.

Table 3.8: Access to Education, Counselling and Testing (2007 & 2008)

Do you have access to education, testing & counselling?	2008 Survey Results			2007 Survey Results		
	Attended Educational Programme [%]	Attended Counselling [%]	Tested [%]	Attended Educational Programme [%]	Attended Counselling [%]	Tested [%]
Yes	75.7%	25.4	25.7	77.6	9.4	20.9
No	24.3%	74.6	74.3	22.4	90.6	79.1
Total	100%	100.0	100.0	100%	100%	100%

Source: Survey data (2007 & 2008)

The results show some level of bias in favour of males with regard to access to HIV awareness programmes. In other words males are more likely to have access to HIV awareness programmes compared to females. As shown in Table 3.9, in 2008 approximately 80% of males attended HIV-related educational programmes compared to 71% of women. The corresponding figures in the 2007 survey were 79% for males and 75% for females. It may also be worth noting that women's access to HIV-related programmes might have fallen between 2007 and

2008 as indicated by the decline in the percentage of women who reported that they accessed educational programmes (75% in 2007 against 71% in 2008)².

Our results further show a more positive response to testing and counselling from females than males. The 2007 results showed that higher percentage of males attended counselling (10.9% males against 8% females) and testing (22.1% males against 19.3% females). But in 2008, almost 26% of females attended counselling compared to 25% of males. The difference is even much more significant when comparing the proportions of males and females who tested for HIV in 2008 (31.6% females against 20.6% males).

Table 3.9: Access to education, counselling and testing by sex (2007 & 2008)

Year/Access	Attended HIV Awareness programme		Attended Counselling		Done HIV Test	
	Male	Female	Male	Female	Male	Female
2008	79.7%	70.8%	24.9%	25.5%	20.6%	31.6%
2007	79.2%	74.7%	10.9%	8.0%	22.1%	19.3%

Survey data (2007 & 2008)

Further analysis of the 2008 survey results show that a higher percentage of those aged 50 years or above have access to HIV awareness programmes (87.8%) compared to those in the 18-49 year age group (72.9%). This means, those who are less vulnerable are more likely to attend HIV awareness programme than those who are more vulnerable. HIV-related educational programmes may be targeting the “wrong” people. Similarly, the 2008 survey results suggest that those aged 50 years or above are more likely to attend counselling compared to their younger counterparts in the 18 - 49 year age group (approximately 32% of those in the 50+ group attended counselling compared to 23.5% of

² Technical note: We should however exercise caution when comparing the results of the two surveys because, although the two samples came from the same population of teachers and educational workers in Ghana, the studies are based on cross-sectional data using two different samples. The use of a panel dataset helps to improve direct comparison over time because the sample may remain unchanged or slightly changed if some of the previous elements have been replaced.

the younger group). However, the younger ones (those in the 18-49 year age group) are more likely to do HIV test (29.1% of those aged 18-49 years did the test compared to 11% of those aged 50 years or above).

Table 3.10: Access to education, counselling and testing by age (2008)

Age Group	Attended HIV-related Educational programme	Attended Counselling	Done HIV Test
18-49	72.9%	23.5%	29.1%
50+	87.8%	31.8%	11%

Source: Survey data (2008)

In both the 2007 and 2008 surveys, respondents were asked to indicate whether they think it is useful for everyone to know his/her HIV status. In both surveys 85% of the respondents said they think it is useful, as shown in Table 3.10 below. Surprisingly, only 21% of the 2007 sample and 25% of the 2008 sample had done the test.

It is obvious from the results that people are not translating their views about the importance of testing for HIV into action. This may be partly attributable to the fear of the discrimination and the stigma society attaches to HIV. One of the respondents in the 2007 survey said *“I am not fully convinced that the health workers can keep my information confidential”*. Another respondent said he had not done the test because *“...the test centres are within the community. To enter there [the testing centre] may bring rumours that I am HIV positive”*. Our results are a further indication that many Ghanaians still hold the view that when it comes to HIV ‘ignorance is gold’. This notion was confirmed in the 2007 survey by a respondent who said *“I think it is better to be ignorant than to know your status. This is because when you know your status stigmatization alone can kill you easily”*. Another respondent said he wanted his mind *“to be free of the fear of death”*. But it is also true that the low rate of testing among Ghanaians can be partly attributed to the lack of testing facilities in a large number of communities.

Table 3.11: Do you know your HIV status?

Knowledge of HIV Status	2008	2007
Think it is useful to know HIV status	84.6	85%
Know HIV Status	33.9%	27.0%
Done HIV Test	25%	20.9%

Source: Survey data (2008)

One of the surprising findings in the 2007 survey was that a higher percentage of the sample (27%) claimed to know their status compared to the percentage that had tested for HIV (20.9%). The 2008 survey shows similar results (approximately 34% said they knew their status but 27% had done the test as shown in Table 3.11). The seemingly inconsistent results in both surveys are an indication that there are still many people who assume that they do not have the HIV virus because they feel or look healthy. The following are some of reasons given in the 2007 survey or not testing:

“I am very sure that I do not have HIV/AIDS so there is no need to take the test”.

“I have nothing of that sort [because] I am faithful to my husband and the vice versa”.

3.4 The Use of HIV Prevention Methods

As in the 2007 survey, the 2008 survey covered issues relating to the sexual behaviour of teachers and educational workers. Specifically, the survey participants were asked to indicate whether they (i) use condom **always** during sex (ii) they use condom during **casual** sex (iii) they abstain from sex completely or (iv) they abstain from casual sex as a means of preventing themselves (or their sexual partners) from HIV infection. The responses are analysed in Table 3.11 below.

As we can see from the responses, abstinence from casual sex seems to be the most popular prevention method. Sixty percent of the sample in both the 2007 and 2008 surveys said they *abstain from casual sex* as a

means of preventing themselves from infection. The second most popular method is the use of condom “*always*” during sex (around a quarter of both samples said they use condom always during sex). Just about one-fifth of the survey participants abstain completely from sex as a prevention method (19% in 2008 and 22% in 2007).

Table 3.12: Use of HIV Prevention Methods (Total Sample)

HIV Prevention Methods	2008 (%)	2007 (%)
ALWAYS use condom during sex	24	26.7
Use Condom during CASUAL SEX	12.1	16.1
COMPLETE ABSTINENCE from Sex	19	21.
Abstain from CASUAL SEX	59.2	60.1

Source: Survey data (2007 & 2008)

Analysis of the data by sex, by marital status and by age group show similar patterns in the responses in terms of the relative popularity of the prevention methods. As shown in Table 3.13, 3.14 and 3.15 abstinence from casual sex is the most popular prevention method among males and females and also among those who are married as well as among those who are not married. It is also the most popular prevention method among the “old” and the “young” or the “less vulnerable group” and the “most vulnerable group” followed by the use of condom.

Table 3.13: Use of HIV Prevention Methods by Sex of Respondents

Prevention Method	2008		2007	
	Male (%)	Female (%)	Male (%)	Female (%)
Use of condom during sex ALWAYS	27.2	20.3	29.5	21.9
Use of Condom during CASUAL SEX	13.0	11.2	14.4	15.7
COMPLETE ABSTINENCE from Sex	14.8	23.9	20.5	23.6
Abstain from CASUAL SEX	63.8	53.7	53.8	63.3

Source: Survey data (2007 & 2008)

Table 3.14: Use of HIV Prevention Methods by Marital Status

Prevention Methods	2008		2007	
	Married [%]	Single [%]	Married [%]	Single [%]
Use of condom during sex ALWAYS	25.8	18.2	22.2	38.7
Use of Condom during CASUAL SEX	13.6	9.1	15.7	16.5
COMPLETE ABSTINENCE from Sex	12.9	35.4	13.2	39.2
Abstain from CASUAL SEX	65.9	38.8	66.9	45.9

Source: Survey data (2007 & 2008)

Table 3.15: Use of HIV Prevention Method by age group

Prevention Method	18 -49 years [%]	50+ years [%]
Use of condom during sex ALWAYS	24.7	23.3
Use of Condom during CASUAL SEX	11.8	14.6
COMPLETE ABSTINENCE from Sex	16.7	24.7
Abstain from CASUAL SEX	57.6	64.4

Survey data (2008)

4. Conclusion

The findings in this and the previous study have implications for the unions' HIV policy and the fight against HIV/AIDS in the education sector. The results show very high level of awareness among workers in the education sector. It is important that the high level of awareness is sustained and this is likely to be the case. The unions may now need to focus their attention and resources on the promotion of the use of counselling and testing services by their members because, as the survey results show, just about a quarter of their members are currently using these services. For example, the unions can open VCT centres in all regions or districts across the country as a means of encouraging their members to use these services. Moreover, the unions may have to commit more human and financial resources to encourage their members to translate the high level of awareness to behavioural change.

References

Akwara et al. (2005) "An In-Depth Analysis of HIV Prevalence in Ghana: Further Analysis of Demographic and Health Surveys Data". Calverton, Maryland, USA

Amenyah (2005) "The importance of learning for changing sexual practices in response to HIV/AIDS crisis in Ghana": A Dissertation Submitted to the Graduate Faculty of the University of Georgia in Partial Fulfillment of the Requirements for the degree doctor of education. Athens, Georgia

Baah A.Y, L. Jarl and K.N Otoo (2007) "An Assessment of the Awareness of HIV/AIDS and the Needs of Teachers and Education Workers Living with HIV/AIDS in Ghana: *Survey Results*, GNAT/TEWU, Accra

Baku, J. 2004. "HIV/AIDS and the Education Sector in Ghana: review of policy and research documents, 1999-2003". A preliminary report. Accra: ERNWACA

Bennell, Hyde & Swainson (2002) "The impact of the HIV/AIDS Epidemic on the education sector in Sub-Saharan Africa: a synthesis of the findings and recommendations of three country studies". Centre for International Education: University of Sussex Institute of Education

Boler (2003) "Approaches to examining the impact of HIV/AIDS on teachers" Policy & Research: series. UK working group on education and HIV/AIDS

Djokoto (2008) "Ghana National Report on the Progress of the United Nations General Assembly Special Session (UNGASS) Declaration of Commitment on HIV and AIDS": J anuary 2006–December 2007

ERNWACA (2007) "Synthesis of multi-country study on the impact of HIV and AIDS on teachers and teaching in formal and non formal education in Benin, Ghana, Guinea and Niger, Educational Research Network for West and Central Africa. Bamako, Mali

Fobil and Soyiri (2006) "An assessment of government policy response to HIV/AIDS in Ghana". Vol. 3 No. 2 Août 2006 Journal des Aspects Sociaux du VIH/SIDA

Ghana (2008) "Epidemiological Fact Sheet on HIV and AIDS Core data on epidemiology and response" (WHO/Second Generation Surveillance on HIV/AIDS, Contract No. SANTE

Kelly (2000) "The Impact of HIV/AIDS on the Education Sector in Africa Sub-Regional Outlook and Best Practices (Eastern and Southern Africa) Synthesis Paper for African Development Forum 2000". United Nations Economic Commission for Africa. Addis Ababa

La Verle Berry, ed. *Ghana: A Country Study*. Washington: GPO for the Library of Congress, 1994.

National AIDS/STI Control Programme Disease Control Unit (2001) *HIV/AIDS in Ghana :Background, Projections, Impacts, Interventions, and Policy* Ministry of Health. 3rd Edition

Stone (2002) "Globalization and HIV/AIDS Policies in Africa". Aid Transparency: Regional Think Tank on HIV/ AIDS

Tamukong (2004) "The impact of HIV/AIDS on teachers and other education personnel in West and Central Africa. A synthesis of the literature from 2000 to 2004". Yaoundé, Cameroon

The Kaiser Family Foundation :HIV/AIDS Policy fact sheet (2005) *The HIV/AIDS Epidemic in Ghana*"

UNESCO HIV and AIDS Education Clearinghouse Newsletter: Issue 41 November 2007