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Street youth in Accra city: sexual networking in a high-risk environment and its implications for the spread of HIV/AIDS

John K. Anarfi[a] and Phyllis Antwi [b]

[a]*Institute of Statistical, Social and Economic Research University of Ghana, Legon, Ghana*

[b]*AIDS Control Programme Ministry of Health, Ghana, Accra*

Efforts to find a solution to the AIDS pandemic so far have been characterized by the use of shortcuts that bring quick results. This has resulted in stereotyping certain categories of people as high-risk behaviour groups and thereby concentrating attention on them: homosexuals and intravenous drug users in the industrialized countries and female prostitutes in developing countries, mainly in Africa. In the process certain groups have become marginalized and hence cut off from both mainstream heterosexual and targeted homosexual AIDS prevention campaigns. Incidentally, some of such marginalized groups have become the bridge along which the Human Immunodeficiency Virus (HIV) escapes from the so-called high-risk groups to the general population.

In the United States for example, there was the initial rhetoric concerning AIDS with the use of terms such as 'gay plague'. As such the potential for harm to women seemed vague and was virtually neglected. The result was that by 1986 AIDS was the leading cause of death among women 25-34 years in New York (Wofsy 1987). Since 1983 the proportion of female AIDS cases in the United States infected through sexual contact has increased from 14 per cent to 26 per cent, indicating an increase in heterosexual transmission (Guinan and Hardy 1987; Kaplan 1987). Another study shows that in 1986 approximately 70 per cent of the heterosexual cases of AIDS had primary partners who were intravenous drug users, and 18 per cent of primary partners of female cases were bisexual men (Curran et al. 1988).

In Africa deviant groups like homosexuals and intravenous drug users are not considered important groups for the spread of HIV/AIDS and hence no attention has been given to them. But non-conventional sex, homosexual or heterosexual, is not new and existed even in prehistoric times (Kinsey, Pomeroy and Martin 1948). The lack of focus on homosexuality and bisexuality in Africa is explained by the 'nature of the overt conventional response to the phenomenon by Africans in general, which is often fright, confusion and denial of such forms of sexuality' (Aina 1991:81). Writing about the Azande of Sudan, Evans-Pritchard (1974) mentioned adolescent and situational bisexuality when discussing the phenomenon he called 'marriage with boys'. This relationship gave men who were not yet capable of legal access to women the chance to release tension by having orgasm between the thighs of the boys. Also mentioned in Aina's (1991) study is ritual bisexuality which he explained as a whole class of sexual relations related to the gaining of mystical powers and witchcraft. The main one involved sexual intercourse with someone who is socially undesirable such as a destitute or a seriously disabled person.

> The rationale behind this is that, through this interaction, the normal dominant partner draws from his less fortunate partner the predestined store or essence of good fortune and fate that all human beings are supposed to possess spiritually (Aina 1991:83)

The other activity, believed to be practised by the Yoruba and Hausa of Nigeria, involved anal intercourse by which the dominant partner is believed to 'augment and/or charge like a battery his own store of such quality or essence, thereby contributing to his increased success in whatever endeavours he undertakes' (Aina 1991:83).

The evidence for the practice in Africa aside, the pattern of these supposed traditional forms of bisexuality and homosexuality needs pointing out. It involved dominant males, possibly wealthy, and less fortunate partners, mainly boys. This pattern has continued into the present time with increased intensity due to urbanization and modernization-Westernization. Recent studies have observed that male prostitutes can be found in virtually all large African cities and tourist centres around the five-star and other hotels catering mainly to an expatriate clientele and the local rich. Often they double as pimps procuring female prostitutes for heterosexual relations (Aina 1991). Again the element of unequal relationships could be discerned: an affluent Western tourist and a poor African youth ready to do anything for what amounts to a mere pittance in external money. Similar observations have been made in other developing countries in Southeast Asia (Sittitrai 1988; Sittitrai et al. 1989; Muangman et al. 1988, on Thailand), and in Brazil (Parker 1989).

Two observations can be made. In terms of gender, the literature on female prostitutes in developing countries is much larger than that on male prostitutes. Regionally, research on bisexuality and homosexuality seems to have received a little more attention in Southeast Asia and Brazil than in Africa, and the few studies in the latter tend to be more speculative than empirical. The establishment of the practices in these other developing societies only reminds African researchers that they can no longer behave like ostriches and continue to bury their heads in sand in the face of the danger posed by AIDS.

One other effect of earlier researchers' focus on high-risk behaviour groups is the fear and prejudice that have characterized AIDS globally. Some recent researchers, however, have called for the redirection of attention from the behaviour of individuals and groups towards institutions and environments within which they operate, thereby allowing the conditions within which the behaviour occurs to be studied (Muir 1991). Writing on AIDS in Uganda, Barnett and Blaikie (1992) emphasized that focusing on individual behaviour alone can provide a clear target for scapegoating since it identifies those who are most vulnerable to infection and who, therefore, are 'dangerous' to the rest of the society. They observed that, because of civil disruption, war, smuggling and unequal access to economic resources, 'the question has become less one of certain sexual behaviour being risky, but all sexual behaviour being risky because the environment is one of high risk' (Barnett and Blaikie 1992:68).

In line with the WHO classification of global epidemiological patterns, which is basically conceived in relation to types of behaviour, research on AIDS in Africa has been dominated by efforts to identify people's high-risk sexual behaviour. In the process prostitutes have been singled out for much emphasis (Mann 1988; Yeboah-Afari 1988; Nagelkerk et al. 1990; Ahmed et al. 1991; Nzila et al. 1991), and long-distance truck drivers similarly (Carswell et al. 1989; Nzyuko 1991; Orubuloye, Caldwell and Caldwell 1992). Also targeted for research is an amorphous sexually active population. Uganda is about the only country in Africa where adolescents have been specifically targeted for study beyond the usual knowledge, attitude and practice (KAP) research. But most of the studies have been on students (Kisekka 1976; Ankrah and Rwabukwali 1987), and others focused on regular adolescents as part of the general population (Konde-Lule 1992). Intervention programs in the whole of the continent

have followed a similar pattern with attention turned to the general population or the youth as if all people have equal access to information.

Adolescents and young adults are generally believed to be at increased risk of becoming infected with HIV because they are in a stage of cognitive, physical and emotional development and experimentation with sex and drugs. Peer pressure is very important at this stage and health problems are primarily due to STDs (see King et al. 1988). Street-involved youth are particularly vulnerable because they may engage in higher-risk behaviour and because they are alienated from social-service providers and school systems. That puts them outside the AIDS information networks while they of themselves lack the social supports to change their behaviour. Although the problem of street children in Ghana has not reached the proportion found in some Western countries (Caswell and Green 1988) or even in Brazil (Parker 1989; Larmer and Margolis 1993), there is evidence that they exist and the number is growing. This group is in part the product of the educational and economic reforms that have taken place under the country's structural adjustment program and there is evidence that it is growing numerically.

For example, with the phasing out of the former elementary school system, no provision was made for the upgrading of the holders of the former Middle School Leaving Certificate. Institutions such as the four-year Teacher Training Colleges which were absorbing some of these young people have all been phased out. In addition, the new Junior Secondary School system does not make provision for those who fail the Basic Education Certificate Examination to repeat the examination; neither are there facilities for those who do not get entry to the Senior Secondary School (SSS) to upgrade themselves. Yet, for 1993, out of 138,000 candidates who qualified for admission to the SSS, only 60,000 could be offered places. Most of the unfortunate ones will find their way to the cities to join the growing army of unemployed youth.

AIDS in Ghana

AIDS cases were first seen in Ghana in 1986 and in that year the AIDS Control Programme was set up to educate the public about the dangers posed by the disease and to keep track of the progress of the disease. In January 1992 a total of 6,009 HIV-positive cases had been reported in the country, of whom 4,075 (about 68 per cent) were females. The number of AIDS cases in the same period was 3,290 and nearly 74 per cent were females. By July 1993, the number of detected HIV-positive cases had almost doubled to 11,940 and that of AIDS cases had more than tripled to 10,285. The current figures indicate that the proportion of female HIV-positive cases has increased slightly to 71 per cent and that of AIDS cases has fallen by five per cent.

As elsewhere in Africa, the figures must be interpreted with caution. The fluctuations in the number of cases reported could be affected by two factors. One is the availability of reagents for testing for the AIDS virus. There can be a lull in reported cases when there are no reagents, which is possible in an African situation. The figures will show a sudden jump from the time testing resumes. The other factor could be a general improvement in recording HIV/AIDS cases. It must be pointed out that in Ghana HIV tests are mainly performed in the symptomatic stage of the disease. Most HIV/AIDS cases are observed when people report sick, as very few people go for voluntary screening. A few cases are also observed during blood donation. Screening at antenatal clinics has also become almost universal in Ghana as well as at STD clinics. This may explain the slight increase in the proportion of female HIV cases while their proportion in the AIDS cases is falling.

The age distribution of HIV/AIDS cases in Ghana reflects the general pattern observed globally. Nearly 90 per cent fall within the most economically active age group of 15-49. The

1992 figures showed that about 74 per cent of reported AIDS cases were aged between 20 and 39. About three per cent were aged 15-19 years. Given the generally long incubation period of AIDS it is probable that a substantial proportion of seropositive persons in Ghana contracted the virus in their teens. As elsewhere in Africa, the mode of transmission of HIV in Ghana is mainly through heterosexual relations. This study, therefore, describes the socio-economic characteristics of street-involved youth in Accra, their attitude and knowledge about human sexuality, and their sexual behaviour and perceptions about sexually transmitted diseases (STDs) including AIDS. A section examines sexual networking within the environment of the youth and those involved in the network. The possible escape routes for HIV from this environment to the general population are highlighted and recommendations for averting a potential danger of spread are offered.

The study

The study was prompted by the need to established an AIDS intervention program that specifically targets 'street children'. The initial problem was how to operationalize the concept of 'street children'. Muir has conceded that

> street youths can be difficult to quantify, for they range on a continuum from those who live at home but spend a great deal of time 'hanging out', to those who actually live on the street (often in abandoned buildings and underground parking lots) and whose financial and personal support comes from street life. Street youths can be as varied as the general population (Muir 1991:139).

Young people trying to sell their petty goods to people in passing vehicles along some of the major streets in Accra are now a common sight. But they may not be necessarily homeless; some may even be continuing pupils and students who sell full-time during vacation or part-time when school is in session. Some may still live at home but spend most of their time on the street, possibly working for their parents. The idea therefore was to target street-involved youth which it was hoped would include all the categories mentioned above.

The fieldwork

The data for the study came from two main sources: a questionnaire survey and focus-group discussions. The fieldwork was conducted between 11 and 27 August 1992 in the centre of Accra. Two areas, the Kantamanto and Agbobloshie markets and the transport stations adjoining them, were selected as the survey areas. A staff of four interviewers and one supervisor carried out the fieldwork. The Accra Metropolitan Assembly had organized the street-involved youth into groups to facilitate their mobilization for voluntary work such as clean-up exercises, and possibly for taxation. Each group had a leader and an area within which it operated. The co-ordinator of all the groups was used as the 'insider' contact man who also was one of the interviewers. Before every day's operations the contact man organized the group in which interviewing would be conducted. Five groups were identified and in each all willing persons 10 to 24 years old were interviewed until there were 50 respondents per group.

After the interviewing, four homogeneous groups of eight individuals each, selected on the basis of age and sex, were engaged in focus-group discussions.

The setting

The area selected for the study is the hub of brisk commercial activities which attract a teeming number of people during the day. Set within the study area is an undeveloped piece of land, part of which is used for the dumping of refuse. A few makeshift structures add to the general atmosphere of substandard conditions. The sheds serve as the places of rest for most of the youth during the day. Although the peddling and smoking of marijuana is illegal in Ghana, these activities are done openly in and around these sheds. The pedlars and smokers seem to find safety in numbers which are quite large at certain periods of the day: between five and seven o'clock in the morning when the smokers 'charge up' for the day's task, around noon to one in the afternoon when they go for 'refuelling', and from six to seven in the evening when they retire from the day's activities. There is no regular pattern of activities for the rest of the day as they cope with their survival strategies. In the night, the frontage of shops and sheds in the markets offers shelter and the tables serve as beds for many.

Even in these circumstances everything is highly monetized. The youth pay money for the use of a makeshift bath house, to visit the toilet and even to sleep on the verandahs. A condition of the survival of the fittest prevails in the environment, the stronger ones exploiting the situation to their advantage. Some of the strong ones hire out mats for use on the verandah at night at the cost of 100 cedis (about US 20 cents) a night. Those who want a screened verandah for intimate relationships pay something extra. There is such an intense pressure on the street-involved youth to always have money, that all values, decency and pride have been cast aside. The need to get money in order to survive compels them to go into socially unacceptable means of earning incomes: the boys into the sale of marijuana, petty stealing and swindling. Some of the girls are forced into 'survival sex'. The legitimate activities for earning a living include porterage and cleaning. A few sell petty items in the street.

Most of the youth do not have fixed daily schedules. The porters, for example, can spend the whole night around the fire expecting a cargo truck to arrive. Almost all of them are compelled to wake up early, sometimes as early as four in the morning, before owners of stores and sheds come to work. The early part of the day is thus spent roaming about before sunrise. This unavoidable situation makes them fall foul of the law quite often as they usually encounter police on patrol. The participants in the focus-group discussions were bitter about the criminal activities of some law enforcement officers. The girls complained bitterly about the activities of a task force set up by the Metropolitan Assembly to clear the streets of pedlars. Some of the girls, in fact, changed over from petty trading into commercial sex when their wares were seized by the task force. Items seized were never returned to their owners. Some of the girls arrested were handed over to the wives or mistresses of the members of the task force to serve them for a period. The sex trade receives the bulk of the displaced girls because, as they put it, 'there is no harassment involved'.

According to the porters, night raids by the police have become a regular affair. Those caught in such raids are made to empty their pockets and the contents, often including money, are never returned to their owners. They are then put in a van and abandoned at another end of the city. When they are taken to the police station they are released only after paying huge sums of money. The boys, however, conceded that they often get involved in some illegal activities which put the police and the People's Militia on their trails. Almost all the porters smoke marijuana as well as get involved in illegal gambling. The life of the street-involved youth in Accra is thus one of continuous struggle for survival in an atmosphere of fear, intimidation, violence and vulnerability. Their environment, therefore, makes them susceptible to infection and their limited resources reduce their capacity to seek adequate medical help.

Characteristics of the sample

Table 1 shows the basic characteristics of the survey population. The total sample size was 250 of whom 70 per cent were males. The median age for both sexes was 20.1 years with males slightly older than females (20.2 years and 19.6 years respectively). A substantial majority (84%) described themselves as working. Males were likely to be porters (47.4%) while the largest proportion of the females (33.3%) were in the sex trade. The majority (91.2%) had at least primary school education (six years). Males were more likely than females to have had some post-primary education (62.9% versus 6.7%). About 64 per cent professed to be Christians and some 18 per cent described themselves as Muslims. Almost 11 per cent said they had no religion.

Nearly two-thirds migrated to Accra from other parts of the country, most of them as primary migrants. About 53 per cent spent their childhood years in Accra or another city in Ghana and another 20 per cent lived in medium-sized towns. In fact, only six per cent spent their childhood years in a rural environment. It could thus be said that almost all the respondents have been shaped by urban conditions for the best part of their lives.

Table 1
Basic characteristics of sample population

	Males	Females
Age and sex distribution (%)		
10-14	9.1	6.6
15-19	38.3	46.7
20-24	52.6	46.7
Median age	20.2 years	19.6 years
Level of education (%)		
No education	7.4	12.0
Primary	29.7	81.3
Post primary	62.9	6.7
Occupational distribution (%)		
No work	14.9	18.7
Mechanic	7.4	-
Porter/labourer	47.4	6.7
Petty trading	27.4	29.3
Prostitution	-	33.3
Dressmaking/barber	2.7	12.0
Religious affiliation (%)		
Christianity	60.0	72.0
Islam	20.6	13.3
Traditional	6.9	8.0
No religion	12.5	6.7
Total	100.0	100.0
N	175	75

Residential and feeding arrangements

About 51 per cent of both sexes sleep away from their homes (Table 2). Females were more likely than males to sleep at home (53% versus 47%). Most of them (37%) slept in the market (males 39%; females 32%). About ten per cent sleep at bus stops. A few females said they sleep in hotels (1.3%).

Almost all of them (98.8%) spend most of the day away from home (see Table 2). They are mostly found in the market (70%) and the transport station (14.4%). Just six per cent spend some time at workshops.

Food does not seem to be a problem to the study group. The majority of them (82%) said they eat three times a day and another 17 per cent eat twice a day. Only nine per cent take their regular meals at home and another four per cent take some meals at home. The majority take all their meals away from home. There seems to be no organized eating habit with just a quarter of them saying that they take their meals from organized food stalls. The members of the group mainly cater for themselves. About 14 per cent said parents provide some of their meals and another four per cent mentioned siblings as the providers of some of their meals.

Table 2
Residential arrangements (%)

	Males	Females
Where do you sleep at night?		
At home	47.4	53.3
Market	40.0	36.0
Bus stop	10.9	8.0
Restaurant	1.7	1.3
Hotel	0	1.3
Where do you spend most of the time in the day?		
At home	0.6	2.7
Transport station	17.7	6.7
Workshop	7.4	2.7
Street	7.4	10.6
Total	100.0	100.0
N	175	75

Family background and extent of parental influence

From the respondents' accounts, the educational background of their parents was reasonably high by Ghanaian standards (Table 3). Only 16.8 per cent of fathers had not had any formal education, compared with 42.4 per cent of mothers. Most of the parents have primary education (43.2% for fathers and 36.8% for mothers). Fathers were more likely than mothers to have post-primary education (20% against 4%). Surprisingly, a significantly large proportion did not know the educational background of their parents (20% for fathers and 16.8% for mothers); this reveals that an appreciable proportion of the group were not familiar with their parents.

Table 3
Level of parents' education (%)

	Fathers	Mothers
Level		
No school	16.8	42.4
Primary	43.2	36.8
Post-primary	20.0	4.0
Don't know	20.0	16.8
Total	100.0	100.0
N	250	250

The majority (58%) came from single-parent homes. At the time of the survey 41 per cent lived alone and another 20 per cent lived with other siblings. Only eight per cent stayed with both parents; a further nine per cent of respondents stayed with their mothers only and three per cent with fathers only. Most of them did not benefit from the joint upbringing by both parents in their childhood years. Only 41 per cent spent most of their childhood years with both parents. The majority either stayed with mothers only (31%), grandmothers (9%) or fathers only (7%). By their own judgement only 31 per cent thought that both parents had been responsible for their upbringing. The largest proportion (35%) said mothers had been responsible for their upbringing and another 12 per cent gave the credit to grandmothers. Only eight per cent mentioned fathers.

When asked whether they talk with their parents 44 per cent answered in the affirmative. Another 26 per cent said they talk to mothers only and just eight per cent talk to fathers only. About 21 per cent said they do not talk to their parents at all. Giving reasons why they do not talk with parents, 81 per cent said they did not live together, three per cent said they did not know the whereabouts of their parents, and two per cent said the parents were annoyed with them.

Reduced parental influence is revealed in another perspective. Both sexes were more likely to report to siblings in case of trouble (24%), than to mothers (23%) or fathers (13%). Almost 13 per cent consult friends when in trouble. Similarly, they were more likely to take their important decisions alone (37%) or with friends (18%), than with siblings (14%), and parents (4%). Interestingly, males were more likely than females to consult mothers on important decisions (14% versus 1%), whilst females were more likely than males to consult fathers (9% versus 5%).

Knowledge and attitude about human sexuality

People's attitudes towards sex tend to affect their sexual behaviour. A battery of questions were put to the respondents to test this. To the question ‘Can one stay away from sex?’, 58 per cent responded in the affirmative. About 39 per cent said it was not possible and three per cent did not know. Giving reasons for the inability to stay away from sex 35.2 per cent of those who answered in the negative said ‘it can't be avoided’, 28.6 per cent said ‘it is natural’ and 15.2 per cent said ‘it is important’. These responses are consistent with the general belief among the participants of the focus group discussions that normal human beings can never stay away from sex. They saw sex as a biological need that must be met. About two per cent said it cannot be avoided for economic reasons (see Table 4). When the question ‘How often must one have sex?’ was put only 14.4 per cent did not respond and 8.4 per cent said they did not know. That means that even some of those who said one can stay away from sex gave their views about the frequency of sexual contact. About eight per cent thought sexual contact should be every day, 44 per cent said it should be two to three times a week and 19 per cent said once a week (see Table 5).

Table 4
Reasons why one cannot stay away from sex (%)

	Males	Females
It’s important	16.4	12.5
It’s natural	31.5	21.9
Can’t be avoided	37.0	37.5
Economic necessity	1.4	3.1
Not stated	13.7	25.0

Total	100.0	100.0
N[a]	73	73

[a]Contains only respondents who answered 'No' to the question 'Can one stay away from sex?'

Only 15 of the males (9%) and eight of the females (11%) knew any sexual taboos: almost all the taboos related to females. They included the avoidance of sex before a girl is taken through puberty rites or female circumcision, and the avoidance of sex during menstruation. Although the last is still observed by many people but not necessarily as a taboo, the first two have lost their significance mainly as a result of modernization and the influence of Christianity.

Both males and females had similar opinions about the earliest age a person must have sexual relations. The mean recommended age for first sexual intercourse for males was given by males as 17.1 years and by females as 18.9 years: while that for females was 17.2 years recommended by males and 16.6 years by females. There is, however, a difference between the ideal and reality. Both sexes mentioned that their closest friends had their first sexual experience earlier than when they thought it should be. The mean ages at first sexual experience of their closest friends were 15.9 years for males and 14.9 years for females. For both sexes, the earliest age at first sexual experience reported (seven years), was among those who grew up in a medium-sized town. For those who grew up in the rural areas the earliest ages reported were 13 years for males and 15 years for females.

Table 5
Reported frequency for sexual intercourse (%)

	Male	**Female**
Every day	6.3	13.3
2-3 times a week	45.7	38.7
Once a week	20.6	16.0
1-2 times a month	6.9	4.0
Don't know	6.3	13.3
Not stated	14.2	14.7
Total	100.0	100.0
N	175	175

Respondents' own experiences were very similar to what they reported about their friends (see Table 6). The mean age at first sexual experience was 15.9 years for males and 16 years for females. The earliest ages at first sex (6 years for males and 9 years for females) were experienced by respondents who spent most of their childhood years in Accra or another city. For those who spent most of their childhood years in the rural areas, the earliest age at first sex was 16 years for males and 11 years for females. Females were more likely than males to have a fairly good idea about the age of menarche. About 97 per cent of the females mentioned the age of first menstruation to be between 11 and 19 years as against 57 per cent of males identifying puberty as starting at this age. As many as 40 per cent of the males, as against three per cent only of the females, responded that they did not have any idea. Similarly, females were more likely than males to have an idea about the 'safe' period to have sexual relations with a view to preventing pregnancy. Only 39 per cent of the females as against 62 per cent of the males reported that they had no idea about the 'safe' period.

There appeared to be a positive relationship between education and knowledge about the 'safe' period for having sex with a view to preventing pregnancy. The proportions reporting no knowledge about the safe period stood at 100 per cent, 65 per cent and 56 per cent among

those with no education, primary and post-primary education respectively. However, the pattern is better observed among the males than the females. For example, there was virtually no difference between the proportion among the females with no education and those with post-primary education (44% and 40% respectively).

Table 6
Age at first sexual experience of respondents (%)

	Male	Female
Below 10 years	2.9	1.3
10-14 years	17.1	21.4
15-19 years	48.0	60.0
20-24 years	9.2	12.0
No sex	21.7	4.0
Not stated	1.1	1.3
Total	100.0	100.0
N	175	75

The observation brings to light the fact that sex education is not given much attention in Ghanaian schools and much of what people know about sex is learnt away from school. In fact most of both sexes (62%) received information about sex from friends (peer group members). A very small proportion (9%) received some information from mothers and a similar proportion through eavesdropping (Appendix A). Expectedly, females were more likely than males to receive some sex information from mothers (12% versus 7%). Much of the information passed on was pregnancy-related (54%). A quarter of both sexes mentioned disease-related issues as the topic taught in the education. Females were more likely than males to discuss pregnancy-related issues instead of diseases (65% pregnancy, 43% disease) and the reverse is true in the case of males (30% disease, 18% pregnancy).

Sexual behaviour

Seventeen per cent of the respondents had never had sexual relations. Females were more likely than males to have become sexually active (95% versus 78%), but reported significantly fewer sexual partners than males.

Although many had begun sexual relations, fewer said they had sexual intercourse in the last year, and fewer still in the last three months (see Table 7).

Among those who had ever had sexual intercourse, the number of partners reported was significantly higher for males (Table 8). Cultural restrictions may explain the differences in reporting. Traditionally a woman is expected to remain the sexual partner of one man either within or outside marriage. Therefore, a woman may be more likely to report one partner at a time.

Table 7
Percentage sexually active by sex

	Males	Females	Total
Ever	78.3	94.7	83.2
In the last year	76.6	94.7	82.0
In the last 3 months	70.3	90.7	76.4

Table 8
Mean number of sexual partners by sex

	Males	Females	Total
Life time[a]	5.9	4.3	5.4
In the last year[b]	3.2	2.3	2.9
In the last 3 months[c]	2.4	2.3	2.4

[a]Among those who ever had sex

[b]Among those active in last year

[c]Among those active in last 3 months

However, the proportions of the sexes who reported 'Too many to count' sexual partners are quite revealing (see Appendix D). In the last three months 2.7 per cent of females reported too many partners to count as against none of the males. The proportions in the last year and over a lifetime stood at eight per cent versus 3.4 per cent and 21.3 per cent versus 17.8 per cent respectively. The females who reported too many sexual partners were certainly in commercial sex. For them sex was for survival. This comes out clearly in Table 9. Giving reasons for having sexual relations a majority of the males (54.3%) said it was for pleasure as against only 36 per cent of the females. Rather, commercial consideration was mentioned by 24 per cent of females as against only 1.1 per cent of males.

Table 9
Reasons for having sexual relations (%)

	Males	Females
For pleasure	54.3	36.0
For money	1.1	24.0
Want a child	16.0	18.7
Want to marry	2.9	6.7
Friends do it	1.1	1.3
Test fertility	0.6	2.7
No reason	0.6	4.0
Not stated	1.7	1.3
No sex	21.7	5.3
Total	100.0	100.0
N	175	75

Another form of the sexual activity of the respondents is revealed in Table 10. The majority of the respondents (64.8%) said they had sex either daily or between one and three times a week (80% for females and 58.3% for males). Again the figures bring out the difference between sex for pleasure and sex for survival. For some of the girls sex must be a daily affair if they are to survive. Details of their sexual activities are discussed below. About 42 per cent of both sexes said they had intercourse with their sexual partners at home, which is significantly lower than the proportion who reported sleeping at home at night (49%). A lot of sexual activities take place in the open: 28 per cent in the market and another seven per cent 'any place'. Some boys said they sometimes sleep with more than one girl at a time on the same 'bed'.

Table 10
How often do you meet your sexual partners? (%)

	Males	Females
Daily	16.0	36.0
1-3 times a week	42.3	44.0
1-2 times a month	5.7	9.3
Occasionally	9.2	4.0
Not stated	5.1	1.3
No sex	21.7	5.3
Total	100.0	100.0
N	175	75

Generally the males were not frightened by the possibility of their sexual activities resulting in pregnancy. The girls were to some extent, but, like the young men, they did not do anything to prevent pregnancy. Abortion appeared to be very common in the group and members were more likely to have an abortion than to allow a pregnancy to continue. The girls were particularly against the use of foaming tablets saying that they cause abrasions which in turn cause heavy discharges.

Sexual networking

Sexual networking in the environment of the street-involved youth has as its participants the members of the group themselves on one hand, and on the other, members of the general resident population in Accra and others from outside Accra whose activities bring them into the environment regularly. Figure 1 illustrates the sexual networking in the environment of the street-involved youth. A lot of sexual activities take place among the youth themselves. Most of them have partners from within the group which forms part of the survival strategies of the girls. From these 'quasi-regular' partners the girls get about 500 cedis (around US$1.00) a day as food money. This compels the girl to satisfy the boy's sexual demands every time. In the night some of the girls leave their partners to go to solicit clients in town. There was evidence of partner swapping within the group. For example during the focus-group discussions several boys pointed to a particular girl from whom they thought they had once contracted venereal disease.

The forces sustaining the relationships among the youth easily become apparent. On the one hand are boys who see sex as a form of pleasure. On the other are vulnerable girls who need money to survive but do not have the requisite qualifications to enable them to secure a respectable means of livelihood. In addition, they need protection in a potentially violent environment and a place to rest in the day time; these are controlled by the boys. The relationships are, therefore, not very stable and have within them elements of recklessness.

Another sexual relationship involves the porters and some of the resident traders and hawkers. A relationship with a porter enables a trader to get allocation of goods for sale without going through the struggle which usually follows the arrival of a cargo truck. Some of the trucks arrive before dawn and a trader has to be around if she wants some allocation of items to sell. This is where the relationship with a porter counts. Since the porters do the offloading they can easily make allocations to their favourites. To the porters the relationship is easy access to something they regard as pleasurable and the prestige of being intimate with a respectable woman. To the traders it is pure business and a way of maximizing profit without much trouble.

Some of the porters have casual relationships with some of the female itinerant traders. The cost of offloading goods from trucks is borne by the owners of the goods. The porters befriend the traders either by offloading their goods free of charge or by lending them money to pay the truck drivers until their goods are bought. A close relationship with a porter may also make it possible for an itinerant trader to get a place to rest while waiting for her goods to be bought.

The long-distance truck drivers who bring goods to the study area also have sexual relationships with some of the itinerant traders. Most of the items brought to Accra are perishable and getting transport at the right time and regularly is an important aspect of the business of the traders. A relationship with a truck driver ensures this.

A number of the female members of the street-involved youth practise commercial sex. They can be found at the street corners and around hotels where they solicit clients. As prostitutes they are also easily accessible to some of the truck drivers.

The foregoing illustrates the complex sexual networking that goes on in what appears to be a simple environment. Four routes along which HIV/AIDS can travel from the high-risk environment to the general population and vice versa can be observed.

Route 1 is from the female prostitutes. Males in the general population can contract the disease from them and in turn pass it on to their wives and regular partners. The reverse is also possible.

Route 2 is along the same direction but from the males, through the female resident traders and hawkers to the general resident male population.

Route 3 is from the female itinerant traders to their male partners in other localities outside Accra.

Finally, route 4 is from the truck drivers to their female partners in other localities outside Accra.

Sabatier (1987) has explained that when the AIDS virus is introduced into a society it tends towards the path of least resistance. This is often the path trodden by the poorest, most disadvantaged, least powerful, or most stigmatized (Muir 1991). Almost all the adjectives describe most, if not all, the groups identified above. In fact, during the focus-group discussions participants strongly condemned the negative messages the general population constantly directs at them which make them view themselves as inadequate, powerless and unworthy (cf. Turner, Miller and Moses 1989).

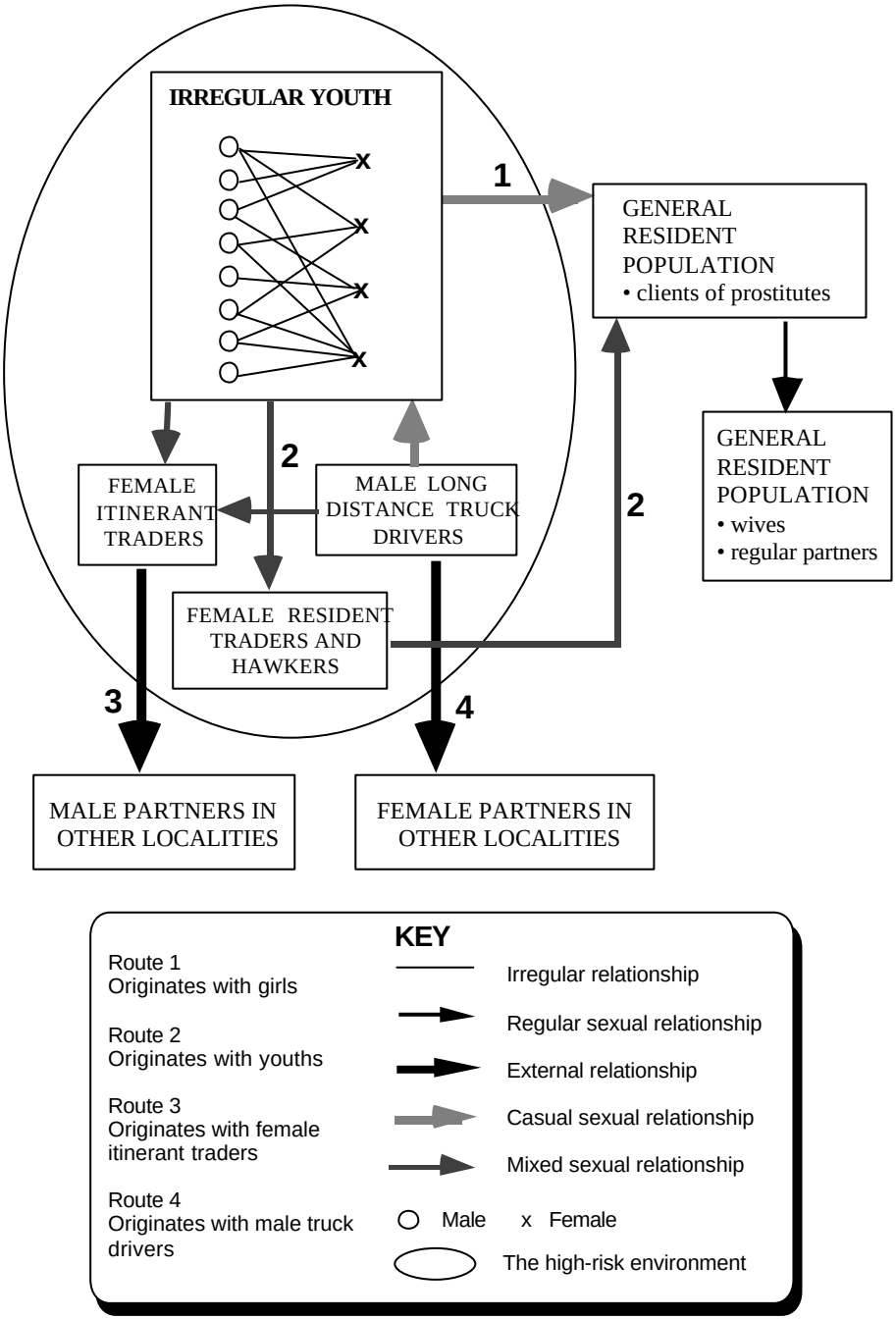
Other studies have observed that ultimately the 'basic reproductive rate' of AIDS, that is, the number of other people that the typical HIV-infected person goes on to infect, will determine the severity of the spread of the disease (Lewis, Watters and Case 1989:37). If the rate is less than one, then the spread of AIDS will be restricted mainly to the core group. If the rate is more than one, the AIDS epidemic is likely to spread alarmingly, affecting increasing numbers of the general population. As elsewhere, the basic reproductive rate among the group is not known. However, the steady progress of the disease in the country so far leaves no doubt that AIDS is firmly established in Ghana. The number of possible escape routes in the environment indicate that if the disease is introduced into it (if this has not already occurred), the effect will be tremendous. Much will, however, depend upon how much the youth know about STDs in general and AIDS in particular, and the extent of the presence of other co-factors, especially venereal diseases.

Knowledge of STDs/AIDS

Awareness of STDs is high, with 98 per cent of both sexes having heard of the diseases. About 22 per cent reported having been treated for STDs before, the male proportion being almost twice that of females (26% and 15% respectively). It must be emphasized that venereal diseases are highly stigmatized in Ghana and sufferers are likely to keep the

information to themselves. There is, therefore, reason to believe that the figure is

Figure 1: Illustration of sexual networking in the environment of the study group



conservative for the proportion reporting ever having an STD. Evidence to this effect came up during the focus-group discussions: at one of the all-female sessions participants made a passionate appeal to us to get them examined through special arrangements. Following that, an arrangement was made to get two males and two females examined and treated in an STD clinic in Accra. The plan was to assess how much it would cost to operate a larger-scale clinic specifically for the street-involved youth. The initial test showed that all the four had STDs and the girls had multiple infection of two to four different types of venereal disease. The level of knowledge of the early symptoms of STDs was also quite appreciable. Without being prompted 67 per cent of respondents mentioned discharge and 66 per cent mentioned pain in the lower abdomen or genital organs as some of the symptoms.

Table 11 shows the respondents' knowledge of the mode of transmission of STDs. It shows that most know they are transmitted by sexual contact and male and female responses are quite similar. However, the level of misconceptions is disturbing and females are more likely than males to hold them. For example, 50.7 per cent of females and 36.6 per cent of males attributed the transmission of STDs to witchcraft, and 14.7 per cent of females and 6.3 per cent of males attributed it to act of God or supernatural causes. Self-medication is the chief method used to treat STDs in the group. The usual prescription was penicillin in either *akpeteshie* (a local gin) or palm wine. There was so much unsatisfactory treatment that some boys had developed chronic pain in their penis. During the survey one male in the group was rushed to hospital in serious pain from retention of urine for three days. In addition to the misconceptions they had about ordinary STDs, the young people did not regard them as serious ailments. Some confessed that they still had intercourse when they knew they had an STD, just for enjoyment.

Table 11
Knowledge of respondents on the transmission of venereal diseases[a] (%)

	Males	Females
Through sexual contact	88	93
Through sex with prostitutes	93	87
Act of God/supernatural	6	15
Witchcraft	37	51
Through blood transfusion	64	65
Through kissing	31	27

[a] Multiple answers

Similarly, awareness of AIDS was very high (98%) and about a fifth had seen an AIDS patient. Table 12 shows their knowledge of the mode of transmission of AIDS. Most people knew about the transmission routes. However, as with STDs, certain misconceptions were still held, including that AIDS was caused by kissing, by witchcraft and by act of God or supernatural causes. Again females were more likely than males to express those misconceptions.

Table 12
Knowledge on the transmission of HIV/AIDS (percentage distribution)[a]

	Males	Females	Total
Through sexual contact	92	97	94
Through sex with prostitutes	91	93	92
Act of God/supernatural	9	19	12
Witchcraft	34	48	38
Through blood transfusion	76	91	80
Through kissing	54	47	52

[a] Multiple answers

Risk-reduction behaviour

Nearly 90 per cent of the youth knew of condoms but only 34 per cent had ever used them. Only six per cent always used condoms in the last three months and another 19 per cent used them occasionally. For those who use condoms the main reason was to prevent venereal disease. About four per cent mentioned AIDS specifically. Another 40 per cent said they used condoms to prevent pregnancy. The main reason for not using the condom was that they 'just didn't like it' (33%). Another eleven per cent felt that condoms do not give any protection. About five per cent did not use condoms because 'they had faith in their partners' and a few others said they wanted babies (3%).

On whether there had been any change in their sexual behaviour since hearing of AIDS only nine per cent said they practise abstinence and another ten per cent said they insist on the use of condoms. What most of the respondents regarded as changed behaviour included 'no sex until partner was well known' (45%), 'reduction in the number of sexual partners' (42%), and 'avoidance of sex with prostitutes' (33%) (see Appendix C).

Discussion

Current records show that AIDS has become established in Ghana. Knowledge of the disease is almost universal not only because of the continuous education but also because significant numbers of people are falling ill and AIDS-related deaths are becoming widespread in many communities. As is the general situation in Africa, poverty seems to play a part in the spread of STDs including HIV/AIDS in Ghana. Communities and individuals struggling to survive, with inadequate facilities and low incomes, are often more at risk. Patterns of infection reflect inequality between the sexes. Women's lower social and economic status often makes them less able to protect themselves against the risk of infection resulting in a 3:1 female to male ratio among AIDS sufferers. However, in both sexes HIV/AIDS patients are predominantly young, within the age group 20-39 years.

Accordingly, most AIDS intervention programs have been tailored along these observed lines. In addition to the general programs aimed at the so-called sexually active population, some group-specific studies have been initiated. One example is a continuing condom promotion study among prostitutes in Accra being undertaken by the AIDS Control Programme. Two categories of prostitutes are involved in the study, resident and non-resident prostitutes. The former have fixed residential addresses where they receive clients. The latter have no fixed addresses and solicit for clients from the streets and hotels. A nagging problem faced by the study is the inability to retain participants, particularly from the second category of prostitutes, for follow-up and monitoring. The experience in the fieldwork for the current

study was different. All participants were co-operative and some of the females voluntarily asked for advice and assistance for medical examination and treatment of venereal diseases. In addition, they agreed to participate in focus-group discussions on condition that they would be supplied with condoms.

Another example was the United States Agency for International Development (USAID)-sponsored KAP study on youth and young adults aged 15 to 30 years. This was a two-stage study — before and after — meant to evaluate a media campaign aimed at the study population. After ten months of media campaign the evaluation showed that while there had been a significant increase in the level of awareness among the young people, sexual behaviour, such as the number of sexual partners and condom use, had remained virtually unchanged (see McCombie and Anarfi 1991, 1992). In this study it was assumed that all young people had equal access to information. Only young people found at home were included in the study. However, the current study has revealed that there are a number of young people in Ghana who have no fixed accommodation and spend most of their time on the streets.

It has been conceded that education about AIDS prevention may be difficult with adolescents and young adults because of 'their emerging independence, rebellion, their sense of invincibility, distrust of adults or governments, and present-time orientation, and because of peer pressure' (Muir 1991:143). However, the absence of a known vaccine or cure for AIDS leaves us with education and information as the only means of averting the spread of the disease. This study has confirmed the general observation that young people are more sexually active than many adults may realize, and as a group, they value sexual experience more than they do chastity (King et al. 1988). Sexual behaviour among the study population could be described as dangerous, with some involved in sex for survival and an appreciable proportion contracting STDs every now and then. Their life was one of high stress (in seeking food, shelter, and protection), with little money, unemployment, and a lack of medical services. Although awareness of AIDS was almost universal among the group, the preventive messages were largely ignored in the drama of meeting their more immediate needs, such as where to sleep and how to obtain food, or for those who were on drugs, when to get the next dose.

Their centre of activity, and the kind of work most of them were doing for a living, brought them into contact with other people with whom they had sexual relationships: truck drivers, resident women traders and hawkers, and itinerant women traders. The environment, therefore, offers a very good opportunity for involving concurrently some of the known AIDS-related high-risk and vulnerable groups in an intervention program. The network of sexual relationships which reaches beyond the environment of the young people to the general population in Accra and beyond, will be very useful as routes for the dissemination of AIDS prevention messages.

Recommendations

Given that most of the behaviour of the street-involved youth helps them cope and survive in their adverse environment, AIDS intervention programs must be innovative and follow an integrated approach. In addition to mass awareness campaigns, an office must be set up preferably at the centre of activity of the youth to cater specifically for their needs. This will make certain medical and educational facilities more accessible to this category of people who feel cut off from the main society. The young people should be able to visit the office for advice and counselling or even treatment without the fear of being tagged. Social marketing could be put to good use in such an office.

The treatment of sexually transmitted diseases should be made a priority. There was evidence that those who contracted STDs were not able to treat them properly. Untreated STDs are known to facilitate the spread of HIV. Such treatment must be subsidized.

Effort must be made to improve the social and economic conditions of the youth and reduce their dependence on practices such as the peddling and abuse of drugs and prostitution. Those who require training in certain skills must be given the opportunity to upgrade themselves.

Lessons could be taken from similar programs elsewhere to improve the effectiveness of the AIDS education. The education must be specifically designed to help individuals build decision-making, communication, and assertiveness skills. A study by Kipke, Boyer and Hein (1989) in Canada observed that increased knowledge improved behavioural skills and enabled individuals to refuse certain behaviour and to negotiate lower-risk sexual activity.

Other studies have observed that educational programs which make use of 'insiders' as role models have proved particularly successful (see Batjes and Pickens 1988; Conant et al. 1989). The program must, therefore, have components of peer support and peer education. Above all, the integrated approach requires that the program must be run by a team of dedicated experts with varied backgrounds. They should include a social scientist, a medical practitioner, a psychologist, a counsellor and a social worker to offer career guidance. However, for many of the young people environmental factors like dysfunctional families will need to be addressed before HIV prevention can be most effective.

Appendices

Appendix A: Respondents' sources of sex education

	Male	Female
Friend (peer)	59.1	64.7
Mother	6.8	11.8
Eavesdropping	11.4	5.9
Media	6.8	8.8
School/teacher	9.1	2.9
Older siblings	4.5	2.9
Health worker	2.3	2.9
Total	100.0	100.0
N[a]	44	34

[a] Only represents those who have ever had some sex education.

Appendix B: Reported content of sex education

	Male	Female
Topic		
Pregnancy -related	43.2	64.7
Disease-related	29.5	17.7
Can't remember	20.5	11.7
Not stated	6.8	5.9
Total	100.0	100.0
N[a]	44	34

[a] Only represents those who have ever had some sex education.

Appendix C: Modified sexual behaviour since hearing of AIDS (% of those who reported modified behaviour)[a]

	Male	Female
No sex until partner well known	44	47
Reduced number of partners	40	45
Avoids anal sex	23	35
Insists on use of condom	8	13
Avoids oral sex	18	32
Practises abstinence	10	8
Asks about partner's behaviour	25	28
Avoids sex with prostitutes	32	36

[a]Multiple response

Appendix D Number of sexual partners over certain periods(%)

	Male	Female
In the last three months		
0	8.0	4.0
1	25.2	36.0
2-5	28.0	34.7
6+	3.4	5.3
Too many to count	0	2.7
Can't tell	13.7	12.0
No sex	21.7	5.3
In the last year		
0	1.7	0
1	22.9	29.3
2-5	28.6	33.3
6+	8.0	5.3
Too many to count	3.4	8.0
Can't tell	13.7	18.7
No sex	21.7	5.3
In lifetime		
1	6.3	6.7
2-5	26.2	37.3
6+	15.4	4.0
Too many to count	17.8	21.3
Can't tell	12.6	25.3
No sex	21.7	5.3
Total	100	100
N	175	75

References

Ahmed, H.J., K. Omar et al. 1991. Syphilis and Human Immunodeficiency Virus seroconversion during a 6-month follow-up of female prostitutes in Mogadishu, Somalia. *International Journal of STD and AIDS* 2,2:119-123.

Aina, T.A. 1991. Patterns of bisexuality in Sub-Saharan Africa. Pp.81-90 in *Bisexuality and HIV/AIDS,* ed. R.Tielman, M. Carballo and A. Hendriks. Buffalo: Prometheus Books.

Ankrah, E.M. and C.B. Rwabukwali. 1987. KAP study for school Health Education: implications for AIDS control. UNICEF Uganda Publication.

Barnett, T. and P. Blaikie. 1992. *AIDS in Africa*. London: Belhaven Press.

Battjes, R.J. and R.W. Pickens. 1988. Needle sharing among intravenous drug abusers: national and international perspectives. NIDA Research Monograph 80. Rockville MD: US Department of Health and Human Services.

Carswell, K.W., G. Lloyd, et al. 1989. Prevalence of HIV-1 in East African lorry drivers. *AIDS* 3:759-761.

Caswell, A. and S. Green. 1988. *AIDS Prevention and Street Youth - An Exploratory Study.* Victoria: BC Public Interest Research Group.

Conant, S.B. et al. 1989. Innovative AIDS education for adolescents: strategies for behaviour change. Paper presented at Fifth International Conference on AIDS, Montreal, 4-9 June.

Curran, J.W. et al. 1988. Epidemiology of HIV infection and AIDS in the United States. *Science* 239:610-616.

Evans-Pritchard, E.E. 1974. *Man and Woman among the Azande*. London : Faber and Faber.

Guinan, M.E. and A. Hardy. 1987. Epidemiology of AIDS in the United States: 1981 through 1986. *Journal of the American Medical Association* 257:2039-2042.

Kaplan, H.S. 1987. *The Real Truth about Women and AIDS*. New York:Simon and Schuster.

King, A.J.C., R.P. Beazley, et al. 1988. *Canada Youth and AIDS Study.* Ottawa: Federal Centre for AIDS (Health and Welfare).

Kinsey, A.C., W.B. Pomeroy and C.E. Martin. 1948. *Sexual Behaviour in the Human Male*. Philadelphia: W. B. Saunders Company.

Kipke, M., C. Boyer and K. Hein. 1989. An evaluation of an AIDS risk reduction education and skills training (ARREST) programme for adolescents. Paper presented at Fifth International Conference on AIDS, Montreal, 4-9 June.

Kisekka, M.N. 1976. Sexual attitudes and behaviour among students in Uganda. *Journal of Sex Research* 12,2:104-116.

Konde-Lule, J.K. 1992. Adolescents and AIDS in Rakai District, Uganda. Paper presented at Workshop on AIDS and Society, Kampala, 15-16 December.

Larmer, B. and M. Margolis. 1993. Dead-end kids. *Readers Digest*, April:57-62.

Lewis, D.K., J.K. Watters and P. Case. 1989. The prevalence of high-risk sexual behaviour in male heterosexual and bisexual men: clinical manifestations, 1978-1989. Paper presented at Fifth International Conference on AIDS, Montreal , 4-9 June.

Mann, J.M. 1988. Condom use and HIV infection among prostitutes in Zaire. Pp.105-106 in *The Heterosexual Transmission of AIDS in Africa*. Cambridge MA:Abt Books.

McCombie, S. and J.K. Anarfi. 1991 and 1992. Results from a survey of Knowledge, Attitudes and Practices related to AIDS among young people in Ghana - 1991/1992. USAID, AIDS Technical Support, Public Health Communication Component and Ministry of Health, Ghana.

Muangman, D. et al. 1988. Report of a KAP study of high risk groups for AIDS in male sex workers and male clients in Thailand (Manuscript).

Muir, M.A. 1991. *The Environmental Contexts of AIDS*. New York: Praeger.

Nagelkerke, N.J.D. et al. 1990. Transition dynamics of HIV disease in a cohort of African prostitutes: a Markov model approach. *AIDS* 4,8:743-747.

Nzila, N., M. Laga et al. 1991. HIV and other sexually transmitted diseases among female prostitutes in Kinshasa. *AIDS* 5,6:715-721.

Nzyuko, S. 1991. Teenagers along the Trans-African Highway. *AIDS and Society*, July-August.

Orubuloye, I.O., J.C. Caldwell and P. Caldwell. 1992. The role of high-risk occupations in the spread of AIDS: truck drivers and itinerant market women in Nigeria. *Health Transition Working Paper* No. 4. Canberra: Australian National University.

Parker, R.G. 1989. Youth, identity and homosexuality: the changing shape of sexual life in contemporary Brazil. *Journal of Homosexuality* 17,3/4:269-289.

Sabatier, R.C. 1987. Social, cultural and demographic aspects of AIDS. *Western Journal of Medicine* 147:713-718.

Sittitrai, W. 1988. Qualitative research for development of IE&C materials for high-risk groups in Thailand. Paper presented at First International Symposium on Information and Education on AIDS, Ixtapa, Mexico.

Sittitrai, W., et al. 1989. Demographic and sexual practices of male bar workers in Bangkok. P.714 in *International Conference on AIDS, Montreal, Quebec, June 4-9,* Abstract No. MDP19.

Turner, C.F., H.G. Miller and L.E. Moses (eds). 1989. *AIDS: Sexual Behaviour and Intravenous Drug Use.* Washington DC: National Academy Press.

Wofsy, C. B. 1987. Human Immunodeficiency Virus in women. *Journal of the American Medical Association* 257:2074-2076.

Yeboah-Afari, A. 1988. Helping prostitutes in Accra. *AIDS Watch* 4:4-5.