

# Sexuality, migration and AIDS in Ghana - A socio-behavioural study



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## **Abstract**

Sexual behaviour in Ghana characterizes a society in transition. Although cultural restrictions against sexuality are no longer strictly enforced, the very nature of the social organization puts a brake on some excesses. Migration removes people from these restrictions into a situation where sexual fulfilment is enhanced. This paper explores the risk factors associated with migration. Results of a large survey across Ghana indicate widespread sexual networking. There is, however, an apparent decline in the number of sexual partners in recent periods which may be related to the AIDS campaign. Yet migration acts to increase the extent of sexual networking. While many migrants have regular sexual partners, there are a substantial number of encounters with casual partners. The circular nature of migration and the maintenance of links with home through frequent visits puts people at risk at both ends of the migratory movement. This risk is increased with international migration, associated with higher than average numbers of sexual partners. An appropriate policy for the control of the spread of AIDS in Ghana, therefore, would be one which combines educational programs with strategies for removing the factors which compel young people to migrate.

## **AIDS in Ghana**

The first case of AIDS in Ghana was reported in March 1986. By 31 July, 1991, 2,525 AIDS cases had been reported. Initially 85 per cent of the diagnosed cases were females. The male to female ratio of reported cases of AIDS in Ghana has risen from 1:8 in 1986 to 1:3 in 1990. At the onset, most of the AIDS cases had a history of living outside the country and almost all of the females were involved in prostitution in another country (Konotey-Ahulu 1989). The proportion of people with a history of staying outside the country among the AIDS cases has declined from 89 per cent in 1986 to 56 per cent in 1990. This implies that diffusion of the disease is taking place within the country and that Ghana has gone past the introductory stage and is well into the propagation stage of the spread of AIDS. So far the main features of the disease in the country appear to be that it affects more females than males; that the majority of the affected have a history of living outside the country; that almost all the women affected have been involved in international prostitution; and that the local diffusion of the disease is gaining prominence.

However, there are still gaps in our knowledge about the demographic, social and economic characteristics of the population at risk. The available information indicates that an understanding of the transmission of AIDS in Ghana will, to a large extent, depend upon our knowledge of the behaviour, social and cultural factors that determine people's risk of HIV infection, in particular their perception and attitude towards sex, their sexual habits and these of the society in general. We need to be informed of the aspects of social networks through which the disease is likely to be transmitted. This knowledge will never be complete in the Ghanaian situation if we do not understand the conditions that predispose people to the risk of AIDS in migration.

### **Migration and AIDS**

The spread of any infectious disease can be accelerated in a situation of large-scale migration, especially in the face of inadequate facilities to contain the disease.

Population movements have national and international dimensions. Internal migration comprises rural-urban migration to the modern wage sector; rural-rural migration, whose subsets include nomadic pastoralism, movements to the rural agricultural wage sector, and those for land colonization; urban-urban migration; and urban-rural migration which includes return migration. International migration consists of labour migration of cheap labour as well as 'brain drain', 'brawn drain', undocumented or illegal migration, and the movement of refugees. Apart from these established forms of migration there are short-term movements such as tourist traffic, sailors docking at ports and trips to international meetings (international travel). There is also commercial migration (Sudarkasa 1977) which is now dominated by females, and which may be internal or international in form. All these movements have one thing in common; they expose movers to others with whom they may engage in casual sex and increase the movers' risk of diseases or ill-health that could require blood donation or injections, the primary transmitters of AIDS. The circulatory nature of most population movements in Africa implies that two points - the destination and the origin areas - are at the risk of the outbreak of the disease a migrant may transmit.

Previous research on migration has shown that it is highly selective by sex, age and education. It has been established, for instance, that rural-urban migration involves more males than females in Africa, although an increasing number of females are becoming migrants both at national and international levels; that migration peaks at age 20-29 and generally involves those aged 15-44 years; and that the more educated migrant is likely to be unmarried, and if married, may leave the wife behind. The high sex ratio (male dominance) at migration destinations implies that females are in demand for casual sexual relations hence the persistence of promiscuity and prostitution in urban areas. Baldo and Cabral assert that

The most important historical structural processes concerning HIV transmission in Southern Africa are the Low Intensity Wars (LIW) and the disruption of the economy, particularly the rural economy. Various population groups are forced into continuous movements, including displacement flight from the war affected areas, regular armies and groups of bandits, rural populations moving to towns (joining the poverty and marginality circle including prostitution and street children), and rural populations moving near army barracks for trading (promiscuity) (Baldo and Cabral 1990:40).

Free movement of people, including prostitutes to 'where business is profitable', which in turn is linked to the 'gold rush' to where tourists gravitate, has been blamed as partly responsible for the high AIDS incidence in the ex-British colonies like Uganda, Zambia and Tanzania (Konotey-Ahulu 1989). Similarly, Mabey and his colleagues have observed that about two-thirds of the infected prostitutes in the Gambia were from the surrounding French-speaking Senegal and Guinea (Mabey et al. 1988:1). In Ghana, available records show that a very large proportion of the known cases of AIDS had a prior history of staying outside the country especially in Côte d'Ivoire (Konotey-Ahulu 1989). This makes migration a very important factor in our understanding of the spread of AIDS in the country. This study identifies issues relating to migrants' adjustment at their destinations and identifies those likely to favour contracting AIDS.

### **Risk factors and behaviours in migration: conceptual framework**

Some earlier works in the general field of mobility and diseases yield concepts that are relevant to the study of sexuality, migration and AIDS. Wessen (1974) has drawn attention to the fact that in population movements, of whatever kind, epidemiological concern is with problems of

- (a) the possible transmission of disease by those who move: they are active transmitters in their effect upon the health status of the community into which they move; and
- (b) the exposure of those who move to various health hazards in the course of movement and at the destination: these movers are passive acquirers.

Writing in connection with anti-malarial programs, Prothero (1977) suggested that human factors should be given at least as much attention as that given to the parasite and vector factors. In view of the unpredictability of human beings regarding mobility, and in view of the fact that with AIDS human beings are the vectors and the hosts at the same time, they should be given more attention in our search for a way out of the AIDS problem. AIDS may be contracted through sex, blood transfusion and intravenous injection.

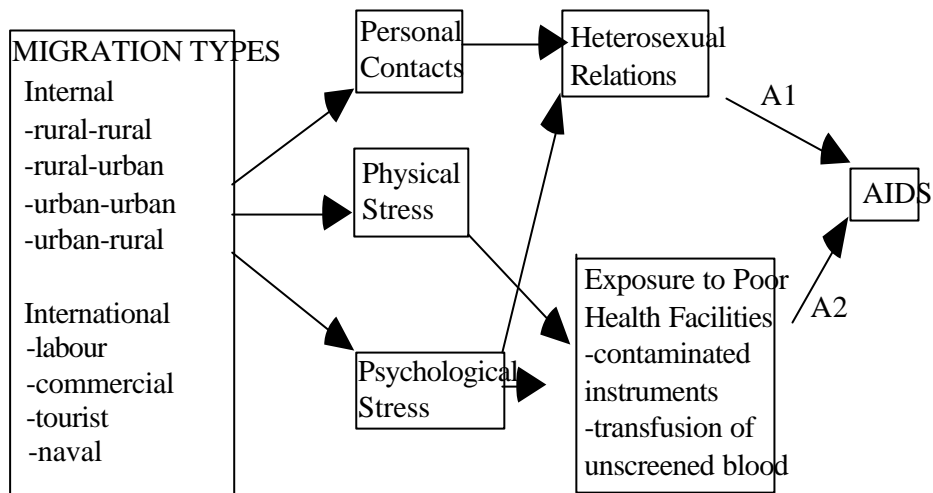
Through population movements of many different kinds people may be subjected to a variety of health hazards, as well as engaging in social and risk behaviour likely to enhance the spread of AIDS (Figure 1). The health hazards may come about in various ways.

**Contacts between people.** In Africa migration is dominated by males who are in the active age group, usually unmarried, or, if married, unaccompanied by their wives; if the migrant is an autonomous female she is usually young, unattached and lacks basic skills to compete for jobs in the new destination. This, coupled with the repetitive and overpowering nature of the sexual appetite in males, creates the condition for prostitution. The impersonality of prostitution makes it particularly suited to strangers. The man away from home, away from his wife or the circle of girls that he knows, cannot in a short time count on seducing a respectable woman in the place where he happens to be. The prostitute's involvement with multiple sex partners is where the risk lies for the migrant.

**Physical Stress.** Fatigue may result from movement especially if it is over a long distance or if illegally across an international border which is usually hazardous. This may lower the migrant's resistance and so increase susceptibility to infection. A migrant may also encounter problems of undernutrition and malnutrition through difficulty in making economic adjustments, with periods of unemployment and thus limited means of acquiring food, or through difficulty of adjusting to new kinds of food. Under such circumstances, a new migrant may be compelled to go for substandard treatment including the possibility of the use of infected needles, or he may require blood donation: two principal means by which AIDS is transmitted.

**Psychological Stress.** This may come about because of socio-cultural and economic pressure in adjusting to new environments. This creates conditions for interpersonal relationships and conditions similar to the first-mentioned above. Traditionally the habit of lodging in a hotel is not so well developed in Africa. In the absence of a relative or friend, the prostitute's availability to a stranger and her readiness to harbour him for some days, are some of her appeals. Psychological stress may also manifest itself in physical disability which may require medical treatment and therefore exposure to poor health facilities. Treatment may include use of contaminated instruments and transfusion of unscreened blood.

**Figure 1**  
**Risk factors and migration**



A1 - Direct, from person to person

A2 - Indirect, through blood donation or infected needle

### The survey

The fieldwork for the study was carried out between May 22 and July 28, 1991. The country was divided into three ecological zones, namely the coastal, forest and northern savanna zones. Each zone was further divided into three subzones - Western, Central and Eastern, to reflect distance from Ghana's western neighbour Côte d'Ivoire, a major focus for migrants in the West African subregion. In each subzone one urban centre and a rural area close to it were randomly selected for the survey.

The urban survey areas were divided into clusters and three were randomly selected in each and interviewers allocated to them. Each rural survey area was treated as one cluster. Houses in the clusters were listed and every other house selected. Within each house, households were further listed and one of them randomly chosen. A male 17-49 years or a female 15-45 years was randomly picked for the interview. Interviewing continued until a specified number of respondents per cluster was attained.

Two different questionnaires were used as the survey instruments: a life history module and a main questionnaire which included questions on the characteristics, attitudes and behaviour of individuals, and the experiences of migrants. There was a section which allowed for in-depth interviewing of some selected AIDS patients. The interviewing was followed by Focus Group Discussions (FGD) in some selected areas.

The allocation of respondents to the survey areas was proportional to the size of the population of the area based on the 1984 population census. At Agomanya where the St. Martin's Hospital runs a home based care program for AIDS patients 30 of them were selected for a special interview. A total of 1360 respondents were interviewed and 51 per cent were males.

## The survey results

### The population

The population was relatively young, at the lower end of the reproductive life span (mean age of 28.5 years). The males were slightly older than females (mean age of 29.8 years and 27.2 years respectively). Almost 60 per cent were of the Akan ethnic group. The rest were Ewe (14.5%), Northern Tribes (16.3%) and Ga-Adangbe (9%). Less than one per cent of the respondents were non-Ghanaians (Table 1).

Nearly 60 per cent of the population practise the matrilineal system of inheritance and another 34 per cent practise the patrilineal system. The remaining seven per cent practise a bilateral system of inheritance (Table 2). About 96 per cent of all the respondents with a matrilineal system of inheritance are Akans. All the other ethnic groups are overwhelmingly patrilineal. Quite a large proportion of the Northern Tribes (37%) practice a bilateral system.

**Table 1**  
Distribution of survey population by ethnicity

Group	No.	%
Akan	812	59.7
Ewe	193	14.5
Ga-Adangbe	123	9.0
Northern Tribes	221	16.3
Non-Ghanaians	7	0.3
Total	1360	100.0

The educational standard of the sample population was quite high by Ghanaian standards (Table 2). Only 23 per cent had no basic education, compared to the national figures of 32 per cent for males and 52 per cent for females. Consistent with the national situation a greater proportion of the females (30.6%) than males (16%) had no basic education. The level of educational attainment was lowest among the Northern Tribes (52.3% have no basic education) and highest among the Ewes (9 per cent only) followed by the Akans (11.7%). Similarly, urban respondents were more likely to have basic education than rural respondents (85.1% and 79% respectively).

**Table 2**  
Characteristics of the survey population

	Males %	Females %	Both sexes %
<b>A. System of inheritance:</b>			
Matrilineal	57.9	59.5	58.7
Patrilineal	35.6	32.5	34.1
Bilateral	6.5	8.0	7.2
<b>B. Level of education:</b>			
None	12.6	22.3	17.4
Drop-out	3.5	8.3	5.8
Basic Education	40.3	43.9	42.1
Secondary Education	26.7	18.1	22.5

6 SEXUALITY, MIGRATION AND AIDS IN GHANA

Post Secondary	12.6	5.7	9.2
University	4.3	1.7	3.0
<b>C. Occupation:</b>			
Professional and technical	17.5	9.9	13.7
Administrative and clerical	6.6	3.6	5.1
Commerce	8.1	40.0	24.1
Farming and mining	21.9	11.7	16.8
Transport workers	4.5	0.3	2.4
Craftsmen	19.0	8.5	13.8
Services	5.5	2.6	4.0
Unemployed	16.5	23.4	20.1
<b>D. Income distribution (cedis):*</b>			
No income	11.0	16.9	13.9
Less than 50 000	12.0	16.2	14.0
50 000 - 151 000	19.8	25.6	22.6
151 000 - 300 000	28.4	24.0	26.3
301 000 - 450 000	18.3	11.7	15.1
451 000 - 600 000	7.2	3.8	5.5
600 000+	3.3	1.8	2.6
<b>E. Religion:</b>			
Christian	74.6	81.1	77.8
Muslim	14.6	9.6	12.1
Traditional	2.3	2.1	2.2
Eastern religion	0.3	0.3	0.3
No religion	8.2	6.9	7.6
Total	100.0	100.0	100.0

\*The exchange rate at the time of the survey was 350 *cedis*=US\$1

The survey population is basically self employed (Table 2). Most people take to trading and farming and mining<sup>1</sup> as their major or subsidiary occupations. However, the females are more likely to be found in trading (40%) as the main occupation than in farming (12 %) while the reverse is true with the males (22% and 8% respectively). The unemployment rate among the population is quite high (20%). Lack of job opportunities re-echoed as the main problem facing the communities in all the focus-group discussions held. Female unemployment tends to be higher than male. The category is likely to include women who are engaged in subsistence farming or other family ventures. In fact, the idea of a full-time housewife is almost absent in the Ghanaian society. A Ghanaian woman works to cater for herself, her children and other members of her extended family. Most women work and tend to earn a separate income (Oppong 1974; Oppong and Abu 1987). About 58 per cent of the married women in the study population have their separate income.

The income levels of the study population may fall within the second quartile of the national income brackets (Table 2). Over 50 per cent of them have annual incomes of 150,000 *cedis* or less compared to a national minimum wage of about 72,000 *cedis* per annum. Males tend to have higher incomes than females; while a majority of the former (57.2%) have incomes of 151,000 *cedis* or more, only 41.3 per cent of the latter have a similar range of income. Incomes are slightly higher in urban areas than in the rural areas. However, the proportion of people without any personal income is higher in the urban areas (14.4%) than in the rural areas (13.1%).

<sup>1</sup> About four years ago the Ghana government passed a law legalizing small-scale mining. Many people have since gone into the mining of gold and diamonds in particular. Until then the government was losing a lot of revenue through the illegal mining called 'gallamsay', meaning 'gather them and sale'.

The study population was predominantly Christian, over three quarters of them belonging to various denominations (Table 2). Muslims constituted the next most important religious group (12.1%) with the rest being followers of traditional religions (2.2%) and eastern religions (0.3%). A significant proportion (7.6%) did not belong to any religion. It is worth noting that eight out of ten Muslims are from the Northern Tribes while nine out of ten of the Christians are from the other ethnic groups to the South.

As is typical of Ghanaian society, marriage is important among the study population. Six out of ten of the respondents have ever married and 50 per cent of them were currently married (Table 3). Customary marriage is the most important type of marriage constituting about 79 per cent of all forms of marriage. Church or civil marriage is still not very popular in Ghana. A marriage registration law (Customary Marriage Registration Act, PNDC Law 112) has been recently enacted to popularize the registration of customary marriages which in turn will facilitate the enforcement of an Intestate Succession Law (PNDC Law 111). Customary marriage seems to be more important among the Ga-Adangbe, the Akan and the Ewe who have well over 80 per cent of their respondents in some form of customary union. However, the Akan are more likely to go into full customary marriage than the other ethnic groups. This disparity explains the differences in the procedures involved in marriage rites, and the amounts paid as brideprice among the various ethnic groups. The Akan marital rite is about the simplest and cheapest in Ghana. In the other ethnic groups the elaborate rites and the high bride price mean that many young people can only partly meet the demands.

The urban respondent is more likely than the rural respondent to remain single: 45.3 per cent of the former as against 37.5 per cent of the latter have never married. The permissiveness of urban life is demonstrated by the significantly higher proportions of urban than rural respondents in partial customary unions and free unions (Table 4). The tendency of a significantly higher proportion of the urban residents to have civil or church marriages may also be explained by the greater exposure of the urbanites to modern Western influences.

Monogamy is more common than polygyny among the respondents. To every five monogamously married persons there was only one polygynously married person (see Table 3). The proportion of women in polygyny was much smaller than those found in the Demographic and Health Survey (33.3%, Ghana 1989) and the Ghana Fertility Survey (35%, Ghana 1983).

**Table 3**  
**Marital status, forms of marriage and type of marital union**

	Males %	Females %	Both sexes %
<b>A. Marital status:</b>			
Never married	46.0	38.0	42.1
Currently married	48.7	51.4	50.0
Widowed	0.4	1.2	0.8
Separated	0.7	2.5	1.5
Divorced	4.2	6.9	5.5
<b>B. Forms of marriage:</b>			
Full customary	65.9	55.8	60.8
Partial customary	15.7	20.3	18.1
Free unions	5.0	7.6	6.3
Church/civil	4.2	7.6	5.9
Muslim	9.2	8.7	8.9
<b>C. Type of marital union:</b>			
Monogamy	86.3	81.8	84.0

Polygyny	13.7	18.2	16.0		
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<b>D. Forms of marriage by ethnicity</b>	<b>Ga-Adangbe</b>	<b>Akan</b>	<b>Ewe</b>	<b>Northern Tribes</b>	<b>Non-Ghanaian</b>
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Full customary	39.1	71.3	54.7	35.6	50.0
Partial customary	54.3	13.1	29.8	14.4	0.0
Free unions	4.4	7.4	6.0	2.2	25.0
Church/civil	2.2	6.3	8.3	3.4	25.0
Muslim	0.0	1.9	1.2	44.1	0.0
Total	100.0	100.0	100.0	100.0	100.0

**Table 4**  
**Marital status by region of residence**

Marital status	No.	Rural		No.	Urban	
			%			%
Never married	205		37.5	368		45.3
Full customary marriage	196		35.8	218		26.8
Partial customary	388		6.9	85		10.4
Free union	14		2.6	29		3.6
Church/civil	12		2.2	28		3.4
Muslim	30		5.5	31		3.8
Widowed	7		1.3	4		0.5
Separated	4		0.7	16		2.0
Divorced	41		7.5	34		4.2
Total	547		100.0	813		100.0

On average, both sexes have married 1.3 times in their lifetime: the figure may include plural marriages in the case of the males; for the females, however, it means different marriages since polyandry is not practised in Ghana. This tends to indicate that marriages are less stable for females than males; it also indicates that there are chances for remarriage after divorce.

The mean age at first marriage for the total population was 23.3 years. The figure was lower for females (21.3 years) than males (25.8 years), but much higher than the national figure of about 18 years given by both the Ghana Fertility Survey (1983) and the Demographic and Health Survey (Ghana 1989). The range of age at first marriage was 14 to 38 years for females and 18 to 39 years for males. There is a positive relationship between the level of education and age at first marriage (Table 5). The earliest age at marriage, however, is found not among those who have never attended school but the dropouts from the primary school. For females, untimely pregnancy has been observed to be one cause of dropout from school (Akuffo 1987).

**Table 5**  
**Age at first marriage by education**

Educational level	Mean age at marriage (years)	Range (years)
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None	22.3	15 - 38
Drop- out	20.3	14 - 32
Basic education	23.3	15 - 38
Secondary	23.3	15 - 39
Post secondary	25.4	18 - 37
University	24.4	23 - 36

About 61 per cent of the women interviewed had at least one child, compared - about 77 per cent found in the Demographic and Health Survey (DHS) (Ghana 1989). The mean number of children ever born per women was 2.3, a little lower than what was obtained in the DHS (3.2). Mean number of children ever born was higher in the rural (2.4) than in the urban areas (2.0).

Child fostering was observed in the study areas as obtains in Ghana generally. The mean number of children fostered out of households was 0.6. Consistent with the findings of an earlier pilot study, the practice seems more prevalent among the matrilineal Akan (0.7 child) than the patrilineal Ewe and Northern Tribes (0.3 child each). There is a net fostering-out in the rural areas and a net fostering-in in the urban areas. Children are sent to urban areas so as to enable them to take advantage of the better educational facilities there and to serve as house-help (Oppong 1974).

## Sexual behaviour

### Premarital sexual relations

Premarital sex is a common practice in all communities studied. There were, in the past, traditions, customs and beliefs that prohibited premarital sex but they have ceased to be effective. Among many of the ethnic groups puberty rites were performed to mark a girl's entry into physical maturity, signalled by menarche: these rites symbolized a woman's ability to become a wife and mother. Sex before puberty rites, often made public by a resultant pregnancy, was considered a criminal offence. Offenders were punished and the sanctions ranged from ritual cleansing to ostracism of the couple (Banuako 1975). Among some of the Northern Tribes a bride's virginity was tested on the first night she was taken to her husband; a bloodstained white cloth, spread on the bed for this purpose, was the proof of the brides' virginity. In all the societies sexual relations and pregnancy occurred in socially recognized relationships; however, owing to the influence of Christianity, education and urbanization, puberty rites are not accorded the same significance as they used to be (Sarpong 1977).

**Table 6**  
**Respondents' opinion about female virginity at first marriage**

Question	Response	Male %	Female %
Should a woman be a virgin at marriage?	YES	72	71
Does it really matter?	YES	68	69
Do you think your daughter should be a virgin at marriage?	YES	81	83
Were you or your partner a virgin at marriage?	YES	10	13

There is a general wish that women should remain virgins at marriage. Over 70 per cent of the respondents hold that belief and eight out of every ten respondents think their daughters should remain virgins till marriage (Table 6). It is felt that remaining a virgin at marriage brings honour to a girl's parents and herself, enables her to get a responsible husband, and helps to prevent contracting diseases.

In reality, however, the situation is different. About 60 per cent of respondents think a woman remaining a virgin till marriage is necessary today. The Ga-Adangbe (86.2%) and Akan (61.5%) respondents felt more strongly about it than the Ewe (47%) and the Northern Tribes (55%). Those who thought the practice is necessary felt it would prevent diseases and unwanted pregnancies (27%) and maintain certain religious and traditional values. For those who think it is unnecessary the main reason is that economic hardships make it impossible to enforce the law these days. Others thought remaining virgin till marriage is bad biologically and that premarital sexual relations give the opportunity for people to know the partner before marriage.

Only ten per cent of the males and 13 per cent of the females were virgins at marriage.; among the Northern Tribes, however, an appreciable proportion (25%) were virgin at marriage. The corresponding figures are 9.8 per cent, 9.3 per cent and 7.1 per cent for the Ga-Adangbe, Akan and Ewe respondents respectively.

Most people in all the ethnic groups, except the Northern Tribes, have their first sexual experience between ages 15 and 19 years (Table 7). By year 24 over 90 per cent of respondents from the other ethnic groups had already had sexual experience. On the other hand, as late as 29 years the proportion of respondents from the Northern Tribes that had experienced sex was less than 90 per cent. It has been observed that the Northern Tribes are the least educated among the sample population. Their regions (Northern, Upper East and Upper West) are among some of the least urbanized in the country (Ghana 1984 Census). It could therefore, be inferred that the Northerners are the least touched by modern Western influences and thus still retain certain traditional values.

**Table 7**  
**Age at first sexual experience by ethnicity**

Age	Ga-Adangbe	Akan	Ewe	Northern Tribes	Non-Ghanaian
	%	%	%	%	%
No sex	1.6	5.0	6.6	10.0	0.0
11 - 15 years	2.5	6.8	9.6	0.9	14.3
15 - 19 years	63.4	51.5	64.6	39.2	71.4
20 - 24 years	30.9	22.9	16.7	39.5	0.0
25 - 29 years	1.6	3.4	2.5	10.9	14.3
30 years +	0.0	0.4	0.0	0.5	0.0
Total	100.0	100.0	100.0	100.0	100.0
( )	(123)	(182)	(198)	(220)	(7)
Range	14 - 27	8 - 39	8 - 28	13 - 30	14 - 25
Proportion at exact age					
19 years	65.9	68.3	74.2	39.1	85.7
24 years	96.8	91.2	90.9	78.6	85.7
29 years	98.4	94.6	93.4	89.5	100.0
39 years	94.4	95.0	93.4	90.0	

**Table 8**  
**Age at first sexual experience by urban/rural location.**

Age	Rural		Urban	
	No.	%	No.	%
No sex	42	7.7	36	4.4

11 - 15 years	25	4.6	54	6.6
15 - 19 years	315	57.5	479	58.9
20 - 24 years	133	24.3	211	25.9
25 - 29 years	31	5.7	26	3.6
30 - 34 years	0	0.0	2	0.3
35 - 39 years	1	0.2	2	0.3
Total	547	100.0	813	100.0
Proportion at exact age				
19 years		62.1		65.5
24 years		86.4		91.4
29 years		92.1		95.0
39 years		92.1		95.6
Range		11 to 39 years		8 to 37 years

The Ghana Fertility Survey (1983) observed that the Northern Tribes had one of the lowest ages at first union but a high age at first birth. That implied a longer waiting time to childbirth after marriage or that it takes longer for unions to be consummated. The evidence seems to point to the idea that the Northerners still hold certain traditional values that regulated sexuality and entry into marriage. In the traditional Akan system, for example, parents restricted the movements of their daughters who had reached puberty until the necessary rites were performed and the girl married (Amoah 1990). The urban-rural differentials in the age at first sexual experience also support the above conclusion (Table 8). Urban respondents began sexual activity earlier than the rural respondents: the earliest ages at first sexual experience were eight and eleven years for urban and rural respondents respectively. The urban areas of Africa are more exposed to modernizing influences than rural areas.

**Table 9**  
**Age at first sexual experience by religion**

Age	Christian	Muslim	Traditional	No religion	Eastern religion
	%	%	%	%	%
No sex	4.9	11.5	0.0	6.8	0.0
11 - 15 years	6.5	1.2	0.0	7.8	0.0
15 - 19 years	61.7	37.0	50.0	62.1	25.0
20 - 24 years	23.1	40.0	30.0	21.3	75.0
25 - 29 years	3.5	9.7	20.0	1.0	0.0
30 years +	0.3	0.6	0.0	1.0	0.0
Total	100.0	100.0	100.0	100.0	100.0
Range (yrs)	8 to 39	13 to 30	15 to 26	8 to 37	19 to 24

Religion may also explain the ethnic differentials already observed. Christians and people with no religion seem to become sexually active much earlier than Muslims and traditionalists (see Table 9). It has been observed that the Northerners are predominantly Muslim and it is likely that their sexual behaviour has been influenced by that religion. Although the traditionalists begin sexual activity relatively late none remains celibate for life; this underscores the universality of marriage in the traditional African society.

**Table 10**  
**First sexual partner by urban/rural location**

Partner	Rural		Urban	
	No.	%	No.	%
Married friend	41	7.5	44	5.4
Unmarried friend	344	62.8	556	68.4
Relative	2	0.4	29	3.6
Proposed spouse	96	17.6	112	16.8
Stranger	18	3.3	22	2.7
Prostitute	4	0.7	14	1.7
No sex	42	7.7	36	4.4
Total	547	100.0	813	100.0

It may be observed from Table 10 that most people had their first sexual experience with unmarried friends. For some, their first sexual partners were their proposed wives. Yet an appreciable proportion of the respondents in both urban and rural settings had their first sexual experience with married people. Strangely this is more likely to happen in rural areas than in the urban area. Also, females are more likely to have their first sexual experience with married rather than unmarried men (8.2% as against 4.3%).

Sexual relations between a married man and an unmarried woman are acceptable in Ghana although the man is expected to keep it secret from his wife for the wife has to be compensated. Sexual relations between a man and a married woman are less acceptable and considered criminal. The study revealed that, even so, such relationships do occur.

A significant proportion of the respondents had their first sexual experience with strangers and prostitutes. The latter are commercial workers, which implies that money changed hands soon after the sexual act. Prostitution in Ghana is basically an urban phenomenon. Intercourse with a prostitute is considered disgraceful and the man who has it is considered impure.

The Ghanaian extended family system tends to restrict people's sexual partners particularly in small localities. Strangers to the towns, therefore, offer some people the opportunity to have sexual partners. The term stranger could also imply casual relationships.

A few of the respondents had their first sexual experience with maternal or paternal cousins depending upon the lineage system. Among the matrilineal Akan, for instance, cross-cousin (mother's brother's child or father's sister's child) marriage is a preferred form of marriage, because the two parties involved are from different matrilineal clans: therefore sex among such relations is not incestuous. Sexual relations with parallel cousins and people of the same ancestry, however distant, constitutes incestuous behaviour. The strong patrilocal links among the members of the patrilineal society mean that paternal relations are accorded more importance than maternal relations in some respects.

First sexual experience was dictated by need, circumstances or own volition. Over a third of the respondents had their first sexual experience for enjoyment and another 18 per cent succumbed under peer group influence. Premarital sex is condoned if partners have the intention to marry: over 21 per cent of the respondents had their first sexual experience as a prelude to marriage. Others first had sexual relations. Unable to care for their numerous children some parents tacitly support their teenage daughters' sexual activity because of the benefits that accrue from it. In fact, a few of the respondents (3%) reported that they were pushed into their first sexual act by their parents; a few others were either deceived (7.8%) or forced (2.5%) into the first sexual experience.

The incidence of premarital sex is high, particularly among males. About two-thirds of the ever married males and 50 per cent of ever married females had two or more premarital sexual partners. As many as 12 per cent of the males could not count their premarital sexual partners because there were too

many; the females generally had fewer premarital sexual partners than the males. Societal norms expect a woman to remain the sexual partner of one man at a time so it is likely women may not report all their sexual experiences.

There is a general belief that marriage must be preceded by some period of courtship during which the prospective partners are expected to study one another in all aspects. In most cases this also involves sexual activity which has serious implications for the spread of STDs.

#### **Extramarital sexual relations**

Data on Ghanaian females' extramarital sexual relations must be treated with caution, because the society strongly condemns extramarital sexual relations, particularly among females. Extramarital sexual relationships involving married women are often not publicized as are those of men, but they do occur as this study has already confirmed. There is secrecy surrounding the extramarital affairs of women since public opinion is much more lenient towards men's extramarital relations than those of women. Even males are expected to be discreet about their extramarital affairs.

Some men indulge in extramarital sex when they are dissatisfied with their wives' behaviour, in particular their lack of sexual cooperation. Others do it when their wives are practising postpartum abstinence or when they are away. The majority of men, however, do it for enjoyment. Most women, on the other hand, take up extramarital sex in retaliation for their husband's promiscuous behaviour. Sometimes, women engage in extramarital relations for material gains; this is common in the urban areas where women are tempted to keep abreast with fashion. In a few instances women who were forced by parents to marry against their wish continue to have secret sexual relations with their childhood lovers.

There are a few occasions when men have had sexual relations with the wives of relatives; most of these instances are with the wives of brothers or cousins. It must be borne in mind that in the Ghanaian context there is no difference between a brother and cousin. In the Akan tradition, for example, marriage between cross-cousins is acceptable. In some of the cases reported in the study the acts were performed in line with acceptable custom and tradition; in most of the instances, however, satisfaction was the motive. Cases of women having sexual relations with the relatives of their husbands were also reported: these were mainly with the brothers or cousins of husbands. Sex with nephews of husbands also occurs, mainly in the Akan societies. This relationship is permitted customarily but it may happen only in a situation of widow inheritance.

As in all other societies, marriage in Ghana has been undergoing some transformation. Certain practices which were allowed by custom in the past no longer occur: for example a few male respondents reported that in the past unmarried men and men whose wives were practising postpartum abstinence, could take for their sexual partners the wives of their relatives; this practice seemed to be more common in the patrilineal Ewe, Northern tribes and Ga-Adangbe ethnic groups. A few respondents hinted at the possibility of the practice still prevailing in the purely traditional societies. In the past widowed men preferred to have sex with relatives' wives so as to unite them to the family. In some societies of the Northern Tribes this was because of the difficulty in getting a wife. Most of these practices have become obsolete through modernization and the influence of Christianity.

Postpartum female sexual abstinence has been a common feature of the marital life of West African women for a long time (Caldwell and Caldwell 1977). It was used to protect the life of children by achieving long intervals between births. In most West African societies postpartum female abstinence averaged 24 months and above. The mean period of abstinence reported by the female respondents was 12.4 months, compared to the DHS figure of 13.5 months for the whole country. About 52 per cent of the women abstained for nine months only. Consistent with anthropological findings the mean period of abstinence is shortest among the Akan (9.9 months) and longest among the

Ewe (17.1 months) followed by the Northern tribes (16.4 months). Some of the women confessed that they missed sex during the period of abstinence (35 per cent of the total female population); the proportion was smallest among the Akan women, the group with the shortest abstinence period.

A majority of male respondents (67%) reported that many men now have sexual relationships with girlfriends when their wives are lactating; such relationships can develop into marriage because of the institution of polygyny. Some others have relations with prostitutes (16%) with whom they do not want to get committed. It seems that as a way of limiting the extra-marital sexual activities of their husbands Ghanaian women are cutting down the overall period of abstinence in marriage. Caldwell and Caldwell's 1977 study indicated that some West African women were exposed to sex in marriage for only a little over one third of their reproductive life span. The institutionalization of polygyny, among other things, was to ensure that men did not go without sexual partners for too long. One way of meeting husbands' sexual demands is the reduction of the period of postpartum sexual abstinence. The use of contraceptives to achieve child spacing seems to be becoming popular; about 49 per cent of the mothers reported that they use some form of contraception, compared to a national figure of 12.9 per cent (Ghana 1989).

Widow inheritance was practised in the past in all the societies studied and is still practised in some of the traditional societies. Unlike the situation in some East and Central African countries (William 1990) there is no element of compulsion in most of the ethnic groups regarding widow inheritance. The man can refuse to inherit the deceased's wife for one reason or another. In many instances the marriage is just symbolic, the man only playing the role of a benefactor. This role ceases when the widow remarries. Some women too may, and do, refuse to be inherited often out of lack of love for the inheritor; unfortunately, these women suffer deprivation as a result. At present widow inheritance is almost an obsolete customary practice because of modernization and the influence of Christianity; only five per cent of the male respondents reported that they would inherit a relative's wife. A smaller proportion still (40 %) would like their sons or nephews to inherit their wives.

### **The extent of sexual networking**

Eliciting information on sexual partners in Ghana incurs a fundamental conceptual problem. To many Ghanaians the idea of a sexual partner implies the *mpeña* relationship or concubinage; the same idea may be expressed idiomatically as 'a person who keeps you company'. This connotes a regular or permanent relationship. As expected, such extramarital relationships are not stable since partners have no legal control over each other. However, neighbours tend to know such relationships and to ensure that some decorum is maintained. Casual relationships are generally not respected and terms like 'a bowl in a restaurant' (in other words a public bowl) are often used to describe a girl in such a relationship if more than one man is involved. Therefore if a person is unmarried, not in a regular relationship and has not had a casual affair lately, questions about sexual partners in the short term may not bring out the true picture of a society's sexual networking. Similarly people in a regular relationship who did not have sex with their partners in the reference period may answer that they have no sexual relationship. It was also not easy interpreting the word 'current'. When does the current period really end? What is the boundary between the current period and last week for example? Some of these problems may have influenced the information shown in Table 11.

The table summarizes the extent of sexual networking in the research areas. The first observation is that multiple partnerships exist in the areas and are more numerous among males than females. Secondly, although the lifetime figures bring out a great deal of sexual networking, there seems to be a decline in recent periods. While about 80 per cent of the males and 68 per cent of the females have had more than one sexual partner in their lifetime, only about 25 per cent of the males and seven per cent of the females have multiple partners currently. The slight decline between current and previous week's

sexual partners may be explained by the conceptual problems discussed above. The change between the lifetime and more current figures could also possibly be due to the campaign on AIDS going on in the country. AIDS has become a major health concern in many parts of Ghana and people are scared about it. The increasing incidence of AIDS-related deaths in recent times has brought the reality home to many people.

**Table 11**  
**Number of sexual partners for various periods by sex**

Period	No.	Male %	Female %
Current	0	16.6	17.2
	1	58.9	76.0
	2-4	22.9	5.5
	5+	1.6	0.9
	too many to count	0.0	0.3
During previous week	0	23.8	25.5
	1	59.0	69.3
	2-4	15.9	4.3
	5+	1.3	0.7
	too many to count	0.0	0.2
During previous month	0	21.0	24.6
	1	57.0	69.4
	2-4	19.8	4.5
	5+	1.9	1.2
	too many to count	0.0	0.3
During previous year	0	16.9	19.8
	1	50.2	68.4
	2-4	26.1	9.0
	5+	6.1	2.2
	too many to count	12.4	8.7
During their lifetime	0	6.5	6.9
	1	13.6	24.9
	2-4	27.7	41.4
	5+	39.8	18.1
	too many to count	12.4	8.7

The proportion which reported 'too many to count' sexual partners is of particular interest. The females who reported this could be practising commercial sexual activity. No male made such a response in the current periods but a small proportion of females did. The contrast brings out the difference between doing something for fun and doing it as a necessity. To many women, entering into commercial sexual relationships is a matter of survival and there will always be a small proportion of them regardless of the consequences. The small size of such a group is compensated for by the number of sexual partners. The general picture portrayed by Table 11 has serious implications for the spread of AIDS.

Table 12 shows respondents' latest sexual partners. The idea is to indicate the extent of sexual networking but it is incomplete. The network would be more comprehensive if partners' partners could

be found but this is not easy. Nevertheless, the table reveals some useful information. It shows that more sexual activities go on outside marriage than within. More females than males are likely to have sex within marriage. There is still evidence that some commercial sexual activity goes on in the study population. These observations certainly have some relevance for AIDS intervention programs.

**Table 12**  
**Respondents' latest sexual partners by sex**

Partner	Male		Female	
	No.	%	No.	%
No partner	45	6.5	46	6.9
Spouse	287	41.4	312	46.8
Regular friend	309	44.6	264	39.6
Casual friend	42	6.1	33	4.9
Relative	5	0.7	2	0.3
Prostitute	3	0.4	-	-
Non-response	2	0.3	10	1.5
Total	693	100.0	667	100.0

**Table 13**  
**Number of sexual encounters with latest sexual partner within one month by sex**

Encounters per month	Male		Female	
	No.	%	No.	%
0	107	15.4	155	23.2
1 - 4	288	41.6	165	24.7
5 - 9	140	20.2	178	26.7
10+	81	11.7	69	10.4
No response	9	1.3	14	2.1
Not applicable	68	9.8	86	12.9
Total	693	100.0	667	100.0
Mean	4.7		3.6	

Some idea of the sexual behaviour of the population may also be observed from the frequency with which respondents have sexual encounters with their partners. Table 13 shows the number of sexual encounters within one month. The frequency is higher among males than females, the mean standing at 4.7 and 3.6 times per month respectively. This is not unexpected. The woman's sexual role is expected to be marginal and passive: she is not even to give any indications that she is enjoying the sexual act (Amoah 1990). It can be inferred from the table that the majority of the study population is sexually active.

### Migration

Diseases, like many other things, may find their way to a place either by developing there independently, or by moving there from another place. In Ghana the first recorded AIDS cases were a couple who returned from West Germany in 1986. Whether or not there had been locally developed cases before these is not known. The records, however, consistently indicate a preponderance of cases of people who have a history of staying in another country. Such an observation does not tell us

anything about why staying outside Ghana has this connotation. This section explores the factors which may predispose migrants to the disease.

Migration in Ghana took a new turn in the mid-1970s when international migration assumed an increasing importance. Inequalities between countries in economic development and deepening economic crisis in Ghana have been the main driving force behind migration in the country. As elsewhere in Africa, young adults have always dominated migratory movements in Ghana. Formerly, migrants were mainly males who were likely to be unmarried and had at least basic education; in recent times females have also been moving in large numbers. The female migrant is likely to be younger and less educated than the male (Anarfi 1990). Until the early 1980s Nigeria was the major destination, for male migrants in particular; Libya and Europe are the major attractive centres now. For female migrants Abidjan, Côte d'Ivoire, has become the main destination. The epidemiological concern here is that many Ghanaians are either becoming active transmitters of HIV in the communities into which they move or passive acquirers of it by their exposure to health hazards in their new areas. Already AIDS has been identified as the leading cause of adult death in Abidjan (de Cock et al. 1991), a major destination for many Ghanaian women (Anarfi 1990).

Migrants are known to be very innovative; both within and outside the country they have been known to create jobs for themselves when the situation demands. Stiff competition and a certain amount of job discrimination in receiving countries have narrowed the range of job choices for migrants. Many find themselves in easy-entry jobs: most of the already disadvantaged women, given their lower educational background, have been driven into the 'sex trade'. That creates a fertile environment for the spread of AIDS.

Migration in Africa is circular. People who leave their places of origin come back eventually either in the short term or in the long term. In the interim they maintain a continuous link with their places of origin through visits. Ghanaian migrants often visit home during festive occasions such as Christmas and local festivals, most of which are given over to revelry, in an atmosphere of laxity and permissiveness. A good example is the *Apo* festival of a section of the Bono people: during the two weeks of the festival, there is a general licence to flout the existing law and order. It is reported, for example, that a man cannot divorce his wife on the grounds of adultery if another man sleeps with her during the festival period. Thus migration makes the relocation of the disease possible and the social activities facilitate its diffusion.

Some of the migrants come home with a lot of wealth; a few are able to acquire immovable property like houses on their return. The life of the majority of the returned or visiting migrant, however, is characterized by ostentatious spending. They are never without friends, especially members of the opposite sex, who may be lured by the apparent wealth they display.

In Ghana, as in many parts of Africa, migrants tend to move to areas where there are relatives and friends (Caldwell 1969; Nabila 1974). This process of chain migration is to ensure that migrants overcome their initial settlement problems with the minimum effort. This situation stems from the fact that hotel facilities are not well developed and the few that are available are not within the means of many people.

Table 14 shows the type of accommodation people used in each movement. In both internal and international migration relatives and friends play a major role in the settlement of migrants. This role seems to diminish steadily in subsequent moves. It appears that having made the first move multiple migrants become more and more independent. This is seen in the relatively minor variation in the number of times people found their own accommodation in later moves. It is also worth noting that hotel accommodation and lodging with prostitutes assume importance in international migration; in some countries of West Africa, big apartments housing prostitutes are often referred to as hotels (Anarfi

1990), so there is the possibility of linking hotel accommodation in some of these countries to lodging with a prostitute. Thus the process of settlement in migration has within it sexual relations involving spouses, friends of the opposite sex and prostitutes.

**Table 14**  
**Forms of accommodation in migration by type of move**

Accommodation	Internal Moves				International moves
	1st move	2nd move	3rd move	4+ moves	
Lodged with spouse	145	43	42	26	20
Lodged with relatives	575	222	69	50	89
Lodged with friend - same sex	133	81	31	26	50
Lodged with friend - opposite sex	13	16	2	0	9
Own accommodation	280	168	143	156	82
Hotel accommodation	3	0	0	2	21
Lodged with prostitute	0	2	0	2	20
Hostel accommodation	133	62	18	30	10
TOTAL	1282	594	305	292	301

The majority of the migrant respondents (59% of males and 55% of females) reported that they had sexual relations with members of the opposite sex in their destination in the last month. The Ga-Adangbe are more likely to have sex in migration than the other ethnic groups followed by the Ewe (77% and 73% respectively). Most of the sexual encounters of migrants are with regular sexual partners; nevertheless, there is a substantial number of encounters with casual partners particularly in international migration.

An earlier study has observed a large concentration of Ghanaian women prostitutes in Abidjan, Côte d'Ivoire (Anarfi 1990). Talking about their numbers, a participant in a focus group discussion remarked that Ivoiriens think that there are no more women left in Ghana and that all of them are in the sex trade. Some of their male compatriots serve as pimps and maintain a form of consensual union with the women; that may explain the significance of sexual relations with prostitutes in migration. Prostitution and sex with prostitutes are some of the high-risk factors identified for the spread of AIDS. The circular nature of migration in Ghana puts many people at risk at both ends of the movement irrespective of the size of the population that indulges in high-risk behaviour.

Another risk factor is the number of sexual partners per person. In an average of about 16 per cent of episodes (25% for males and 7% for females) migrants had two or more sexual partners, increasing to 42 per cent in international migration (43% for males and 40% for females). Of interest is the proportion who answered 'too many to count'. Again the international migration experiences are outstanding (see Table 15). The seriousness of the situation is further compounded by the fact that the majority of the people who moved (60% of the males and 72% of the females) did not take any precautions against disease. In practice, many Ghanaians do not take any precautions against disease despite the awareness of the dangers of AIDS.

**Table 15**  
**Number of sexual partners in migration by type of move and by sex**

Type of move	0	1	2	3	4-9	10+	Males Too many to count	No response	Total
No movement	35.0	40.4	11.2	2.6	3.1	0.6	3.2	3.6	100.0
<b>Internal:</b>									
1st move	36.8	37.6	12.6	2.8	1.9	0.3	1.6	6.4	100.0
2nd move	18.8	43.0	17.6	5.1	2.7	0.0	4.9	7.9	100.0
3rd move	6.5	64.3	12.3	6.3	5.6	0.0	0.8	4.2	100.0
4+ moves	5.6	69.4	16.9	2.6	1.2	3.5	0.8	0.0	100.0
Emigration	3.7	48.7	20.8	6.7	8.5	1.8	5.5	4.3	100.0

Type of move	0	1	2	3	4-9	10+	Females Too many to count	No response	Total
No movement	36.8	54.3	3.3	1.0	0.7	0.1	1.2	2.6	100.0
<b>Internal:</b>									
1st move	31.1	59.1	3.4	1.2	0.0	0.0	0.5	4.7	100.0
2nd move	10.1	72.6	7.8	1.0	1.0	0.0	1.0	6.5	100.0
3rd move	6.6	81.1	5.4	0.0	0.0	1.9	0.0	5.0	100.0
4+ moves	4.4	88.0	1.8	0.0	0.0	0.9	2.2	2.7	100.0
Emigration	6.6	46.5	6.8	2.0	2.2	0.7	28.6	6.6	100.0

There is no discrimination against strangers in Ghana but when it comes to sex some caution is exercised; about 90 per cent of all the respondents think that sex with a complete stranger at first sight is bad. Nearly three-quarters see people who engage in such activity as irresponsible and morally weak, branding them prostitutes or promiscuous. The majority of the migrants have the same opinion about sex with strangers, but 19 per cent of the males and 17 per cent of the females agree that in any place one should get along with strangers. A much reduced proportion, however, agree that such relationships should include sex.

Opinions were sought about certain AIDS-related high risk behaviours from current and past migrants. The level of awareness of such risk behaviours determines to a large extent how people comport themselves. Table 16 shows that the level of awareness of AIDS-related high-risk behaviours is quite high among the Ghanaian population. The Ministry of Health has conducted a consistent educational campaign on the disease since 1986, and it seems to be making an impact. Yet the table also reveals that there is still more to be done. It appears that people are more aware about the sexually-related high-risk behaviours than the medical ones. Perhaps a disproportionate attention has been devoted to sexuality and AIDS in Africa to the detriment of the other risk factors.

There are still a few misconceptions about the disease. Some of these are:

- that the disease is shameful and that it only affects bad people;
- that females are to be blamed for the spread of the disease;
- that it is a strain of the known venereal diseases like gonorrhoea and syphilis and that there is a traditional cure for it as there was for the earlier ones, only it has not been explored;
- that one can get it from eating with a patient or drinking from the same cup; and
- that the disease can spread through spitting.

**Table 16**  
**Opinion about AIDS-related issues**

	Male			Female		
	Agree %	Disagree %	No Response %	Agree %	Disagree %	No Response %
1. In any place one should get along easily with strangers.	19	77	4	17	80	3
2. Every social relationship between a man and woman should result in sex.	9	89	2	5	93	2
3. For any disease injection is the best	14	81	5	19	76	5
4. A patient must be treated by any doctor at all times.	19	77	4	24	72	4
5. One should donate blood to a patient.	17	79	4	15	78	7
6. One sex partner is the best option for all.	74	22	4	86	10	4

Other misconceptions are built on the stigma attached to the disease. The general opinion is that sufferers of the disease must be killed or at best be confined. Another opinion is that a child found to have HIV must not be allowed to go to school lest he spreads the disease. Female returned migrants in particular are highly stigmatized and those from a particular country are openly shunned; this situation stems from the fact that almost all the AIDS-related deaths in the communities have been those of females. Deaths of males suspected to have AIDS have started occurring in a few areas: one such case put a whole community into a state of panic when it was revealed that the deceased had had sexual relations with 15 girls between the time of his return from a sojourn in Abidjan and the time he died, a period of about three years.

## Conclusion

Sexual behaviour in Ghana characterizes a society in transition. Certain cultural values that used to restrict people's behaviour either have lost, or are losing, their effectiveness. It cannot be said that new ones have yet replaced the old ones. The general atmosphere, therefore, is one of chaos with influences coming from all forms of religions, Western education and powerful modernizing factors.

Although cultural restrictions against sexuality are no longer strictly enforced, the very nature of the social organization puts a brake on some excesses; for example many young people think it improper to openly let parents and other elderly relatives know of their sexual activities. Given the extended family system most young people may not have the privacy for fulfilled sexual relations in their family homes. Migration removes them from these restrictions into a situation where sexual fulfilment is enhanced. There is thus the tendency for young people away from home to abuse their social freedom by engaging in indiscriminate sex which is a high-risk behaviour. Economic necessity may compel some girls to translate their new found autonomy into money making through the sex trade, a high risk occupation.

Migration in Ghana, and indeed the whole of Africa, does not mean permanent removal from one's place of origin. Until they finally return, migrants maintain a close contact with their homes through

visits. The period of the visits, so chosen to coincide with occasions of revelling, is a fertile ground for the spread of any STDs the migrants might have contracted.

The effect of migration to the spread of AIDS in Ghana is the creation of conditions for the diffusion of the disease first by relocation, followed by contagious diffusion. The current pattern of the disease seems to support this conclusion. An appropriate policy for the control of the spread of AIDS in Ghana, therefore, would be one which combines educational programs with strategies for removing the factors which compel young people to migrate. No AIDS prevention program can afford to ignore the socio-economic aspects of sexual behaviour or operate in isolation from the need for action on poverty and gender inequality.

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