32. Nice guys, condoms, and other forms of STDs protection: sex workers and AIDS protection in West Africa[1]

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Introduction

Relative to North America and Europe, estimates on the incidence of AIDS in Africa are still uncertain[2]. This notwithstanding, or perhaps *because* of this uncertainty, the spread of the disease on the continent has generated a number of studies on sexual relations (Adomako Ampofo 1993, 1994, 1996; Anarfi 1992; Ankomah 1990; Caldwell *et al.* 1989; Schoepf 1988, 1992). Many of these studies have followed the Knowledge-Attitude-Belief-Practice (KABP) format and focused on 'high-risk' behavior[3] among adolescents and single urban adults (Adomako Ampofo 1993, 1997a; Ankomah and Ford 1993; Ford and Norris 1991); the sexual behavior of prostitutes has come under special scrutiny (Adomako Ampofo 1995; 1997b; Moses *et al.* 1991; Painter 1992; Schoepf 1988). The demographic picture

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[2] The World Health Organization (WHO) routinely collects statistics on AIDS cases through voluntary reporting by national authorities. WHO believes that the total number of cases reported in Africa is underreported and estimates the number based on public health surveillance data and the use of an AIDS-estimation model. As of December 1992, WHO estimated a cumulative total of 2,5 million AIDS cases worldwide (compared to 612,000 reported) with a disproportionate 71 percent believed to have occurred in Africa (United Nations 1994). Many African researchers and physicians, however, believe this to be an overestimation (Latham 1993). Certainly, the AIDS situation in Africa calls for concerned action, however, for a continent where 'diagnosed' individuals have later been reported as having been 'cured', the data must be read with some caution.

[3] Risk in sexual relationships in the era of AIDS is typically measured in terms of non-condom use where multiple partners are assumed to exist.

of AIDS in sub-Saharan Africa[1] suggests the complex socio-cultural dimensions of both the disease and the sexual relations, which are acknowledged to be primarily responsible for its spread (Ankomah 1990; Caldwell and Caldwell 1993; Langstone 1989). Hence there is a need for a more specific understanding of people's interpretation of risk to themselves. Several studies indicate that there is widespread knowledge about the existence of AIDS and the sexual nature of its spread (Adomako Ampofo 1995; Ankomah and Ford 1993; Ghana Demographic and Health Survey 1993; Kenya Demographic and Health Survey 1993)[2]. Nonetheless, sexual behavior among many groups continues to be 'risky' (Akande and Ross 1994; Bertrand and Bakutuvwidi 1991; Dodoo and Adomako Ampofo 1996; Gold 1993; Ingham 1995).

Although studies among young people and single adults have generally examined mutually 'risky' behavior among partners, studies of prostitutes have tended to examine their behavior from the perspective of their risk to their clients/partners, neglecting an analysis of their attempts, and abilities, to ensure their own (or their partners) protection. A further important gap in the discourse has been an examination of the relationship between perceptions of well being, sickness and disease prevention, accuracy of AIDS-knowledge, a sense of personal risk, and AIDS-preventive behavior. Relying on data from a sample of Ghanaian sex workers in Ghana and Côte-d'Ivoire, this study examines two issues: firstly, the relationship between women's AIDS-related knowledge and their perceptions about promoting sexual health, and their (sexual) behavior; and secondly, how the strategies women employ are related to the material basis of their sexual relations. Specifically, how the women's perceptions regarding sexual health, and their economic situations, translate into behaviors. Focus is on why some women have adopted the use of condoms and others have not, and since women form the majority of AIDS cases in West Africa, and Ghana and Côte-d'Ivoire currently have the highest number of reported cases in the sub-region, focusing on their protection is crucial.

A brief background to the development of 'modern'[3] bio-medical health care in Ghana is presentend and followed by a summary on traditional beliefs about diseases and health care. Some theoretical considerations about health beliefs and condom use are suggested. Research data, methods and findings are described; and finally suggestions for future research and policy interventions are offered.

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[1] In East and Central Africa the male: female ratios of AIDS victims are almost equal, in West Africa in the early 1990s females outnumbered males about 3:1. The age group mainly affected is between 20-35, however, rates among teenagers are climbing, especially among females (WHO 1993; AIDS Control Programme Ghana 1994).

[2] This knowledge has been found to be lower in the Francophone countries of Central and West Africa than the rest of the continent (Ingham 1995).

[3] 'Modern' is used here to describe the form of health care that came with industrialization and Western technology.

The development of modern health care and traditional concepts of disease

The colonial medical system

The rudiments of a colonial medical service date back well into the nineteenth century. In the 1880s, the Gold Coast[1] medical department was set up. However, in the early years of colonial medical services, the primary mission of the staff was to protect the health of Europeans, as well as a few African soldiers and civil servants, rather than the health care of the general African population. In the early 1900s the governor expressed his dismay with the conservatism, racism and complacency of much of the medical staff (Patterson 1981). Although the physician population more than doubled between the early and mid-1900s, as a result of a high rate of population growth, the physician/population ratio remained high. In 1906 there were 41 government physicians and the population per physician was 47,073. In 1921 there were 43 government physicians and the population per physician was 59,302. By 1953 there were 97 government physicians, and the population per physician was 55,433 (Patterson 1981: 110-111, table 2).

African doctors had been employed in the colonial medical service since the nineteenth century (Patterson 1981), however, by the turn of the century, rising racism and the desire by Europeans to monopolize the higher positions blocked the careers of Africans in all branches of the colonial service. For example, Dr. Easmon was removed in 1897, and another able African Gold Coast physician, Dr. B. W. Quartey Papafio, was passed over in favor of a white candidate (Patterson 1981). Eventually, following governor Guggisberg's argument that Africans with medical degrees were less competent than Europeans, Africans were appointed to the separate rank of 'African Medical Officer,' with attendant lower salaries (Gale 1973).

Not surprisingly, none of this worked to endear modern medicine to the indigenous people. However, the majority of people living in the Gold Coast were unaware of the political and racial dimensions of the medical system. There were far more 'practical' factors which worked together to affect attitudes to modern medicine.

Factors inhibiting reliance on modern western medicine

Urban and sex bias

There was a clear urban bias in health care services, which persists to this day. By 1973 it was estimated that the number and distribution of hospitals and clinics was such that they could not offer any kind of service to more than, at best, 20 percent of the population (Sai 1973). Historically, a sex bias also existed in access to medical services, due, partly, to the fact that the colonial government provided free medical care for several almost exclusively male groups – soldiers, police, civil

[1] This was the colonial name of Ghana.

servants, and prisoners. More important, however, women were less likely to be educated or have direct contact with the British, hence they were more likely to feel distrust for Western medicine (Patterson 1981). Women were also probably less likely to be willing to submit themselves to examinations and intrusions by (white) male staff. Since women generally had the responsibility for not only their own health care, but also that of children and young adults, their attitudes were influential in the community.

Mistrust of the health branch

Although 'modern' medicine had gained some acceptance by the 1960s for certain curative aspects of health care, preventive medicine, as practiced by the Health Branch, resulted in more resentment than esteem among Africans. Complaints about the policies and conduct of the sanitary inspectors were frequent. Patterson (1981) reports that the (male) inspectors, would enter people's homes every few weeks, without giving prior notice, and examine the premises thoroughly. Water, which had been carefully collected and stored in barrels, would be poured away on the basis that stagnant water bred mosquito larvae. Women were frequently disturbed in their baths in the process of these sanitary inspections. People who were considered to have transgressed sanitation prescriptions were dragged to court and fined. Generally, the Health Care Branch practiced a lot of coercion but little education. The result was that the message was invariably thrown out with the messenger.

Traditional health beliefs

The response of Ghanaians to Western medicine at the turn of this century was generally cautious and pragmatic and was based upon their concepts of disease causation. In the context of African cosmology, illness is not conceived as just the result of pathological changes, which was the idea proposed by Western medicine. Rather, the supernatural is invariably invoked along with the main causal factors. Within this framework the concepts of the etiology of illness are far more behavioral than biological (Twumasi 1975). The traditional cosmology has no room for a purely naturalistic notion of illness, because there is no clear-cut conceptual separation of the natural or physical world on the one hand, and the supernatural on the other, as there is in so-called modern medicine. Health and illness are not isolated phenomena, but are part of the whole magico-religious fabric, and the physical signs of disease are frequently ascribed to supernatural sources (Owusu-Ansah, forthcoming). The malefic action of another, or the intervention by a supernatural power, may cause illness, which may be cured by resorting to the appropriate magico-religious formula, or by appealing to the supernatural power (Twumasi 1975). This worldview leads to startlingly different interpretations from those arrived at by modern science. For example while sanitary inspectors would pour out drinking water in homes for containing

mosquito larvae, Africans held that the presence of the larvae indicated that the water was not poisoned (*Gold Coast Independent* 1930).

This does not mean that African societies do not appreciate the natural causes of illness, or that they did not traditionally rely on physical causes and treatment. In fact, at the beginning of a disease no supernatural danger is felt and home remedies are given. It is prolonged and dangerous conditions that are generally ascribed to spiritual causes. The disease-causing agents generally include lesser gods, ancestral spirits, witchcraft, and violation of taboos that protect a society from pollution (Owusu-Ansah, forthcoming). Ordinary persons can only speculate as to which of these agents is responsible for their condition, thus expert advice is sought. In order to increase the odds of healing/protection, a pluralistic/pragmatic approach was applied and recorded often in the accounts of nineteenth century Asante for example. The prescriptions of local medicine men, Muslim holy men, and later Western missionaries and doctors, were combined in health care. Islamic remedies were particularly accepted in Africa because of the degree of similarity between the African and Islamic cosmologies–world views that both recognize a multiplicity of spirits. As expressed by Asantehene Osei Tutu to British Consul Joseph Dupuis, the royal interest in Islamic prayers and amulets was based on the conviction that "those objects had come directly from the higher god" (Dupuis 1824). In the hierarchical structure of the Akan spirit world, medicine that came from the direct word of the supreme being was understood to be more powerful than local ones thought of as only originating from intermediary powers such as the lesser gods (Dupuis 1824). The power of the Asante empire in the nineteenth century probably contributed to the important role attained by the use of (Muslim) amulets and charms in traditional health care in much of modern Ghana (Owusu-Ansah, forthcoming).

Generally, one can say that among Ghanaians there exists a desire to find quick relief, and an unwillingness to undergo lengthy treatments (Patterson 1981). Injections, for example, which provide quick relief, were and continue to be very popular[1]; prophylactics, on the other hand, had little success in the early part of this century and remain less popular[2]. While modern medicine generally requires prolonged and dedicated application, traditional medicines frequently work under less disciplined regimes. If the healing process sometimes suffers temporary relapses it, in most cases, provides symptomatic relief. There are also adequate explanations for instances where a cure is not found or healing does not take place –usually this is blamed on the antisocial conduct of the victim or some member of his or her family. Thus, where the diagnosis of an illness is viewed as the diagnosis of a social offence, the cure requires the (re)establishment of normal social

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[1] Yaws treatment for example was by an injection, which brought relatively quick relief and greatly enhanced the popularity of modern medicine. It also contributed to the belief in the efficacy of injections for almost any condition.

[2] Patterson (1981) reports that quinine treatment for malaria was largely unsuccessful until recent times because of its bitter taste and the fact that people did not take the medication regularly or consistently.

relations and allows for the maintenance of harmonious community and family relations. Modern medicine makes no room for such social explanations or cures.

Eventually the individual uses his or her limited powers of prediction and control to determine which is his or her best option (Twumasi 1975). Western medicine never gained total acceptance and traditional medicine continues to play a social, psychological and also a medical role (Acquah 1958; Kilson 1974). Many people take an eclectic approach, seeking a combination of elements of various systems, or sometimes by using Western medicine in 'traditional' ways (Nukunya *et al.* 1975).

Health belief models and condom use

Information, Education and Information (IEC) messages aimed at changing sexual behavior have generally taken a standard approach, without considering the unique socio-cultural conditions in which individual sexual relations are grounded. The Global AIDS prevention strategy has two foci vis-à-vis changing behavior and hence promoting 'safer sex' (1) promoting condom use, and (2) exhorting people to reduce the numbers of their sexual partners, better still, to 'stick to one partner.' Implicit in these messages is the assumption that people make 'rational' choices and that they have personal control over their sexual health. I will address these two assumptions separately.

Rational choice

Theories about health beliefs and behavior such as Rosenstock's Health Belief Model (1974) are based on the premise that individuals evaluate the level of threat associated with a disease and their own level of risk, and then assess the costs and benefits to them of taking the required action. These frameworks may have some limitations, however, when it comes to assessing sexual behavior. While engaging in 'safe sex' can be viewed as a preventive strategy as far as becoming HIV-infected is concerned, these strategies are not one-time or occasional inconveniences. When it comes to condom-promotion efforts, people interpret advice regarding sexually transmitted diseases (STDs), AIDS, and their own protection, through their own cultural lenses, sometimes avoiding or denying the conclusions posed by the dangers, other times reinterpreting the advise and rejecting the policy directions (Bledsoe 1990). Even among gay white males in the West, a so-called 'high risk' group, there is evidence that awareness of high prevalence is not a consistent predictor of risk-preventive behavior (Gold 1993). One factor that emerged from Gold's study among gay males and heterosexuals was that people rely on perceptible characteristics to infer infection. Gold argues that a partner's good looks, speaking style, the sign of a wedding ring etc, may activate a belief at the moment of possible sexual activity that the person is unlikely to be infected. A similar perception was found to account for

differences in condom use among groups of married men in Kenya (Dodoo and Adomako Ampofo 1996). Findings from a series of surveys carried out under the auspices of WHO in 15 countries[1] between 1989 and 1990 show that people are unaware of the asymptomatic stage of HIV transmission, while others believe that AIDS can be cured (Ingham 1995).

How people define disease, determine its symptoms, and manage its treatment is affected by cultural values and patterns. Social phenomena are constituted by the meanings actors employ to make sense of observed or experienced events (Locker 1981). Within this world of everyday life, a world that is both the scene and the object of our actions and interactions, people develop their own 'common sense knowledge' which may not fit the rational mold of science (Schutz 1962). This world is seen from within what Schutz calls the natural attitude; it is taken for granted as a world of well circumscribed objects with definite qualities; a world which is known and shared by others. This then provides the means for interpreting new experiences and determines people's actions regarding preventive/protective behavior. Since many Africans consider modern health systems as irrelevant for certain illnesses, especially if the causes are ascribed to immutable supernatural forces, exhortations regarding particular preventive strategies may not lead to the same reasoning that the IEC-promotion efforts expected.

Control over personal sexual health

For many women, having accurate information is not enough to bring about changed behavior since they do not have control over their sexual lives. It appears that increasingly many women in contemporary urban environments choose partners depending on the latter's abilities to support them financially. For Ghana this has been documented in a number of studies (Adomako Ampofo 1995, 1996; Anarfi and Fayorsey 1995; Ankomah and Ford 1993). Women seem to see this as one option to supplement their incomes in situations of declining alternatives. If only because of the increasing visibility of prostitutes in Ghana's cities, in spite of sporadic police crackdowns, it seems plausible to assume that commercial sex work is also on the increase. Where a relationship is predicated on financial considerations, women's ability to negotiate for so-called 'safer sex' may be somewhat limited. Furthermore, since condoms are a technology whose use women can only influence and not control, women's protection is largely dependent on their abilities of negotiation and influence, often with an unwilling partner (Heise and Elias 1995).

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[1] The countries were Central African Republic, Côte-d'Ivoire, Guinea Bissau, Togo, Burundi, Kenya, Lesotho, Tanzania, Zambia, Mauritius, Phillipines, Singapore, Sri Lanka, Thailand and Brazil (Cleland and Ferry 1995).

Study sites, data and research methods

Study sites: Ghana and Côte-d'Ivoire

The main aim of this study is to theorize about women's capacity to protect themselves based on beliefs about STDs and AIDS, and within relationships constrained by financial considerations. Women still form the majority of AIDS-cases in West Africa, and Ghana and Côte-d'Ivoire currently have the highest number of reported cases in the sub-region. By the mid-1980s, at a time when AIDS was alleged to be taking on epidemic proportions in East and Central Africa (Caldwell and Caldwell 1993; Latham 1993; Mulder *et al*. 1994), Ghana and Côte-d'Ivoire like most West African countries, appeared to have been spared from the scourge of AIDS. In 1986 the first cases were reported (42 in Ghana, 118 in Côte-d'Ivoire). From 1986 to 1987 there was a slow rise in the number of AIDS cases in both countries with less than 1,000 reported per year in either case. After 1988 the number of reported cases increased at an accelerated rate in both countries.

In Ghana, 83 percent of AIDS cases reported in the first year were female. During this period the overwhelming majority of cases were found among 20-29 year-olds (66 percent). Although after 1989 the female proportion of total AIDS cases in both countries had dropped by about 10 percent, in the late 1990s AIDS remains a predominantly 'female disease.' Focusing on women in countries with high and low levels of knowledge (Ghana and Côte-d'Ivoire respectively) permits some assessment of the impact of knowledge on protective behavior.

The sample population and sites

The data used in this paper come from a larger study carried out between September 1992 and July 1994 among 188 Ghanaian prostitutes and single women living in Ghana and Côte-d'Ivoire. The present analysis is limited to interviews with 131[1] prostitutes living in three cities, Accra, Kumasi (Ghana) and Abidjan (Côte-d'Ivoire). These cities were chosen because all three are in highly urbanized, commercial-settings. All three have also had small settlements of prostitutes since colonial times, and their commercial basis has seen the emergence of other kinds of sex work in recent years. Abidjan was included in the study for three additional reasons. Firstly, there is some evidence that Ghanaian women have been working as prostitutes in that city from as far back as the 1940s (Kouassi 1986). Secondly, more recent studies suggest that Ghanaian women feature prominently among prostitutes working in Abidjan (Painter 1992). Thirdly, many residents of Abidjan travel fairly regularly between both countries and

[1] Forty-six single women (not sex workers) are excluded from the analysis; 11 interviews with sex workers were excluded for reasons such as incomplete data, poor recordings etc.

connections have been suggested between this and the introduction of AIDS to Ghana (*New African* 1993).

Definitions

Traditional Western definitions of prostitution obscure the complexity of sexual relationships that exist in Africa. Most deal primarily with concepts of promiscuity as defined by having several partners. An additional idea is that of the non-emotional nature of the relationship and payment for purely sexual services (see for example Little 1975). In Africa, however, prostitutes may be found who perform 'domestic' services for clients, developing close relationships, and women who do not consider themselves to be prostitutes may establish sexual relationships primarily for financial support[1]. In this study a female prostitute or commercial sex worker refers to a woman who engages in sexual acts, including those which do not actually involve vaginal copulation, on a more or less regular basis, with individuals of the opposite sex other than an established partner, such as a husband or boyfriend, for a consideration which has a pre-defined monetary value. Services of a non-sexual nature may be performed and emotional involvement may or may not be present[2]. The terms prostitute and sex worker are used synonymously. A distinction between clients and other partners was made on the basis of the respondent's own classification and whether the woman expected/demanded support/payment specifically for *sexual* services.

Three different categories of prostitutes, which apply to both Côte-d'Ivoire and Ghana, were identified. It was necessary to interview women from each of the different categories because I expected that they would differ by demographic characteristics, operating modes, client selection criteria, and charges, all of which could be associated with knowledge and behavior. Drawing distinctions between categories, especially *Roamers* and *High-Class* in Abidjan, was not simple. In such instances, respondents were separated on the basis of the predominant form of operation.

— *Roamers* are women who, as their name suggests, *roam* from place to place in search of clients. These venues range from hotels and nightclubs, through open areas such as lorry parks, to secluded street corners. They are often not 'full-time' prostitutes and may be apprentices learning a vocation, students, traders, or have some other source of income outside *sex work*. Usually their charges are lower than for the other categories of prostitutes.

— *High-Class* prostitutes, hereafter referred to as High-class, is the name I give to the group of women who, because of the nature of their dress, clients, location of operation, and level of sophistication appear to be financially better off than their colleagues. They are also more likely than other groups to have foreign (higher-paying) clients.

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[1] Arguably, this latter situation can be said to be true for many non-prostitutes the world over.

[2] Same-sex prostitution is, as far as I am aware, non-existent among African women, and none of the respondents engaged in sexual relations with other women.

— The *Seaters*, or *Tuutuu*[1] as they are traditionally known, operate from their homes, sitting in front of their doors to receive clients. Seaters are older women, mostly widowed or divorced, who have completed childbearing.

The following analysis is based on the interviews of 45 High-class, 39 Roamers and 47 Seaters.

Methodology

A variety of non-random methods were used to select women from the different categories. Particular locations where the women worked were identified using information from Public Health officials, media reports, and personal knowledge of the Principal Investigator (PI) and the interviewers. Respondents were primarily selected on the basis of availability once a location was visited. On some occasions women themselves took the initiative in approaching an interviewer; on other occasions a woman who had been successfully interviewed would introduce the interviewer to a colleague. With all the Seaters in Ghana, and all the respondents in Abidjan, a person who had had some contact with the women in the context of an AIDS-education project was utilized to gain entrance. With the Seaters this was necessary because many had been subjects in Public Health AIDS IEC efforts, and I did not wish to create the impression, neither among the women, nor among the health workers, that a new health project was being presented[2].

Respondents were informed about the objectives of the study, told that the interview would be recorded, and assured of anonymity and that they could discontinue the interview at any time if they so chose. Free and willing consent was considered crucial. Women who consented to be interviewed chose a pseudonym, which was used throughout the interview and ensuing analysis. Once concluded the respondents were paid an honorarium, provided with condoms and/or educational audiotapes. The refusal/discontinuation rate was lower than anticipated and was primarily because women did not have the time for an interview or felt they might lose a potential client to a colleague (N=5). In two locations fear expressed by one respondent that interviewers were from the media or police spread to her colleagues and those particular locations thus became inaccessible. Overall, the women approached were willing and interested, and in one location even made a donation to the interview team before we had an opportunity to pay the honoraria. At various stages of the study I worked with one female and three male interviewers. There appeared no consistent pattern to differences in subject's responsiveness, or content of information, by interviewer's sex.

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[1] The name originates from colonial times, when the women's charge was two shillings and two pence, hence Tuutuu.

[2] In Abidjan, it was especially necessary to rely on introductions because we had almost no knowledge about where Ghanaian sex workers lived and/or worked. Furthermore, Ghanaian women in the city were extremely cautious about talking to strangers.

The study instrument

Since AIDS prevention efforts need to target changes in attitudes and behavior, the study followed a Knowledge-Attitude-Belief-Practice (KABP) format. A structured interview-guide rather than a questionnaire was used to permit the exploration of issues central to the concept of 'safer sex' behavior.

The interview started out with less intrusive questions related to the respondent's demographic background in order to promote a degree of comfort between interviewer and subject. The main interview included questions about women's sexual experiences/relationships; attitudes and feelings regarding sex; marriage, pregnancy, abortion and child-bearing histories; contraceptive knowledge and use; condom use; AIDS-awareness; knowledge about HIV-transmission routes; beliefs about AIDS and protection methods; incidence of STD symptoms; and knowledge about prevention and treatment of STDs.

A facesheet covering basic personal details of the respondent, and a trajectory mapping out the main landmarks of her life (in terms of education, occupations, relationships, pregnancies and births) was also filled out. The data were analyzed using the computer software *Ethnograph*.

Reliability and validity

The present analysis is limited to female sex workers, and the nature of the study makes generalizations to the larger population difficult; however, the women are in no way unique. Although they come from predominantly lower socio-economic backgrounds, they cut across ethnic, religious, and educational lines. Some are not 'full-time' prostitutes and others are 'seasonal' prostitutes. Without exception they long for a life outside prostitution and are primarily concerned about making a living for themselves and/or their children. Since economic hardship can push a woman from any sector of the economy into prostitution, the findings are applicable to the larger population

As Ferry *et al.* (1995) describe regarding a series of World Health Organization KABP surveys, there is no simple, standard, or even satisfactory way of validating data on sexual behavior. There are problems of definition of concepts, respondent recall, and respondent willingness to divulge sensitive and sometimes painful information. Nonetheless, in assessing the relationship between socio-cultural factors and KABP, it is arguably more important to examine the plausibility of overall patterns and relationships. Although I concede that studying sexual relations is challenging, I believe that the issue of the validity of reported behavior was overcome to a large extent by cross-checking answers with information from a series of (pilot) Focus Group Discussions.

Demographic characteristics of the sample, entry into prostitution, and STD-knowledge

Age

Majority of respondents are under the age of 35 (93 out of 131; 71 percent) however, important differences are noted among the three categories of sex workers. Most Roamers and High-class are under age 25 (39 percent and 38 percent respectively) while the majority of Seaters are between ages 31-45 (68.5 percent). Mainly divorced or widowed, one of them explained to a female interviewer (in her early thirties) that:

> "We don't allow young girls here. As you [interviewer] are sitting here now, if you come to me I won't take you because I wouldn't like you to come here and waste away since you don't have a child. Unless the woman has been married before and has had all her children, or wives who have been abandoned by their husbands and don't have anyone looking after them … those are the ones we accept here."

Educational status

Although a few of the respondents have secondary education, generally their highest level of education completed is Middle school; however, just as many dropped out as completed. The breakdown is as follows: no education 26.7 percent; some primary 30 percent; some middle 33.6; some secondary 6.1 percent; vocational training 4.6 percent. Even among the High-class, only 4 out of 45 (11 percent) have some secondary school education. A major reason given for dropping out of school is pregnancy or lack of financial support from the family. Seaters have the least education (and 53 percent have never attended school).

Marital status

Five women (4 percent) are currently married under customary law[1], and a further three (2 percent) describe consensual unions. Those who are customarily married live separated from their partners and have virtually no contact with them. Fifty-four (41 percent) of the women state that they have boyfriends.

Dependents

Eighty-eight (67 percent) of the prostitutes indicate that they have at least one living child. Most women have between one and three children (16 percent, mainly Seaters, have four or more children). Seventy-nine (60 percent) women also have other dependents, usually a sibling's child, or a mother. Seaters have more dependents than any other category of women.

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[1] Ghana operates a plural legal system, including customary law and the "Modern" system inherited from, and developed since, colonialism. Couples can be married under customary law or under the ordinance which is usually preceded by customary marriage.

Occupational status

Only four women (3 percent) have never had any occupation other than prostitution. The majority were traders before they entered sex work (N=66; 50 percent); the rest were farmers, hairdressers, seamstresses, or involved in running a 'chop bar' or selling cooked food. Seven women (5 percent) were housemaids or baby sitters (6 in Abidjan), five (4 percent) had previously been in salaried employment, two (1.5 percent) were bar girls (in Abidjan), and one was a traditional birth attendant. However, at the time of the study only fifteen women (11.5 percent) had any occupation or regular source of income apart from prostitution. For 90 percent of respondents sex work was their main source of income at the time of the study, although some indicated that they had seasons when they concentrated on trading, using income earned from sex work as capital. A few High-class suggested that sex work was a means to supplement income from other employment and so provide themselves and/or their children with a better life style.

Entry into prostitution

The subject of the factors pushing the women into commercial sex work is taken up in detail elsewhere (Adomako Ampofo 1995) however, it is important to describe the situation briefly here since there is some relationship between (entry into) specific forms of sex work, and risk perceptions and behavior.

The entire sample frame their responses to questions about their entry into sex work in economic terms. The reasons offered include failure of a business, debt, and non-support from partners (or, among younger women, parents and guardians). Frustration over inability to adequately care for children is frequently mentioned. The collapse of income-earning opportunities has been largely responsible for most respondents' entry into commercial sex work. The modern city economy in many sub-Saharan African countries puts women at a disadvantage in terms of education and jobs. Several writers agree that recent Structural Adjustment Programs may have severely worsened the economic situation for women. Farmers and traders, which most respondents were prior to entering prostitution, have been particularly hard hit (Anker *et al*. 1988; Clark and Manuh 1991; Elson 1991; Palmer 1991).[1] At the same time they are being edged out of the informal sector, women face institutionalized attacks such as 'clean up' campaigns by city authorities to rid the streets of 'illegal' traders. One

[1] As a result of a combination of internal and external factors, the period between 1984 and 1992 was one of rapidly worsening economic conditions in Ghana. This eventually led to the implementation of the World Bank-imposed Structural Adjustment Programme (SAP). Ghana's SAP, like most in Africa, has included trade liberalization, the sale of state-owned enterprises, and laying-off of workers (euphemistically called 'redeployment'). As governments implement SAPs many individuals in the formal sector continue to lose jobs through these 'redeployment' efforts, with women frequently the first victims since they have fewer skills.

of the clients of an Accra Roamer blamed the city's metropolitan authorities (AMA) for women's entry into prostitution, "You know, most of these our sisters are traders and when they are trading their things are scattered (by the AMA guards)... So when you want to go for your things you must pay C15,000 to C20,000"[1]. If she hasn't got then she would say, "I'm a woman, if all this will be happening it would be better to put these things aside (trading) and use myself (euphemism for sex work)".

If, at the same time that women are losing access to economic opportunities, husbands and partners are less supportive financially, this constrains them when it comes to feeding, clothing and educating their children, and many respondents state clearly that they see no options for themselves other than sex work. Respondents frequently described their situation as *ahokyere* (literally to be 'tied up' or 'completely constrained'). Twenty-two year-old Adwoa's story is typical. A 'week-end' Roamer in Kumasi, she has little formal education and used to sell yams to support herself after her parents died a few years earlier. One day she made a heavy loss and subsequently fell into debt. Eventually she began working as a prostitute in order to be able to pay off her creditor. "If within the week I am able to get about C6,000, or, say, C8,000, I use four on food and put four down and save it (for my business) "that's what I have been doing little by little". Adwoa says that (of course) she does not like sex work, but, she argues, at least she does not have to steal or depend on anyone to feed or clothe her. It is interesting, however, that for Adwoa and many other Roamers and High-class, long-term survival is still framed in terms of dependency on male support, preferably through marriage to a caring man. Says Adwoa, "If God permits and I get a loving person who can take care of every need I will stop coming here".

STDs and AIDS: knowledge and treatment

Knowledge about the existence of STDs and AIDS is virtually universal among the sample. Almost all the respondents know the traditional STDs such as gonorrhea and syphilis, associating them with the typical symptoms. AIDS is associated with 'growing lean'. However, knowledge about the way that the HIV-virus is transmitted is not altogether accurate. Although transmission is generally reported in terms of sexual transmission, through blood transfusions, cuts, and needle-sharing, some respondents are uncertain whether the virus can be transmitted through kissing an infected person, drinking from the same cup or via mosquito bites. Upon more detailed questioning, 71 percent of respondents (N=93) indicate accurate knowledge about

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[1] At the time of the interview one thousand Ghanaian Cedis, C1,000, were approximately equivalent to US$1. Minimum monthly wages within the civil service, for example cleaners, ranged from C24,000 - C30,000. The CFA, was double the value of the Cedi: CFA1,000 being approximately US$2. Ivorians were also better paid; the same cleaner might earn CFA30 - 50,000 per month.

HIV-transmission (67 percent of High-class, 66 percent of Roamers, 76 percent of Seaters)[1].

Respondents were asked different questions in order to find out if they had ever had an STD. In some interviews it was possible to ask women directly if they had ever suffered from any of the STDs they had themselves spontaneously mentioned. More usually, however, respondents were first asked if they had ever experienced any of the following symptoms: itching of the vagina, pain when passing urine, a vaginal discharge, and unusual pain during sexual intercourse. Twelve sex workers admitted to having ever had an STD when asked directly; a further 83 incidents of any one of the other symptoms were also recorded. In view of the fact that admission of having an STD is considered to be shameful, the response rate is quite high. Reported incidence of STDs is higher among Roamers and High-class than Seaters, and, apart from High-class in Kumasi, is also higher among women in Abidjan than those in Accra and Kumasi.

Respondents have a variety of ways of treating STDs and this is important for any analysis of AIDS-preventive behavior. The use of local herbs as both prevention and cure for STDs is common. Women stress their efficacy, complaining that in the 'good old days' it was not necessary to think about injections or going to the pharmacy. Yet others rely on prayers and other ritual processes since illnesses are attributed to supernatural causes. Sakyibea, 36 years old and formerly a High-class, but now a Roamer in Abidjan, reports a number of symptoms suggesting she might have AIDS-related illnesses, especially considering her own admission that she rarely uses condoms with her clients. At the time of the interview she has been ill for a long time and explains her worsening condition thus, "When I was sick I was sent to a *Mallam* (a man who is combination of priest and healer, traditionally Islamic). When we went I was told that my sister - we had a misunderstanding over money and she cursed me, I was to stop the curse but I didn't. I was supposed to perform some rites but since I didn't have the means that is why I am still sick".

Many respondents are quick to pay a visit to the pharmacy or hospital for an injection or prescription of penicillin if they notice any symptoms they associate with STDs.

Risk perceptions and behavior

Although 'safe sex' should be a mutual responsibility between sexual partners, as Hart (1992) notes, socio-economic and actual perceptions do not encourage males (clients) to think of themselves as responsible. Thus women carry both the burden of responsibility for protecting themselves and their sexual partners, and they also face undue pressure to have sexual intercourse without using condoms.

Condom use among the prostitutes is quite complex and goes beyond mere considerations of protection from disease. Sex workers

[1] Information was unavailable for 23 percent of the sample.

are themselves not too keen on condoms because they create tension between sexual partners, are uncomfortable to use, dull the client's sensitivity and thus prolong the sex act unnecessarily —generally make their work difficult, the women complain. Nonetheless, the most frequently mentioned form of protection against STDs is the condom. A hundred women (76 percent) indicate that they use condoms at some time with their clients, their partners, or both. Condom use is highest among the Seaters (88.2 percent), followed by High-class (74.1 percent), and then Roamers (67.3 percent). Upon further questioning, however, only 54 percent of prostitutes admit to using condoms with their clients *all* the time (Table 1) and only 7 (5.3 percent) *always* use condoms with their partners. Among Seaters, High-class and Roamers, 61 percent, 59 percent, and 38 percent respectively indicate they *always* use condoms with clients (among Seaters in Accra and Kumasi the proportion is as high as 82 percent). Condom use is lowest among Roamers in Abidjan, and highest among Seaters in Ghana. In general this can probably be explained by the younger age and low educational status of Roamers which translates into less power to negotiate condom use, and the lack of access to information among women in Abidjan. Although Seaters have less education than women in any other category, in Ghana they are also the women who have received the most AIDS-IEC through the Ministry of Health.

The ensuing analysis is directed towards a description of the way in which phenomena are assigned to categories. The data suggests four major categories (Table 1) under which attitudes toward, and therefore forms of protection against HIV-infection among the respondents can be examined. Women in categories 2-4 sometimes gave more than one response regarding protective behavior. For purposes of the analysis I have assigned respondents to categories according to what appeared to be their single most important attitude/behavior.

1. ***Women who recognize they are at risk and use condoms***

This group of women, who insist they use condoms *all* the time, forms the largest of the four categories. They want to protect themselves and their clients and partners and consider condoms the most reliable means to achieve this. Although this suggests a reason for optimism, this category only forms 54 percent of the whole sample (Table 1, row 1). Furthermore, although they form 70 percent of the Ghana sample, they make up only 22 percent of the Abidjan sample (Table 2, row 1). In some of these cases (number uncertain) the efficacy of condom use may also be compromised by the application, of lubricants such as shea butter or petroleum jelly.

When asked if they would consider having sex without a condom if a client offered more money respondents in this category are unambiguous that this carries with it a risk far greater than any amount of money could make up for. One woman exclaims, "If you are going to follow money then you have a bargain with death!"

Table 1: *Risk perception and protection among sex workers by work category, Accra, Kumasi and Abidjan (Column percent in parentheses)*

Risk and Protection	*Roam* Accra	Abidjan	Kumasi	*Seat* Accra	Abidjan	Kumasi	*High* Accra	Abidjan	Kumasi	Total
	N=10	N=15	N=14	N=16	N=16	N=15	N=16	N=14	N=15	T=131
1	4 (40)	9 (60)	2 (14)	13 (82)	13 (82)	3 (20)	14 (88)	8 (57)	5 (33)	71 (54)
2	-	-	6 (43)	1 (6)	-	5 (33)	-	4 (29)	4 (26)	20 (15)
3	4 (40)	4 (26)	3 (21)	1 (6)	1 (6)	3 (20)	1 (6)	2 (14)	1 (06)	20 (15)
4	1 (10)	1 (6)	3 (21)	-	1 (6) [2*]	4 (27) [4*]	1 (6)	[2*]	5 (33) [3*]	16 (12)
NA	1 (10)	1 (6)	-	1 (6)	1 (6)	-	-	-	-	4 (3)

*These respondents, despite their attitudes to risk perception insisted they used condoms with all their partners and are thus included in category 1 and not 4.
Source: Author's interviews 1993-1994.
1.Women who recognize they are at risk and use condoms.
2. Women who acknowledge their risk but feel unable to negotiate condom use.
3. Women whose judgments regarding a 'risky' partner are based on perceptible characteristics.
4. Women who feel they can protect themselves through means other than condoms.

Table 2: *Risk perception and protection among sex workers in Ghana and Abidjan*

Risk perception and protection	Ghana N	Ghana percent	Abidjan N	Abidjan percent
1. Women who recognize they are at risk and use condoms	61	70	10	23
2. Women who acknowledge their risk but feel unable to negotiate condom use	5	6	15	34
3. Women whose judgments regarding a "risky" partner are based on perceptible characteristics	13	15	7	15
4. Women who feel they can protect themselves through means other than condoms	4	5	12	27
NA	5	5	-	-
Total	87	101*	44	99*

*Due to rounding off totals do not add up to 100 percent.
Source: Author's interviews 1993-1994.

Another explains the importance of the condom for her, "My sister, it is true that poverty is a curse ... with these diseases and my coming here, at least seeing my children every day, don't I like it? But as it is, just because of someone's 1,000C (cedis) or something I'll die and leave them at an early age! Sister, is that fair? As for me I think that the condom helps us a lot" (Yaa, Roamer, 40, Kumasi).

Fifty-six-year-old Afua, a Seater in Accra, insists she always uses the condom with her clients. Asked if she would accept C5,000 if the client did not wish to use a condom she retorted, "Where will that person get the C5,000? If that person gives me all that money what will he eat himself ... he should go to his wife. When there was nothing like AIDS it was 'free', there was nothing like the use of condoms, now that we have the disease everyone has to use the condom".

Some of these women claim they can tell when a client has an STD and that men who are unwilling to use condoms have something to hide and must on no account be entertained. Possible infection is protected against by studying the type of penis a man has, "If it's a soft penis you use one (condom), if the penis is hard you use two" (Stella, High-class, 29, Accra). To be absolutely sure they are protected against condoms that tear some women say they always use two condoms, others look for sturdier, more expensive brands. If a condom tears during the sex act they interrupt this to replace it, even though they could infuriate a client. Says one respondent, "If you only use it always (the condom) you can do whatever you like till God calls you home, but if not you will die before your time". Retorts another, "I'm suffering because I don't have anybody to look up to (support her). So if I come across a man I wouldn't let him have sex with me without using the condom" (Roamer, 40, Accra). These women have no illusions about their clients. Stella, the afore mentioned High-class says, "I ask the man to use condom, he say when if I didn't trust myself but he trust himself. I say that I trust myself as you trust yourself but I didn't trust you".

Among Seaters, separating the effects of intent to protect against STD/HIV-infection from cooperative work ethics is not easy, however. In one location of Seaters in Accra the Queenmother[1] has done a lot of educating on condom use among the women under her. Consequently, if any woman is found to not be using condoms with her clients she is reprimanded. Patricia, a 35-year-old Seater in Accra confirms the high rate of condom use. She believes that it is unlikely that any client will find a woman who will agree to have sex without a condom. Condom use among Seaters in Kumasi is also high, for the same reason —there have been regular educational sessions among the women. Fifty-year-old Akosua explains, "I didn't use it initially, I started just about two weeks ago when I returned for the last time. I was told (by Queenmother) on my arrival that everybody was supposed to use the

[1] The Queenmother, generally an older woman who is no longer actively working as a prostitute, 'oversees' the work, calls meetings, ensures that proper work ethics are applied, and generally cares for the women under her. She receives no formal recompense for this.

condom so if I wanted to continue with the work then I should use it". Andrew Osei who works with the AIDS Control Programme (ACP) in Ghana, confirmed that as a result of periodic and regular educational sessions among the Seaters, condom use is high (personal communication, 1993). He cites the example of a woman who was accused by a colleague of taking a client whom another colleague had rejected because he refused the condom. This woman was warned strongly by the Queenmother, and the ACP took the opportunity to reinforce its messages.

Condoms are also used during sexual encounters with regular partners, because the women concede that these men may be seeing other women and that, "men cannot be trusted". A typical response: "It's possible he doesn't know the work the girl does, like me, coming here at night without his knowledge. Or it could be the girl has another boyfriend somewhere who may also be quite promiscuous. So by all means when he comes I have to make sure that I use the condom. You can't sit and deceive yourself that with a boyfriend you are safe and so you won't use the condom" (Comfort, High-class, 23, Accra).

Here are women who are convinced that their own protection depends on consistent condom-use. They are committed to their own protection, that of their clients, and, in some cases, even mention the fact that their clients have wives and it would be unfair for them to contract an STD. "You may have a disease, I don't know, and at the same time I may have a disease and you wouldn't know and we may exchange diseases; probably your wife is at home, so you send her a disease from town" (Seater, 35, Accra).

Since condom use is highest among Seaters (in Ghana), women with the least education as a group, it is plausible to conclude that targeted IEC efforts are more effective in changing behavior than relying on general educational levels and exposure to the mass media. This is not to downplay the effects of formal education in empowering women to acquire knowledge which can change attitudes and behavior, but rather, to suggest that education, per se, is not a sufficient condition for changed behavior.

2. Women who acknowledge their risk but feel unable to negotiate condom use

These women acknowledge the dangers of contracting STDs/AIDS and their own risky behavior; however, for various reasons they feel powerless to insist on the use of condoms. This is either because non-condom sex can earn much needed additional income, or, even ensure that a woman does not lose a client altogether. Furthermore, some clients/partners turn violent when the issue of condoms is raised. Generally, risk is viewed in terms of the probability of becoming infected if the respondent uses a condom *some of the time*.

Fifteen percent of respondents fall into this second category (Table 1, row 2) with the majority being in Abidjan. Indeed, while this category only makes up 6 percent of the Ghana sample, it is the largest category in Abidjan (34 percent; Table 2, row 2). Intuitively this

makes sense since these women are living far away from home and probably face more (economic) pressure to survive and provide for themselves and their families.

Thirty five-year-old Florence has worked as a 'part-time' prostitute in Ghana, and was convinced to come to Abidjan by a friend. Pregnant with her sixth child at the time of the interview, she finds it extremely difficult to make ends meet. Because she needed the money she continued receiving clients, without using condoms and sometimes even during her menstrual period, through the sixth month of her pregnancy, stopping thereafter due to her enlarged abdomen. Currently selling cooked food, she earns less than 1,000 CFA a day. Florence was suffering severe abdominal pains when passing urine, though it was difficult to tell the actual cause of this. She agrees that her behavior is risky but explains her actions in terms of her extreme financial need —she cannot afford to insist on using condoms and risk losing clients.

For a woman in this category the offer of more money for non-condom sex is especially powerful because she frequently has fewer clients, sometimes only one the whole day. She rationalizes that she can use a part of the extra income to buy additional or better health care. Charges for a Roamer in Abidjan could increase from about CFA 5 - 10,000 to about CFA 7 - 20,000 per client, out of which a woman might spend CFA 500 - 2,000 to buy drugs to protect her against STD infection. Although the risk of HIV-infection is acknowledged, this is viewed in relation to the risks associated with having no money —especially for women in a foreign country. A woman *may* become HIV-infected if she does not use a condom, however, if she has no money, she *will* not be able to provide for herself or her children.

Even a woman determined to use condoms may relent if she is physically threatened. Although Agnes is a woman who uses condoms all the time, I include her story here to highlight the pressures women face to give in to men's preferences. A High-class in Abidjan, she had not had a client the whole day. At 2.00 am, a man approached her and they went to an hotel. When she offered the condom he said he was not a child to use one and offered her CFA 25,000. Agnes said she would even accept a mere CFA 5,000 if he would only use the condom. The client begged, saying he was willing to pay more if she would agree to have sex without a condom. She retorted that even for a million CFA she would not. The man became angry, shouting that he would not have sex with a condom, and threw her out - at 3.30 am. Agnes was almost beaten up by gang members, she could have been robbed or raped on the streets of Abidjan, but she has seen two colleagues die of AIDS and says, "as for the condom, I'll use it".

Some respondents also report having been beaten up by boyfriends when they insisted on using the condom. Presumably, among women whose partners do not know that they are sex workers, this is motivated by the partner's suspicion that she is being unfaithful. Fear of disrupting a relationship makes many women comply. One must conclude, then, that even though women in this category may

acknowledge the risks involved in non-condom sex, their financial need and relative powerlessness puts them in a catch-twenty-two situation where they are damned if they insist on condom use, and damned if they don't.

3. Women whose judgments regarding a 'risky' partner are based on perceptible characteristics

For women in this category, protective behavior is determined by a client's appearance; how 'clean' or 'good' he is; whether he is a regular client, a boyfriend, or a 'stranger'. If a man looks 'healthy', or he is a 'good man, or you just like him', then he is not considered to be a (health) risk. This category makes up 15 percent of the sample and Roamers, the youngest women, are the largest within this group (Table 1, row 3). Presumably these respondents are more naive and vulnerable to the notion that a nice-looking man cannot *really* be sick or a carrier of a deadly virus. This is also the category with no noted difference between the Ghana and Abidjan samples (Table 2, row 3). Says 29 year-old Esther, a Roamer in Kumasi, "You see, there is a guy here called Bright, as for him if he says he will not use it (the condom) I will gladly have sex with him because he is a nice guy". Says Gloria, an Accra Roamer, "If the person is clean or neat I don't insist (on the condom)". Laughingly she tells the male interviewer, "Somebody like you, no problem".

Condom use (or lack thereof) also has to do with familiarity. With strangers, foreigners (especially 'white men' who many respondents say are responsible for the inception of AIDS), and a man a woman does not care for she will be 'careful' and use a condom. "If you are my boyfriend I can have sex with you with a condom *if I don't love you*", says a Kumasi Roamer in her twenties (emphasis mine). Says another "If I don't like you and I don't want your blood to enter my blood I use it (the condom)" (Roamer, thirties, Abidjan). However, with men she 'likes' this woman will agree not to use a condom if this is what he prefers. Indeed, non-condom sex is especially common with boyfriends. The typical response when asked why they do not use condoms is simply, "He's my boyfriend!" implying that the question is a ridiculous one.

That as many as 15 percent of respondents fall into this category is cause for concern, especially when one considers that many men eventually become regular clients, and hence familiar to the women. After a level of rapport has been built between a woman and her client, when she comes to realize that the man is not 'sick', it is not difficult to imagine her consenting to have sex without a condom. Clearly, the possibility of asymptomatic transmission of the HIV-virus is still inconceivable to many women.

4. Women who feel they can protect themselves through spiritual and other means

This category includes women who believe that AIDS can be treated, or who attribute HIV-infection to supernatural causes and

fatalistic ideas and as such view protection/cure as requiring spiritual interventions.

Forty-two-year-old Esther, a Seater in Abidjan, when asked whether she had had any major illnesses in her life responds, "Since I came here I have really suffered. I was not really sick, but you see they say that when you come here initially men like you, so there was this lady here called Mansa, she '*jujued*' (cursed) me and anybody who saw me said I had AIDS. I grew very lean. My body was virtually finished, my buttocks, my legs, I couldn't walk ... I was taken to an *Ewe* herbalist, he cured me. The woman did it again. It has happened three times..."

Esther also blames STDs on another's *juju (juju* can simultaneously be a curse as well as a form of protection or empowerment)*:* "Since I came to this house 18 people have been 'jujued' ... and these young girls ... when that happens they have sores in their vagina..."

This fourth category make up 14 percent of the sample, mainly Roamers, except in Abidjan where Seaters and High-class predominate (Table 1, row 4). Making up the smallest category among the sample in Ghana (5 percent), women with beliefs in spiritual causes and protection of STDs/AIDS are the second largest category in Abidjan (27 percent; table 2, row 4). Thirty-nine-year-old Akua, a Seater in Abidjan, is quite fatalistic, and says, "With diseases you cannot tell. If God ordains that you will be attacked by this particular disease you will have it. In Ghana they say AIDS, over here they say SIDA (French acronym for AIDS), but I have not seen any since I came here. It is a curse, I believe it is a curse (emphatically)".

Akua explains why she thinks what people call AIDS is really a curse, citing the hypothetical case of a woman who has an affair with the boyfriend of another woman who invested in her and brought her to Abidjan: "For instance someone brought me here. She may have a partner but still engage in this high-time life and may be the one responsible for my upkeep. Then she realizes you are seeing her man and warns you not to go there anymore. I may be stronger than her, so then I insult her or beat her up. I will be affected if she should curse me because she has spent a lot on me, you see. She may have cursed you with a river or lake so then you start to defecate, vomit, and still don't tell the truth (about the man). Then you are taken to Ghana, when you get there they say you have AIDS. Then you grow very lean, it is all a curse, it is not that disease (AIDS). Whoever says that is lying".

Nana is a 45-year-old Seater in Kumasi who also believes AIDS is a curse. According to her AIDS has become a problematic disease to be contended with in Ghana because of "those who go to Abidjan ... to cheat people, and they are cursed, and those white men ... and when they begin to grow lean people conclude that it is AIDS ... it is a curse, ... but it may also have been brought about by demons".

Thirty-five-year-old Rose is a Seater, in Abidjan. She believes that AIDS is associated with diabetes and witchcraft. She believes this because her aunt, a diabetic, grew very lean after she was ill with diabetes. "It was diagnosed at Korle-Bu (largest hospital in Accra) as

diabetes", she says, "but she had grown very lean ... The disease has got something to do with witchcraft, when these things happen they say it is SIDA". Afua, a High-class in Kumasi says, "Now because of the word of God I see it as a satanic disease. In that situation God is the healer ... if it is His will that I should get AIDS then I will get it ... If God says I will die at *Saturn* (name, not real, of an hotel in Kumasi) even the use of the condom does not matter".

Many respondents place their trust in traditional healers, herbalists or *mallams*. Ablah, a 33-year-old Seater in Abidjan explains that you need to "have incisions with black powder to protect yourself from contracting *gbadza (*local term for an STD, probably gonorrhea) and other diseases". As a result of having had these incisions she considers herself immune to STDs asserting she has never had one.

Closely linked with women who ascribe AIDS to supernatural causes are those who feel they can protect themselves from STDs/AIDS by using various medications. Some rely on antibiotics and other drugs, usually purchased without a prescription ... Says one woman, "It all depends on me, it is I who must all the time protect myself ... All we can do will be to pray God that I don't meet anyone with the disease". The morning after having sexual intercourse with a client she takes antibiotics, and every couple of months she has her blood checked for the HIV-virus. So far the doctors tell her she has no infections and she believes her strategy to be effective. Esther, the Roamer who does not use condoms with 'nice guys' says, "If you are a prostitute, you should take a lot of medication ... *super multivite* and *ampicillin (*names of vitamins and antibiotics). Because if you take the *ampicillin* you urinate a lot and that is good for you". Women in Abidjan frequently felt that urinating after the sex act would rid the body of poisons and disease. Another respondent in Kumasi uses the (contraceptive) pill as a form of protection against STDs; "I use *Secure*, it has the instructions that when you use it and have sex with a man who has any disease it will let you pass everything out." Asked whether she was taking it on a doctor's prescription she answers, " I heard it on the TV and when I go to the drug store to buy it I ask about it before. I read the instructions written on it". Yet other respondents rely on the 'medical knowledge' of local druggists, persons who are frequently not qualified pharmacists. A Roamer in Abidjan explains, "I normally go to the pharmacy and I tell them I am a *hustler* (euphemism for prostitute) and I don't want any strange disease so they should get me some medicine".

Local herbs are another popular form of protection, especially among Seaters, and women in Abidjan. The difference between Seaters in Ghana and women in Abidjan is that the former use these *in addition* to, the latter *instead of,* condoms. Many of these local preparations are inserted in the vagina or are used as vaginal douches, injections or enemas. Urinating immediately after sexual intercourse or after using these preparations implies a cleansing of the body ("you would urinate and even if the man has any disease you would not have it"). Frequently these local preparations are combined with 'modern' medicine, "I use enema, then everyday I take three capsules of

ampicillin, multivite and B-complex —it is standard medicine", explains an Abidjan High-class.

Fatalism, faith in the power of the supernatural, and belief in the efficacy of other drugs, or combinations of all these influence protective behavior strategies among this category of women, and they believe in using herbs, talismans, and *juju*, to protect against STDs and AIDS.

Discussion and conclusion

This article has shown the particular vulnerabilities women face regarding HIV infection through (1) the lack of *accurate* knowledge regarding the nature of the disease, and (2) their compromised ability to control their own sexuality because of the power imbalances between them and their clients/partners.

Protection from STDs, especially HIV-infection, depends on a number of factors, the foremost being knowledge about, and acceptance of, AIDS as a deadly disease with no cure. This cannot be if people are to be convinced that there are (as yet) no known traditional means of either protection or cure. Women who are persuaded that they can become HIV-infected through sex, and by anyone, no matter how healthy he looks, are less likely to engage in 'unprotected' sex. This will be despite precarious financial situations, or a client/partner's physical threats. If behavior continues to be 'risky,' not because people do not know *about* AIDS, but because they ascribe the disease to non-physical causes, or because of a misperception that one can tell an infected person from their appearance, then IEC messages need to move beyond condom-use campaigns. An imperative of IEC efforts, therefore, is the need to stress the asymptomatic stage of HIV-infection, and that carrying the disease can be unrelated to physical appearance for years. Clearly, special efforts at AIDS-education need to be undertaken in Côte-d'Ivoire.

On another level, controlling the spread of AIDS requires that we acknowledge the inequities in gender relations. There is a lot of discussion these days about 'empowering' women to use condoms, especially female sex workers (World Bank 1990), yet little recognition of the problems women face in insisting on condom use. For some women their lack of power relative to their clients and/or partners compromises their ability to do so. For most of these women, the implications of even a *single* act of 'unprotected' sex is moot since without the income from prostitution —including sexual acts where the client may refuse to use a condom— they would be destitute. Furthermore, even if a client does not refuse to use a condom, the possibility of receiving more money for agreeing to sexual intercourse without a condom, makes the prospect of eventually being able to escape from sex work all the more probable. Unless genuine efforts are made to improve women's material conditions so that they have comparable access to resources as men do, and are no longer dependent on supplying sexual services for their livelihood,

exhortations to stick to one partner may be irrelevant even if they appreciate their risk. It must be recognized, however, that even in their disadvantaged situation some African women have always found strength in collective organizations. As seen from the efforts of the Seaters, one of the means to empowering women obviously lies in harnessing the energies found in their organizations, and using these to devise *collective* protection strategies.

In order to 'empower' women, men will also have to be motivated to change their ideas about sexuality —ideas that the use of condoms is not masculine and sex with condoms cannot be enjoyed. This also needs to be a focus of IEC efforts, especially since condoms are a technology whose use women can only influence, but not control. Such an approach will go a long way towards making men feel more responsible about the sexual health of their partners. IEC messages also need to be examined to determine to what extent they reinforce traditional sex-stereotypes and gender roles.

Although survey results suggest widespread knowledge *about* AIDS and how the HIV-virus is transmitted, further micro-level studies are necessary to determine how these responses are related to health and religious belief systems. Attempts at transforming behavior require a realistic appreciation of the factors that inform risk-perception and protective behavior at the individual level. Without this, IEC campaigns aimed at promoting condom use will continue to have only marginal success. On a general level, there is a need for more detailed research on sexual relationships. We need to establish how much people actually know about HIV/AIDS, their sources of information, their levels of confidence in the various sources, and what sense they make of such information. We need to know to what extent they are simply repeating what they have heard through the media, and how much have they really conceptualized an illness which has no cure, but at the same time is not associated with witchcraft and malevolent spirits. We still do not know enough about contemporary concepts of sickness and disease as related to HIV-infection and AIDS, nor the factors which lead individuals to select particular options regarding protection. In view of the importance given to the role of traditional medicine, further research on people's health belief systems is crucial. Intervention strategies need to be constructed on a realistic assessment of the determinants of risk-taking behavior among different groups.

The media may have been successful in getting the message *about* AIDS into communities; it would seem, however, that greater success is achieved where a population group receives regular and consistent information over a period of time, as has been the case with Seaters in Ghana. This can be done through the many groups and organizations people are members of —schools, churches, clinics, youth and women's groups, market women's associations, etc.

No amount of AIDS education can change a woman's disadvantaged financial situation, however, women cannot even begin to become more empowered to take control over the health issues of their lives if they not armed with accurate knowledge. Because of women's

general disadvantaged position in society, they are frequently those with the least access to this information and special efforts need to be made to target women without stigmatizing or 'scape-goating' them.

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Akosua Adomako AMPOFO, *Nice guys, condoms, and other forms of STD protection: sex workers and AIDS protection in West Africa*

Summary — The last two decades have seen the presentation of a variety of Information, Education and Communication (IEC) efforts aimed at changing sexual behavior with the hope that this will slow down the rate of the spread of AIDS. Neglected has been an analysis of how cultural factors influence the interpretation of this information, and consequent behavior. This chapter reports on a study of face-to-face interviews among Ghanaian sex workers. Rather than focussing on risk factors to clients, as has been the tendency, the chapter examines the women's perceptions regarding their abilities to protect themselves, and how this is related to beliefs about disease causation. Also examined is the relationship between the women's behavior and the economic basis of their sexual relations. Four types of perceptions and their related behaviors are analyzed, and the implications discussed. The findings indicate that possessing knowledge about 'risky behavior' is a necessary condition, but not a sufficient one, for changing behavior. The women do not simply absorb information and modify their behavior according to information supplied by 'experts.' More important is the reflection of the knowledge against the context of their beliefs. Furthermore, although accurate knowledge can offset economic precariousness for some of the women, for others their economic dependence on men makes them passive negotiators.

Keywords: traditional health beliefs • AIDS-related knowledge • high-risk behavior • safer sex • condom use • women's HIV-vulnerability.

Akosua Adomako AMPOFO, *"Nice guys", condoms et autres formes de protection contre les MST : travailleurs du sexe et protection contre le sida en Afrique de l'ouest*

Résumé — Durant les 20 dernières années, on a remarqué des efforts en matière d'IEC (Information, Education, Communication) pour changer les comportements sexuels, avec l'espoir de ralentir la propagation du sida. On a négligé d'analyser la manière dont les facteurs culturels influencent l'interprétation de cette information, et les comportements qui en résultent. Cette contribution présente une étude menée à partir d'entretiens individuels avec des travailleuses du sexe ghanéennes. Plutôt que de se concentrer sur les facteurs de risque des clients, comme cela a été

la tendance, ce texte évoque la manière dont ces femmes perçoivent leur capacité à se protéger, en relation avec les croyances sur les causes de la maladie. Sont aussi examinés les liens entre le comportement des femmes et les fondements économiques de leurs relations sexuelles. Quatre types de perceptions et de comportements associés sont analysés, et leurs implications sont discutées. Les résultats indiquent que le fait d'avoir des connaissances sur le "comportement à risque" est une condition nécessaire, mais non suffisante pour changer de comportement. Les femmes n'assimilent pas l'information et ne modifient pas simplement leur comportement selon l'information fournie par les ""experts". Plus importante est la réflexion de la connaissance face au contexte de leurs croyances. En outre, alors que, pour certaines de ces femmes, une connaissance appropriée peut compenser la précarité économique, pour d'autres, leur dépendance économique par rapport aux hommes les rend passives dans la négociation.

Mots-clés : croyances traditionnelles sur la santé • connaissances sur le sida • comportements à haut risque • sexualité à moindre risque • utilisation du condom • vulnérabilité des femmes au VIH.