Developing Country Studies
ISSN 2224-607X (Paper) ISSN 2225-0565 (Online)
Vol.5, No.1, 2015

Women with HIV and AIDS: The Case of Lower Manya Krobo District, Ghana

Bernard Kissi-Abrokwah*
Faustina Adu, University of Cape Coast, Medical School,Cape Coast, Ghana
Email: bernardkissiabrokwah@gmail.com

Catherine Selorm Agbesi
University of Cape Coast, School of Medical School, Dept of Community Medicine,Cape Coast, Ghana
Email: c.a.selorm@uccsms.edu.gh

Theophilus Andoh-Robertson
Ghana Education Service, Breman Asikuma District Office,P. O. Box 29, Breman Asikuma, Ghana
Email: andohrobertson19@gmail.com

Cecilia Tutu-Danquah
Accra College of Education,P. O. Box 221, Legon-Ghana
Email: tuceebaby@gmail.com

Abstract
Ghana is a country in West Africa, which is facing the challenges of improving HIV and AIDS situation. The study investigated the causes, effects and coping mechanism used by female HIV-clients and AIDS-patients in Lower Manya Krobo District. This was a qualitative study underpinning by interpretative philosophical thought. It employed a case study approach and collected data using semi-structured interview guide. Snowball sampling technique was used to sample the view of ten (10) female HIV-clients and convenience sampling for four (4) female AIDS-patients and four (4) selected Key Informants. The data were analysed using thematic analysis. The study highlighted multiple factors that cause female in the Lower Manya Krobo District to be vulnerable to HIV infection. These included women sexual passivity, poverty, promiscuity and poor culture practice. The study also showed that loss of income and discrimination affected female with HIV and AIDS. Finally, the research unveiled that counselling, financial support; acceptance and visitation from friends help them to cope with the disease.
Keywords: Female HIV-clients, Female AIDS-patients, Women Passivity, Poverty, Counselling, and Loss of Income.

1. Introduction

HIV and AIDS among women have being the major worry to many stakeholders and United Nation. Most of the country within Africa and the world continue to spend resources in an attempt to prevent women against HIV infection. In 2002, in an article in the *New York Times*, former Secretary General of the United Nations, Kofi Annan, stated: "today, HIV has a woman's face" (Annan, 2002, p.4). The statement remains true today. The United Nations Programme on HIV/AIDS (UNAIDS) estimates that slightly more than half of the people who are living with HIV and AIDS globally are women.

Table 1: Estimated Prevalence Rate for People Living with HIV and AIDS, 2012

Source	PLWHA	Male	Female	Male (%)	Female (%)
Global	34,000,000	11,900,000	22,100,000	35	65
African	22,780,000	7,061,800	15,718,200	31	69
Ghana	225,477	100,336	125,141	44.5	55.5

Source: UNAIDS, 2011

The figures in Table 1 show that from a global point of view to Ghana, women are more vulnerable to the HIV and AIDS than men. The researchers study decided to research on women with HIV and AIDS in Ghana because from the above table, we could see that women are more prone to the HIV and AIDS than men. The researchers study chose to conduct the study in the Eastern Region, more specifically in the Lower Manya Krobo District because, the Ghana Aids Commission Report, (2010) shows that out of the two hundred and thirty one (231) districts in Ghana, Lower Manya Krobo District recorded the highest prevalence rate of 6.9%. The Ghana Demographic Health Survey in 2003 and 2008, indicates that Agomanya, a town in the Lower Manya Krobo District, always records the highest prevalence rate in Ghana. Indication from the Ghana Demographic Health Survey in 2003, Agomanya recorded 9.3% from the urban sentinel site representing 41% males and 59% female respectively. But in 2008, Agomanya recorded 7.8% from the urban sentinel site representing 45% and 55%

female respectively.

It against this background that the study decided to use female HIV-clients and female AIDS-patients for the study because the study perceived that the issues that affected women to be vulnerable to the HIV could be found with women in the Lower Manya Krobo District. The study is significant in three main ways. First, the results from the study would be available to women organisations in Ghana and also Non-Governmental Organisations (NGOs) who will be interested in the study of HIV/AIDS and why women are vulnerable to it. Secondly, the study should help parents; teachers and counsellors become aware of how and why women are vulnerable to HIV and AIDS. This will enable the community members and general public change societal attitudes and cultural orientation towards women in the Lower Manya Krobo District and thereby find ways of preventing their young girls from contracting the disease. Finally, the study contributes to literature on women with HIV and AIDS in the Ghanaian context.

2. Theoretical Framework

The liberal feminist theory was the most appropriate as the framework within which the findings of the study was discussed. According to Anderson (2006), liberal feminist is the root in the history of liberalism as a mode of political theory, one that developed particular over the course of the nineteenth century and it is centered on the principle of equality and capacity for existing democratic social institutions to create equal right and opportunities for all human beings.

Proponents of this theory suggest that women are vulnerable to HIV because they have been denied the opportunities to have an education. Women who lack education have less access to health care, HIV and AIDS-related knowledge, which makes them vulnerable to HIV. Lack of education is paramount in the deterioration of women's health. Educated women are likely to avoid harmful health practices, and have more self-confidence while confronting their husbands about making major family decisions, as they are more likely to be economically independent (Susser and Stein, 2000).

Following the Liberal Feminist principle, Ghanaian women must be equipped with correct information on sex education, and knowledge on HIV infection. Women must be aware of the HIV/AIDS and everything they need to know must be available to them. However, in Ghana, a significant number of girls and women are denied the opportunity to go to school because of various reasons including traditional attitudes, which places more emphasis on the education of boys, and therefore parents often encourage their sons to go to school but not their daughters. Resources are usually invested in boys, while girls are left to do the household chores. Thus, girls often grow up to be women who are ignorant, disempowered, and dependent on men. Generally, Ghanaian women are socialised to think that men will take care of them, which creates further dependency and low self-esteem (Takyi, 2003).

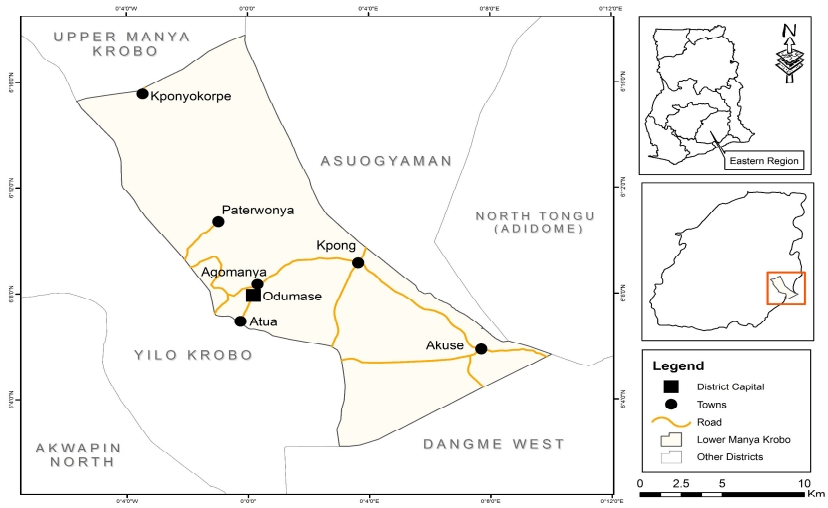
3. Conceptual Framework

Women in Lower Manya Krobo District are more likely to be vulnerable to HIV infections because most women in the district are experiencing high level of poverty, poor traditional practice, sexual assault, rape, vulnerability of sex workers, promiscuity, sexual passivity, sexual aggression and some political reason that constitute to women vulnerability to HIV infection in the Lower Manya Krobo District.

4. Study Area

The major towns in the district include Krobo Odumase, Agomanya, Akuse, Kponyokorpe, Paterwonya, Kpong and Atua. The people are predominantly Krobos. According to the 2010 population census, the total number of people living in the Lower Manya Krobo District is estimated to be 112,903. Like in the national and regional situations, there are more females than males in Lower Manya Krobo District. As with the nation, farming is the backbone of the local economy of the district. Trading is the minor occupation of the people and those involved are mostly petty traders due to inadequate capital to expand their activities. The following are some of the socio-economic problems associated with the Lower Manya Krobo District: high HIV rate, high illiteracy rate among the vulnerable, low awareness of gender mainstreaming, high incidence of child labour and child delinquency. The next sections describe how individual and stakeholders will benefit from the research.

Map of Lower Manya krobo District, Ghana



Source: Geographic and Cartographic Section in University of Cape Coast, (2012)

5.Methodology

5.1 Research Design

The purpose of this study was to investigate the causes, effects and coping mechanisms used by female HIV-clients and AIDS-patients in Lower Manya Krobo District. These informed the study to select qualitative research design, which was underpinned by interpretative research paradigm. The design was chosen because it allows researchers to access the experiences and viewpoints of the research participants (Verma and Mallick, 1999; Kusi, 2012). Secondly, it recognises the role of the study and the research participants in knowledge construction, acknowledging interpretations as 'socially constructed realities.' The researchers and the research participants acquire active roles in knowledge construction. Lastly, it is useful in an attempt to understand a phenomenon in all its complexity in a particular socio-cultural context (Creswell, 2005).

5.2 Research Approach

Qualitative study is an umbrella term that encompasses many research approaches including Historical study, Phenomenological Study, Ethnographic Study and Case Study. The approaches may have some related feature and difference but out of these, the case study approach was chosen for the purpose to investigate the causes, effects and coping mechanisms used by female HIV-clients and AIDS-patients. A case study approach allows an investigation to real-life event or in-depth analysis conducted, usually over a limited period of time, and focuses upon a limited number of subjects (Yin, 2003).

5.3 Population, Sample Size and Sampling

The population constitutes all female HIV-clients, AIDS-patients and selected key informants in the Lower Manya Krobo District. The total estimated HIV-clients and AIDS-patients in Lower Manya Krobo District were 213 consisting of 81 males and 132 females (Ghana AIDS Commission Report, 2013). However, the targeted female HIV-clients and AIDS-patients age ranged from 15-39years but no age ranged was given for the key informants. The sample size was eighteen (18), which consisted of ten (10) female HIV-clients, four (4) female AIDS-patients and 4 key informants through the use of snowball sampling for female HIV-clients and convenient sampling techniques for female AIDS-patients and key informants. This sample size was selected for the qualitative study because it was manageable. Also, it was necessary to select a sample that would enable the phenomenon under study to be explored for a better understanding. Creswell, (2005) argues that selecting a large number of interviewees will 'result in superficial perspectives ... the overall ability of a study to provide an in-depth picture diminishes with the addition of each new individual or site' (p.207).

5.4 Data Collection Methods

Due to the sensitive nature of the study the researchers began the data collection as outsiders since they had neither lived nor worked in the context of the study. For ethical reasons, the researchers wrote a letter to the respective bodies in the district to ask for their convenience. The researchers first visited the context of the study and got acquainted with the authorities that they would be working with. One of the key informants commented that granting interview by the HIV-client and AIDS-patients would be difficult, if you are not from the locality.

Through the researchers' communication and interaction with the participants before and during the interview session, they became professionally close to them, offering them a sense of security and freedom, thus wanting to know what the study was meant for. The researchers' positionality as 'outsiders' changed to 'insiders' through the series of communication and interaction with the participants which made the former familiar with participants and even know them by name.

The researchers' positionality as a 'pseudo-insiders' was successful when the participants saw that the researchers were not 'complete' members of their community, they perceived them as a harmless researchers and therefore, discussed issues openly and dispassionately. Lastly, the researchers took advantage of their 'unfamiliarity' with the issues in the context to ask many questions for extra clarification. After the researchers have achieved the positionality, they then used semi-structured interview instrument to collect data from respective research participants for the study.

5.5 Trustworthiness of the Study

In ensuring validity of the instruments, two (2) lecturers with key knowledge about the topic, administration and data analysis of data were given the instruments for thorough check for flaws. Remarks made were favourable which does not require massive change. To grant the content validity of the instrument, it was given to two (2) senior colleagues with knowledge about HIV and AIDS to scrutinize the instruments.

To check internal consistency of the instrument, it was pre-tested among three (3) female HIV-clients and one (1) female AIDS-patient at Koforidua because among the 40 urban sentinel site, Koforidua recorded the second highest. The other step the researchers' used to check reliability of the study was to ask for clarification from respondents about their comments.

5.6 Data Analysis

The qualitative data was analysed thematically. Thematic analysed is an analytical process which require study to work with data, organising them, breaking them into manageable units, coding them, synthesizing them and searching for pattern (Merriam and Associates, 2002). For instance, a comment like, " I fear of losing my husband so I was not able to negotiate for safe sex" was coded " Female HIV-clients' Sexual Passivity". Furthermore, to attribute comments to the interviewee female HIV-clients, female AIDS-patients and Key informants, the interview transcripts were assigned some serial codes. For example, Interviewee Female HIV-clients (IFHIVC-1 to 10); Interviewees Female AIDS-patients (IFAIDSP-11 to 14) and Interviewee Key Informants (IKI-15 to 18)

6. Socio-demographic Background of Interviewees

The background information of the interviewees were centered on age, marital status, religion, educational level, occupation, the kind of medication being used and how they got to know their status. The ages of all selected female HIV-clients and female AIDS-patients were between 15 years to 39 years. Apart from one teacher who had completed university and the remaindering respondents were traders and farmers who had completed junior high school and some have not attend school before. All the fourteen interviewees had sex partners or boyfriends before they were diagnosed with the virus. With the exception of one interviewee who was a Muslim, all the other thirteen IFHIVCs and IFAIDSPs were Christians. Nine (9) out of fourteen interviewees got to know their status when they were pregnant and were diagnosed with HIV whereas for the other five (5), their boy boyfriends/partners were tested positive before they got to know their status. All of them are under antiretroviral treatment (ART).

7. Results and Discussions

This section presents the results/findings from the qualitative interview data collected from female HIV-clients and female AIDS-patients on causes of women vulnerability to HIV and AIDS in Lower Manya Krobo District. But the related literature will be linked with findings to confirm or disconfirm the respondent's assertions.

7.1 Causes of HIV among women in Lower Manya Krobo District

This section sought to find out the causes of women vulnerability to HIV infection in Lower Manya Krobo District. Analysis of the interview results give an account as to which potential causes of women vulnerability to HIV infection were more frequently perceived to be, most challenging to the interviewees. The consistent interviewee remarks about the causes show higher factors that hinder women toward HIV infection and the lesser comments made by interviewees suggest how low the causes that hinder women towards HIV infection in the district. The data suggested that poverty and women passivity was imagining as the most frequent consistent causes of women vulnerability to HIV infection in the district. During the data collection process the researchers' observed that the district lack job opportunities. Farming is the only job in the district even that is seasonal. For example IKI-16 stated that:

> The cause of women becoming vulnerable to HIV infection is not only in this district but everywhere in the world because worldwide, men continue to enjoy the privilege of gender status while women remain subordinate also cause women to be prone to HIV and AIDS. For this, women become obedient to them and cannot negotiate for when/how sex takes place.

IKI-17 added:

> Could you believe that women in this town are particularly vulnerable to sexual transmission from their partner because there is no such dialogue (safe sex) between husband and wife or partners?

He further posits that, due to the fear of losing their husbands, most women in this community found it difficult to negotiate for safe sex. A number of studies in the field of HIV and AIDS point out women passivity as cause of HIV infection. Feinstein and Prentice (2000, p.24) posit that, in societies where women are encouraged to be sexually passive, men are usually in control of when and how sex takes place. Furthermore, cultural expectation regarding sexual passivity may mean that women within that culture may be discussed or unable to negotiate safer sex practices with their sexual partners, which increase their vulnerability to HIV transmission. But contrary to what Feinstein and Prentice said, Dikotter (1995, p.59) cited in (Hayes, 2007) argues that, the expectation of women as passive beings in sexual matters was ordained in sexual health books of the 1920s whereby the only advisable position during intercourse was with the man on top and woman underneath. He further posits that, this position gave men total control over their sexual partner and relegated the women to a position of submission. The data indicates that the research findings support Feinstein and Prentice (2000), and it added strength to Feinstein and Prentice's findings on women sexual passivity as a cause of HIV infection. Hayes, (2007) challenges the findings; he believes that, the sexual position by men gave them total control over women.

Almost all IFHIVCs and IFAIDSPs interviewees also shared similar view with the key informants. For instance, the HIV infection in this district is further heightened because during the marriage rite (Dipo), the women were thought not to prevent their husbands/partners from sex but they should be submissive to them if only they want to maintain their marriage. IFHIVC-6 confirmed that:

> I know my husband was having affair out but the fear of losing him to another women, I was afraid to tell him to wear condom when he was having sex with me.

IFHIVC-9 added:

> The cause of my sickness is from my husband, because he was having more than one girl friend in the district and hardly come home to sleep. But I was afraid to tell him to wear condom when having sex with me.

When probed about why he was afraid to asked the husband to wear condom, she said, she had children with her and their culture does not allow women rejecting their husband when it comes to sexual matters so I always need to give him whenever he asked for it.

Other respondents suggested that poverty was among the cause of women vulnerability to HIV infection in the district. IFAIDSP-12 and IFHIVC-9 commented that economic hardship and lack of job cause most women in the community to travel to other regions and Ivory Coast in search of greener pastures. Since they have no certificate to secure better job, most of them enter into sex trade (prostitution).

IFHIVC-3 added:

> I travelled with my auntie to Ivory Coast to search for job and when the auntie died, her colleagues from Ghana introduced her to prostitution. I got to know my status when I came home to marry in Ghana.
>
> My brother, when you are living in a community where there is high rate of school dropouts, illiteracy among women and lack of any economic venture, the result will be girls engaging in sex for money. The cause of the HIV among women in this community is because there are no income-generating ventures at their disposal. Even the fishing is seasonal (IKI-15).

IKI-18 added:

> Poverty among women in this community causes them to be vulnerable to HIV infection. For most of them who come to the hospital, even money to buy blade to cut their fingernail is a problem…. So what do you think will be the next step, to find a man who takes care of her?

IFHIVC-5, 8, and IFAIDSP-11 also commented that, lack of job and poverty have compelled most women into sex business. Similarly, Irwin, Millen & Fallows, (2003, p.21) supported that economic hardship is the major motivating factor for many women who exchange sex for money, goods or services. They further asserted that economic depended could affect gender-based power relation within the relationship making safer sex options difficult for the women to negotiate. Whelan, (1995) stated that, rural-urban migration is particularly disruptive to families and marriages, and often results in the formation of 'sexual networks' in urban areas where there is an unequal ratio of men to women and sex prevalence is likely to be high. She cited an example found in the Democratic Republic of Congo, where women refer to such sexual partner as 'spare tyres' (Whelan 1995, p.15) to be used as a last resort.

The second most reported potential causes of women vulnerability to HIV and AIDS in the district was due to the fact of bad culture thought imbedded in the men, peer pressure. IKI-17 believed that thought imbedded in men turns their women to vulnerable to HIV infection. He states:

> Could you believe in this town when a man marries you and you are not able to conceive? The man will divorce the woman for not being able to conceive. So Mr. man, what do you think will happen to the women?... the women will then marry other men or may either turn to sex business. If she contracted HIV in her marriage, it is likely she will infect her new partner.

For example, IKI-15 gave another divergent answer which she believed that gender inequality, in the district and continuation of cultural beliefs of male superiority, also reflected in the partner's respond to disclose their HIV status to their spouse. She stated that;

> "If only the woman have HIV and AIDS the man will immediately ask "How did you get it? and then if the reverse case happens, there is no such questioning. They just say, oh,…. I made a mistake". Based this on most women are afraid to disclosed their status because of the fear of being divorced.

Bleek, (1987) stated that, 'children constitute the meaning of a woman's life and a woman without children is incomplete, useless'. In the same vein, Amoah, (1991) believes society placed high value on fertility may also impact decision making by HIV-positive women during pregnancy because HIV infected women may decide to proceed with her pregnancy, knowing the risk of transmission to her baby, in order to fulfill a societal expectation to bear children. On the contrary, Whelan (1999) believes infertility increased a woman's vulnerability not only because it lowers her social value…. but also because in many cultures, men are allowed to take a second wife or even divorce his first wife when the wife is not able to conceive. He further posits that, her HIV vulnerability is again heightened because her living condition may force her to engage in survival sex (pp. 11-12).

IKI-16 & IKI-8 believe that during "Dipo" and marriage rites, the teaching that are given to the women also cause their vulnerability to HIV infection since the women are taught to conform with their husbands decision without arguing with them. With this, fear is instilled in the women and they find it difficult to request their husbands to use condoms when having sex with them.

In addition, IFHIVC-10 stated that;

> My husband hated condom use. He never allowed it. He used to beat me when I asked him to wear condom… He said "when we are married man and woman how can we use a condom?'…It's a wife's duty to have sex with her husband because that is the main reason you come together." But he didn't listen to me. So I gave in because I really feared.

When she was further probed, she said, she was afraid because she is scared of divorce and she has no one to look after her children. When asked after about the job the husband was doing, she said he is a farmer but the woman was not working before and after she was infected. IFHIVC-1 and IFAIDSP-14 mentioned of peer pressure is the factor that is causing most women to contracted HIV because IFHIVC-1 believes her friends introduce her to some men she was not going out with any man and she was being seen as out- moded but IFAIDSP-14 asserts that some men used to come there to visit her elder sisters so her sister introduced her to one of the men. For example, IFHIVC-2 said;

> When you are a young girl and you don't have a boy or boyfriend people see you to be out-moded and out-cast from the 21st Century world since you cannot talk when your peers are conversing.

IKI-15 she has this to say,

> I don't think there is a 20 year-old virgin in this town, from 12 years onwards, girls are getting pregnant. It has become a competition among the youth that as a growing woman you need to have a sugar daddy.

Two of the key informants gave a controversial statement believing that the government and the media at the time HIV was discovered in Ghana in 1983 caused the higher spread of the virus. For example IKI-16 confirmed that the media campaigns on HIV and AIDS in Lower Manya Krobo District and Ghana always strengthens around World AIDS Day, December 1st, but is almost non-existent for the campaigned in the remainder of the year. He stated that; "the messages are usually very 'hollow' such as be faithful to your partner". He argued that because this type of message is not specific it does not actually convey anything; thus it is not very effective. Jolly and Ying, (2002 p.90) argued that behaviours that are conducive to the transmission of HIV and AIDS are becoming more widespread because after the World AIDS Day in 1st December there are no follow-up messages on the theme conveyed to the public.

IKI-18 added that:

> Primarily the teaching about the virus were highly focused on urban area while leaving the rural area, because they believe such area fall into the 'low risk' category due to the perception about those who are infected with the disease were prostitutes and homosexuals.

He further said, if a politician can move from door-to-door campaigning for votes, why can't we do the same when it comes to HIV and AIDS. This argument is reinforced by Dikotter, who claims that AIDS was initially described in official discourse as an 'evil from abroad', and that it was widely believed that the 'superior

immune system' of the Chinese, combined with their Neo-Confucian values', would mean that HIV would not infect the general population but would largely remain limited to homosexuals and prostitutes who serviced foreign clients (Hayes, 2007, p.255).

7.2 Effects of HIV among women in Lower Manya Krobo District

This section sought to find out the effects of HIV and AIDS among women in Lower Manya Krobo District. The interview findings relating to socio-economic effects of HIV and AIDS t the women two themes emerged when answering this research question. The themes emerged were based on shift of expenses/loss of income and stigmatization/discrimination. For instance IFHIV-4 said:

> The sickness has seriously affected me because first I was working with a chop bar operator. From the time the owner discovered that I was an HIV client, I was sacked. Money to even buy drugs has become a problem if it's not for the help of this NGOs which normally support us with drugs.
>
> I have regretted for disclosing my identity as a HIV positive to the public. Since people do not patronise my food like first. Because of the disease, any money that I have I spend it on drugs. That has caused my business to decline (IFAIDSP-13).

According to IFHIVC-7, her sickness has caused her mother to lose income. Since she is not working but depends on her mother, when her mother comes from the market whatever profit she has goes into drugs. This has caused her mother's business to deteriorate.

IFHIVC-10 stated that,

> When you are infected with HIV, poverty normally follows…. Do you know why? Because money to buy drugs and food becomes a problem? Since HIV/AIDS comes with its own consequence, it affects your entire life including your business; that is why anyone who has HIV you seen as a poor person since most of them cannot work.

IFHIVC-5 & IFHIVC-9 share similar comment about loss of income and shift of expense. "The cause of HIV infection has affected our income as a result of lost of business". In support of the findings, a study in the Free State Province found that HIV/AIDS affected households tended to have monthly incomes one-third less than non-affected households (Namposy-Serpell, 2000). In the Côte d'Ivoire, the income of affected families was half that of total average household income (Mutangadura, 2000). The burden of care giving can deepen the poverty of households, moving some households into destitution. A household study in southern Côte d'Ivoire found households with very high dependency ratio of 3:5 times' national averages, primarily, but not exclusively, due to the caring burdens created by HIV/AIDS (Mutangadura, 2000).

The next theme discusses the stigmatization/discrimination that the interviewees believed as social/economic effect to FHCs in the Lower Manya Krobo District. The interviewees described how they were doubly stigmatised both as 'women' and as a person living with HIV once their status was known. For instance, IFHIVC-4 commented;

> … and even, for women, if you are sick, the community members normally say is HIV. Even if you are just coughing or you have flu, they will say, you have HIV. But for the men, they will always protect him until they are very sick. If you are a woman and you have HIV, the community members normally don't get close to you than if you are a man since they perceive that women who have such disease are either through curse, bewitchment or prostitution.

Almost all the IFHIVC and IFAIDSP interviewees felt that the behaviour of a men with HIV was justifiable/acceptable in the community while negative social response from the family were more common for a woman who contracted the virus. For example, IFHIVC-6 said;

> To me if I was a man, maybe I would have been treated well than what I am going through. Because in this community, if a guy is HIV-positive and he is sleeping around with ladies there is still no problem but if you are HIV-positive woman and you are found sleeping around with men you may be banished or people will start saying negative things about you.

IFHIVC-2 and IFAIDSP-11 added that; if you are a woman and you are growing lean, the moment people perceive it's HIV it will be very hard for you to get married. IFHIVC-1 also shares similar comment,

> When a woman is growing lean, your family members will conclude you are having HIV. But for guys no one complains till they die. The family and community members protect men living with HIV than female living with the virus.

IFHIVC-8 also stated that;

> At first my friends used to relate to me well but since I disclosed my status to them, their relation with me has declined, I don't know if they are afraid of me or not, they think if they come close me they will also be infected. Even at church when we are greeting, I could see from their face that they are afraid.

IFHIVC-3 and IFAIDSP-14 share similar comment on stigma and discrimination as socio-economic effecting women. IFHIVC-3 asserts "even when we go for meetings or to the hospital people with HIV are distanced from others who are not HIV-positive, and even at meeting place people without HIV do not sit in the same place with

those living with HIV/AIDS". "Brother you could see for yourself, why is the HIV unit isolated from the main hospital ward, and even close to the mortuary" (IFAIDSP-14). According to Esu, (2000), Ghanaian women hold negative attitudes or who enact stigmatising or discriminatory behaviour has been referred to as the perpetrators of stigma and discrimination. In contrast, those with or associated with the condition (e.g., HIV) or indulge in promiscuous sexes are considered the targets of stigma. Women are multiple disadvantaged by HIV/AIDS with their gender, familial and economic positioning rendering them especially vulnerable. They are kicked out of houses, blamed to be carriers and so on. It was found in the studies done in Ghana that infected people are forced to leave their marital home after the death of husband infected with AIDS (Esu, 2000).

7.3 Coping Mechanisms used by Female HIV-clients and Female AIDS-patients in Lower Manya Krobo District

This section presents the interview findings relating to how female HIV-clients and female AIDS-patients are coping with the disease. It is the opinion of these women that when they get in contact with others, talk about their challenges and disclose their status, the strategies lessen their pain about the disease. In the quest of answering this research question; the themes that came out were on counselling, financial support and acceptance/visitation from friends and the general public etc. The interviewees described how they felt when their status was disclosed to them the first time but series of counselling and talks from the doctors, nurses and NGO personnel have really helped them in coping with the disease. Almost all the IFHIVCs and IFAIDSPs believe without counselling, their status could have been worsening by now. For IFHIVCs-3, 9, 10 and IFAIDSP 13 the feeling of acceptance and empathetic nature displayed by the doctors, nurses and NGO personnel made them to feel at home. For instance, IFHIVC-7 said,

> Counselling from the doctor, nurses and NGO personnel have really helped me to cope with this disease. Because, the first time they disclosed my status to me I nearly committed suicide. And also my friends introduced me to prayer group that has also helped me to cope with the disease and also increase my faith in the Lord.
>
> The first thought that came into my mind was to kill myself… I quite remember I said "why me" and next decision was to commit suicide since the shame and disgrace attached to the HIV, was unbearable; I don't think I will be able to bear it… but with series of counselling from the doctors and nurses in Atua Government Hospital, has really help me to cope with the disease (IFHIVC-2).

IFHIVCs-1, 5 and 10 stated that it through counselling that they have able to relate to people since they were always indoors and were feeling shy to come out and mingle with friends. IKIs-15, 16 and 18 expressed their concern on how counselling have help people living with HIV and AIDS, being able to be themselves and accept the nature of their conditions. It appeared that their continue existence was influence by counseling they had from leaders in the community. Taylor and Buku, clearly indicate that, crisis counselling is intended to reduce symptoms or bring a problem situation under control. They further asserted that crisis counselling helped HIV clients to develop adaptive problem-solving mechanism so that they could return to the level or state at which they were functioning before the crisis (2006, p.51).

The interviewees expressed concern about financial support as a coping strategy. IFHIVCs-3, 6, and 8 believe that financial support from friends and NGO have really helped her in coping with the situation. According to them, fishing business virtually collapsed once their HIV status was discovered and there was no money to buy drugs and food. But with the financial assistance from friends and the NGO, their conditions have improved and they feel well now. IFHIVC-4 stated that,

> Financial support from my priest and my husband's friends have really assisted me in coping with the situation since I discovered my status was positive after my husband's death… truly his friends have been supportive to me.

IFHIVC-2 added that,

> I am living today because of my pastor; he employed me in the church and they always pay my hospital bills and my accommodation. Without him, life couldn't have been easy for me. My pastor has really helped me in coping with the disease.

IKI-17 also added, "For HIV, it does not kill but when you have no money to buy drugs and eat good food that is when you will start thinking about the condition". He further stated that HIV/AIDS comes with poverty so if there is no financial support or assistance to help them accept their condition it would be difficult for them to cope with the disease. In support of the statement, it has been found that mothers living with HIV who did not have social support and financial support were significantly more likely to have high psychological distress levels compared to HIV-positive mothers who had social and financial support (Bennetts et al., 1999; Blancy et al., 2004). It is noted that the financial effect of HIV and AIDS can lead families to over-extend their borrowing capacity to such an extent that they often found themselves at the mercy of micro-lenders (Goffman, 1990).

Many interviewees explain their coping strategies were through acceptance and home visitation from friends and family members. For example, IFHIVC-1 indicated that phone calls from colleagues and friends contributed to

her feeling of love and belongingness and this has improved her condition. In her words she said,

> "In fact, the phone call I receive from friends motivate me a lot in my daily life since without their encouragement and support I could have been dead"

IFHIVC-6 believes the acceptance from her family members has helped her to cope with the disease. She said,

> The time I disclosed my status to my parents, what they said, "God is in control", They stated since when "God gives you good thing we receive it, so when bad things come we need to also thank the Lord." Their acceptance has really helped me in coping with the disease.

IFHIVC-7 and IFHIVC-10, share similar comment sentiments. According to them, they started coping with the disease when their colleagues from SUWA Ghana started with their hope for the future campaign. They further asserted that, how their friends have accepted their conditions have really motivated them to cope with the disease. For IFAIDSP-12 and IFAIDSP-13, home visit from friends and colleagues have really helped them to cope with the disease and it has really motivated them in life. IFHIVC-6, believed how her family members received her, has really helped her to cope with the disease especially her husband. She said,

> ….my husband cares, supports and loves; always help me to be happy in life. For two of my colleagues, their husbands have divorced them because of the disease but my case it is different. I have been shown love and care. That has really helped me in coping with the disease.

IKI-17 stated that;

> If a person living with HIV and AIDS can cope with his/her condition when the family member and community member should accept him/her in any condition. If the family and community members are able to eliminate any form of discrimination it will help FHCs cope with the disease.

He further stated that, to me HIV hardly kills someone but if there is stigma and discrimination from the general public that cause the person to die. In support of the statement, interviewees indicated that phone calls from colleagues and friends contribute to given them a sense of love and belongingness. Based on Maslow's Hierarchy of needs (Chapman 2001, p.4), Self-actualisation, self esteem needs, belongingness and physiological needs, it could be concluded that people were more motivated to take responsibilities and live positively when they were acknowledged, noticed, affirmed and validated. The response of the respondents revealed that poverty, women passivity, peer pressure, culture thought embedded in the men and some political are believed to have been the cause of HIV in the district. They also asserted that the disclosure of their status affected their socio-economic well being as an individual and perceived to be living because of counselling from doctors, nurses NGOs , financial support and visitation from colleagues.

8. Conclusions and Recommendations

The study was to investigate the causes, effects and coping mechanism used by female HIV-clients and AIDS-patients. The study unearthed that the causes of HIV among women were on poverty, women passivity etc. we therefore, recommend that the government should establish job ventures or industries to help curb the poverty rate and men should be education about the institutionalized marriage.

The study also highlighted that after the disclosure it affected their socio-economic status as human beings. During the data collection it was observed that most of the HIV-clients have problem with financial assistance. We therefore recommend that the local authorities should set up a mutual-aid organisation, which will help the IFHIVCs and IFAIDSP with their hospital bills. In addition, measures should be taken to ensure an average living standard for AIDS patients and their families. However, to strengthen the management of these IFHIVCs, it is also very important to provide them with care and assistance in order to ease their mental pressure and ensure they live a normal life as others.

Training should be given to these IFHIVCs in practical skills so that those with working capabilities can work to support themselves and their families and also the community should be educated to help change their negative perception about how the disease is transmitted.

The key policy makers in the district should help curb the spread of HIV by the effective implementation of various measures and blocking channel for HIV transmission by changing the risky behaviours of the society and individual. The local authorities should set up HIV prevention and control mechanisms and formulate medium and long-term plan for HIV/AIDS. These strategies and plans will help them to know where they have reached in the preventive process. Public education should step up and religious bodies should do a lot more about prevention to help the community members from getting HIV.

References

Amoah, E. (1991). Femaleness: Akan concepts and practices. In J. Becher (Ed.), Women, religion and sexuality: Studies on the impact of religious teachings on women (pp. 129–153).

Andersen, M. (2003). Thinking about women: Sociological perspectives on sex and gender. Boston: Allyn & Bacon.

Annan, K. A. (2002). In Africa, AIDS has awomen's face. The New York Times. Retrieved on 08/11/12

http://www.un.org/news/ossg/sg/stories/sg-29doc-2002htm
Blancy, N. T., Fernandez, M. I., & Bennetts, A. (2004). Psychosocial and behavioural correlates of depression among HIV-infected pregnant women. AIDS patient care and STDs, 18(17), 405-415
Bleek, W. (1987). Family and family planning in Southern Ghana. In C. Oppong (Ed.), Sex roles, population and development in West Africa (pp.138–153). Portsmouth,NH: Heinemann.
Creswell, J. W. (2005). Educational research: Planning, conducting, and evaluating qualitative and quantitative research (2nd ed.). Upper Saddle River, NJ: Pearson.
Esu, E. (2000). Gender & HIV/AIDS in Africa – our hope lies in the future. Journal of Health Communication, 5 (2), 123-127.
Feinstein, N. & Prentice, B., (2000). Gender and AIDS Almanac, UNAIDS, Geneva,viewed18/05/2014,<http://www.unaids.org/gender/docs/Gender%20Package/GenderandAIDSalmanac.pdf>, pp. 22-43.
Ghana Statistical Service (GSS), Ghana Health Service (GHS), ICF Macro. Ghana Demographic and Health Survey 2008. Accra, Ghana: GSS, GHS, ICF Macro 2009.
Goffman, E. (1990). Stigma: Notes on the management of spoiled identity. Prentice Hall: Englewood Cliffs.
Hayes .M. A., (2007). Women Vulnerability to HIV/AIDS in China: A case study for the engendering of Human Security Discourse. Sage publications.
Jolly, S. & Wang, Y. (2003). Key Issues on Gender and HIV/AIDS in China, report for U.K. Department for international Development, viewed17January2013<http://www.genie.ids.ac.uk/docs/jolly_aidschina.doc>.
Kissi-Abrokwah, B. (2013). Women and HIV/AIDS Infection in Ghana: The Case of Lower Manya Krobo District. An unpublished Master of Philosophy thesis submitted to the Department of Psychology and Education, University of Education, Winneba.
Kusi .H. (2012). Doing Qualitative Research A Guide for Studys, Accra-New Town: Emmpong Press
Lorber, J. (2001). Gender inequality: Feminist theories and politics. Los Angeles, CA: Roxbury.
Merriam, S. B. (1998). Qualitative research and case study applications in education. San Francisco, CA: Joseey-Bass.
Merriam, S. B. & Associates, (2002). Qualitative research in practice: Example for discussion and analysis. San Francisco, CA: Joseey-Bass.
Mikell, G. (1997). African feminism: The politics of survival in sub-Saharan Africa. Philadelphia: University of Pennsylvania Press.
Mutangadura, G. B. (2000): Household welfare impacts of mortality of adult females in Côte d'Ivoire: Implications for policy and program Development. Paper presented at the AIDS and Economics Symposium, Côte d'Ivoire .
Namposya-Serpell, N.,(2000): Social and Economic Risk Factors for HIV/AIDS Affected Families in South Africa. Paper presented at the AIDS and Economics Symposium, IAEN, 7-8 July, Durban, South Africa.
Susser, I., & Stein, Z., (2000). Culture, sexuality, and women's agency in the prevention of HIV/AIDS in Southern Africa. American Journal of Public Health. 14(2) 35-39
Takyi, B. K., (2003). Religion and women's health in Ghana: Insights into HIV/AIDS Preventive and protective behavior. Social Science and Medicine. Unpublished
Taylor .I .A & Buku .K.D (2006) Basic in Guidance and Counselling. (2nd ed.). Accra: Yemens Press Ltd.
Whelan, D. (1999). Gender and HIV/AIDS: Taking stock of research and programmes, Key Material, UNAIDS Best Practice Collection, viewed on18/5/2014, <http://www.unaids.org/html/pub/publications /ircpub05/jc419 gendertakingsto ck_en_pdf.pdf#search='gender%20and% 20hiv%2Faids%3 Ataking%20stock% 20of%20research%20and%20 programmes'.
Yin, R. K. (2003). Case Study Research: Design and methods. (2nd ed.). Newbury Park CA: Sage Publication.

The IISTE is a pioneer in the Open-Access hosting service and academic event management. The aim of the firm is Accelerating Global Knowledge Sharing.

More information about the firm can be found on the homepage:
http://www.iiste.org

CALL FOR JOURNAL PAPERS

There are more than 30 peer-reviewed academic journals hosted under the hosting platform.

Prospective authors of journals can find the submission instruction on the following page: http://www.iiste.org/journals/ All the journals articles are available online to the readers all over the world without financial, legal, or technical barriers other than those inseparable from gaining access to the internet itself. Paper version of the journals is also available upon request of readers and authors.

MORE RESOURCES

Book publication information: http://www.iiste.org/book/

Academic conference: http://www.iiste.org/conference/upcoming-conferences-call-for-paper/

IISTE Knowledge Sharing Partners

EBSCO, Index Copernicus, Ulrich's Periodicals Directory, JournalTOCS, PKP Open Archives Harvester, Bielefeld Academic Search Engine, Elektronische Zeitschriftenbibliothek EZB, Open J-Gate, OCLC WorldCat, Universe Digtial Library , NewJour, Google Scholar