

A SOCIO-CULTURAL STUDY OF HIV/AIDS IN THE GAMBIA

Pauline N. Otti, International Consultant
Family Concern International, Abuja, Nigeria

and

Cherno O. A. Jallow, National Consultant
Senior Planner, Department of State for Health and Social Welfare, The Gambia

CONTENTS

Foreword.....	iii	4. Results	18
Executive Summary.....	v	4.1 Background of Respondents	18
Acronyms	vii	4.1.1 Number of Respondents	18
Acknowledgements	viii	4.1.2 Ethnic Composition	18
1. Country Background	1	4.1.3 Marital Status	18
1.1 Introduction	1	4.1.4 Religion	18
1.2 Health	1	4.1.5 Residence	18
1.3 Education	1	4.1.6 Educational Status	18
1.4 Gender Issues	1	4.1.7 Occupation	19
1.5 Economy and Poverty	2	4.2 Cultural and Religious Factors and HIV/AIDS	19
1.6 Socio-Cultural Characteristics	2	4.2.1 Patriarchal Structures	19
1.7 Background to the Study	3	4.2.2 Inheritance Rights	19
1.8 Justification for the Study	5	4.2.3 Female Circumcision	20
1.9 Objectives of the Study	5	4.2.4 Widow Inheritance	21
2. Literature Review	6	4.2.5 Access to Strategic Resources and Health Services	21
2.1 Related Earlier Studies	6	4.2.6 Festivals, Ceremonies and Lumo	21
2.1.1 Sexuality and STI/HIV/AIDS	6	4.2.7 Other Cultural Practices	22
2.1.2 Mother to Child Transmission	7	4.2.8 Female Education	22
2.1.3 Young People and Vulnerability to STI/HIV/AIDS	7	4.3 Socio-Medical Factors and HIV/AIDS	23
2.1.4 Commercial Sex Work	8	4.3.1 Awareness of HIV/AIDS and Prevention Measures	23
2.1.5 Female Circumcision	9	4.3.2 Knowledge of Modes of HIV/AIDS Transmission	25
2.1.6 Religion and HIV Prevention	9	4.3.3 Reproductive and Sexual Health	26
2.1.7 People Living with HIV/AIDS	9	4.3.4 Sexual Practices and Risky Behaviour	26
2.2 Content Analysis	9	4.3.5 Age at First Intercourse	27
2.3 Social Commentary	10	4.3.6 Motivation for First Sexual Experience	28
2.4 Analysis of Social Trends in The Gambia	11	4.3.7 Casual Sexual Relationships	29
2.4.1 Decade of Hope: 1965-1975	11	4.3.8 Extra-Marital Liaison	30
2.4.2 Era of Disenchantment: 1975-1985	11	4.3.9 Part-time Sex Work	30
2.4.3 Re-Defining Years: 1985-1995	11	4.3.10 Commercial Sex Workers	31
2.4.4 Re-Positioning Period: 1996-2000+	11	4.3.11 Forms of Sexual Behaviour	31
3. Research Framework and Methodology	13	4.3.12 Travel Factor and HIV/AIDS	31
3.1 Theoretical Framework and Definition of Concepts	13	4.3.13 Sex Education	32
3.2 Research Design	13	4.4 Condom Use	33
3.2.1 Geographical Coverage and Target Population	13	4.5 Voluntary Counselling/Testing	34
3.2.2 Methodology	14	4.6 People Living With HIV/AIDS	34
		4.6.1 Care of People Living with HIV/AIDS	34
		4.6.2 Reaction on Testing Positive	35
		4.7 Media Influence	36

5. Discussion of Findings	37
5.1 Gender Relations	37
5.2 Poverty	37
5.3 Sexuality.....	37
5.3.1 Age at First Sexual Experience	38
5.3.2 Sex Education	38
5.3.3 Casual Sex Practices	38
5.3.4 Non-Vaginal Sex	38
5.4 Travel Factor	38
5.5 Condom Usage	39
5.6 Voluntary Counselling and Testing	39
5.7 Attitude to People Living with HIV/AIDS	39
5.8 Information Education and Communication Activities.....	39
5.9 "Free Will" and the Spread of HIV/AIDS	39
5.10 HIV/AIDS is a Rural Problem in The Gambia	39
6. Conclusions and Recommendations	41
6.1 General Recommendations	41
6.2 Specific Recommendations	42
References and Bibliography.....	43

LIST OF BOXES

Box 1: What Drives HIV/AIDS in Africa?	3
--	---

LIST OF TABLES

Table 1: Sample Size as Drawn from Enumeration Areas	16
Table 2: Educational Status of Youth	18

LIST OF FIGURES

Figure 1: Educational Grades Attained by Youth.....	19
Figure 2: Practices Perceived to Contribute to the Spread of HIV/AIDS	22
Figure 3: Sources of Information about HIV/AIDS	23
Figure 4: Most Effective Way of Preventing HIV/AIDS	24
Figure 5: Second Most Effective Way of Preventing HIV/AIDS	24
Figure 6: Third Most Effective Way of Preventing HIV/AIDS	25
Figure 7: Perceived Modes of HIV/AIDS Transmission	25
Figure 8: Age at First Sexual Experience by Youth	27
Figure 9: Age at First Sexual Experience by Adults.....	27
Figure 10: Age at First Sexual Experience by Ethnicity	27
Figure 11: Age at First Sexual Experience of Rural and Urban Youth	28
Figure 12: Age at First Sexual Experience of Unmarried Youth	28
Figure 13: Motivation for First Sexual Experience	28
Figure 14: Discussion of Sexual Matters	29
Figure 15: Frequency of Sexual Relations in Previous Three Months.....	29
Figure 16: Number of Casual Partners in Previous Month	30
Figure 17: Different Forms of Sexual Behaviour.....	31
Figure 18: Duration of Journeys During Previous Year	32
Figure 19: Willingness to Use or Urge Partner to Use Condoms	33
Figure 20: Beliefs About Condom Use.....	33
Figure 21: What Should Society Do with People Living with HIV/AIDS?	34
Figure 22: Who Should Care for People Living with HIV/AIDS?	35
Figure 23: Reaction on Testing Positive for HIV	35

FOREWORD

On behalf of the Government of The Gambia and the United Nations Development Programme's Country Office, we are pleased to introduce and commend this important, ground-breaking report on socio-cultural aspects of HIV/AIDS in The Gambia.

The report includes an informative general review of literature, which provides the contextual background and justification for the study, and goes on to present the findings of a wide-ranging series of stakeholder interviews and focus group discussions, and a nationwide sample survey involving some 2,400 respondents.

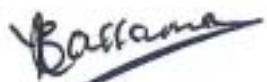
The results reflect the complexity of socio-cultural factors influencing sexual behaviour, condom use and the spread of HIV/AIDS in The Gambia. Whilst awareness of HIV/AIDS was found to be generally high and use of condoms is well known as a preventive measure, few changes in the patterns of sexual behaviour were evident.

Several recommendations are made to enhance capacity to combat the spread of HIV/AIDS in The Gambia, including: establishment and fostering of partnerships between civil society, religious groups, the private sector, the media and people living with HIV/AIDS; mobilisation of support and resources for HIV/AIDS activities; and advocacy on behalf of people living with HIV/AIDS.

The wide range of information obtained by the study is of crucial importance in the fight against HIV/AIDS and will not only help in developing appropriate HIV/AIDS/STD awareness strategies, but will also assist in enhancing other health related programmes and services in The Gambia. It is of particular relevance to the targeting of gender sensitive information, education and communication messages, especially amongst youth who constitute 80% of the population.

The two authors, Professor Pauline Otti and Mr. Cherno Jallow, are to be congratulated for conducting the study and overcoming various constraints. Their investigations were undertaken in close collaboration with the National Aids Control Programme; the Department of State for Health and Social Welfare; the National AIDS Secretariat; the United Nations Theme Group on HIV/AIDS; the HIV/AIDS Technical Committee; the Medical Research Council; UNAIDS Regional Office in Abidjan; and various other partners; all of whom contributed to its successful outcome.

Finally, it is important to acknowledge the very many Gambians who participated in this study as discussants, respondents and team members, and we wish to record and convey our most sincere appreciation to everyone involved for their willing cooperation, perseverance and hard work.



Honourable Dr. Yankuba Kassama
Secretary of State for Health and Social Welfare
Department of State for Health and Social Welfare



Dr. John O. Kakonge
UNDP Resident Representative/
Resident Coordinator of the UN System

EXECUTIVE SUMMARY

This report summarises the findings of a national study of socio-cultural aspects of HIV/AIDS in The Gambia, commissioned by the Government in collaboration with the United Nations Development Programme, conducted by Professor Pauline N. Otti (Lead International Consultant) and Mr. Cherno O.A. Jallow (National Consultant) during March and April 2002.

Terms of Reference

The investigators were asked to: identify trends in sexual behaviour in The Gambia; assess the acceptability of condoms and other preventive measures; and recommend appropriate initiatives and activities for the future.

Methodology

In addition to a wide-ranging review of published literature and unpublished documents and in-depth interviews with key stakeholders, a series of 80 focus group discussions were held across the country and a nationwide sample survey involving some 2,400 respondents was administered.

Study Highlights

Gambian society of 1.4 million remains largely patriarchal, but there are numerous signs of change in generational attitudes relating to various traditional practices, including: widow inheritance; scarification; and female circumcision.

Modernisation, information technology and globalisation have influenced a wide range of social behaviours, including sexuality, and continue to do so.

Awareness of HIV/AIDS across all population groups was generally high and the “Abstinence, Be faithful and use Condoms” (ABC) message was well recognised.

Actual knowledge of the various modes of HIV transmission, however, was limited.

The sample population was sexually active, with earlier experience of intercourse by young people, particularly in rural areas, compared with the older generation.

Various socio-cultural factors indicated that HIV/AIDS in The Gambia is a serious rural problem.

Risky behaviours were on the increase amongst all ethnic groups. Also, with tourism, the intrusion of external cultures and information technology, new forms of sexual activity have been adopted by some 30% of the respondents, with serious implications for the spread of HIV/AIDS.

The numerous social events that characterise Gambian society are mostly held in rural areas and provide various opportunities for casual and extra-marital sexual liaison. Travel is a key factor in risky behaviour and the spread of STI/HIV/AIDS. More than half of the youth aged between 13-24 surveyed (54%) and over a third of adults (35%) had spent one week or more away from home in the previous year.

While condoms were generally acknowledged by the great majority of respondents (74%) to be an effective method of preventing pregnancy and HIV/AIDS, various misconceptions limited wider condom usage.

A substantial proportion of respondents indicated their willingness to receive voluntary counselling and to be tested for HIV/AIDS, though females (both youth and adults) were less willing to be so tested, a finding that requires further examination.

Respondents generally had positive attitudes towards people living with HIV/AIDS (PLWHA).

This study has opened up an important discourse on sexuality and HIV/AIDS in The Gambia and provided a remarkable series of well-informed insights on current patterns of behaviour and on-going change, which are invaluable to understanding the nature and magnitude of the problem that has to be faced and dealt with, and must not be ignored.

General Recommendations

The following recommendations emanate from the analysis contained in this report. Their scope of influence includes, but is not limited to: policy makers; planners; programme staff; and grassroot communities.

1. Mobilise support and resources (particularly grants) for the HIV/AIDS activities, especially at the grassroots level.
2. Equal property rights should be given to women to foster the establishment of sustainable livelihoods and discourage extra-marital sex for economic benefit.
3. Improve community awareness and understanding of the appropriate use of condoms and develop ways and means of making them more readily available in rural areas.

4. Voluntary HIV testing and counselling services targeted at women and youth should be promoted and made more widely available, particularly in rural areas.
5. Priority should be given to community based sensitisation campaigns, linking prevention and care.
6. Facilitate the establishment of a national network of PLWHA support groups, promote home based care for PLWHA and assist the incapacitated to attend clinics.
7. Establish formal links with traditional healers to sensitise them on HIV/AIDS.
8. Simplify information, education and communication (IEC) messages about HIV/AIDS and translate them into local languages for easy dissemination in local communities.
9. Target more aggressive media HIV/AIDS campaigns at youth groups.
10. Empower women to participate more effectively in family planning decisions.
11. Emphasis should be given to poverty-reduction programmes and initiatives to promote alternative sources of income instead of high-risk sex work.
12. Promote an aggressive awareness campaign to reduce stigma and discrimination, and promote positive attitudes towards PLWHA and those who care for them.
17. Establish a management information system (MIS) for a nationwide HIV/AIDS programme to provide routine information and geographically co-ordinated data on the status of HIV/AIDS and management.
18. Develop an updated multi-sectoral plan of action to mainstream HIV/AIDS prevention and control as a development issue.
19. Develop an advocacy and IEC strategy for a more focused approach to reduce risky sexual behaviour and in particular discourage casual sex amongst youth.
 - a) Revive the National IEC Committee, or establish a broad-based National IEC Task Force under the National AIDS Secretariat, for a more coordinated and targeted effort.
 - b) Promote peer group IEC delivery to address the silence on sex and sexuality, targeted at women in general and female youth in particular, through community based, participatory interventions, such as the Stepping Stones Project.
 - c) Develop appropriate STI/HIV/AIDS prevention messages focusing on cultural practices, such as early marriage, wife inheritance, scarification and female circumcision, which may increase the risk to HIV infection.
 - d) Intensify IEC campaigns targeting travellers in transit towns, lumos (market days) and boarder towns/villages.
20. Encourage the wider use of radio as the most effective way of reaching the majority of the rural population, especially those who are illiterate.

Specific Recommendations

13. Review and update the 1995 National HIV/AIDS Policy and Guidelines to provide strategic direction, incorporate emerging issues of the twenty-first century and address youth and gender concerns.
14. Develop a Strategic Action Plan for a renewed and reinvigorated national response as a matter of utmost urgency.
15. Conduct an extensive analysis of current sectoral policies and strategies to mainstream HIV/AIDS concerns in poverty reduction, education, employment, youth and agriculture.
16. Strengthen the National AIDS Secretariat and the National AIDS Control Programme to continue expanding their programmes at grassroot level.

ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome	MRC	Medical Research Council
BAFROW	Foundation for Research on Women's Health, Productivity and the Environment	NACP	National AIDS Control Programme
CBR	Crude Birth Rate	NBD	North Bank Division
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women	NGO	Non-Governmental Organisation
CRD	Central River Division	OAU	Organisation of African Unity
CSW	Commercial Sex Worker	PLWHA	People Living With HIV/AIDS
DCD	Department of Community Development	POP/FLE	Population and Family Life Education
DHS	Demographic and Health Survey	PRS	Poverty Reduction Strategy
DSF&EA	Department of State for Finance and Economic Affairs	SPA	Strategy for Poverty Alleviation
EA	Enumeration Area	S/RH	Sexual and Reproductive Health
FAO	Food and Agriculture Organisation	SSA	Sub-Saharan Africa
FBO	Faith Based Organisation	STD	Sexually Transmitted Diseases
FGD	Focus Group Discussion	STI	Sexually Transmitted Infection
FGM	Female Genital Mutilation	TBA	Traditional Birth Attendant
GAMCOTRAP	Gambian Committee on Traditional Practices	UN	United Nations
GDP	Gross Domestic Product	UNAIDS	Joint United Nations Programme on HIV/AIDS
GBA	Greater Banjul Area	UNDAF	United Nations Development Assistance Framework
GFPA	Gambia Family Planning Association	UNDP	United Nations Development Programme
GOTG	Government of The Gambia	UNESCO	United Nations Educational, Scientific and Cultural Organisation
HIV	Human Immuno-deficiency Virus	UNFPA	United Nations Fund for Population Activities
HPI	Health for Peace Initiative	UNGASS	United Nations General Assembly
ICPD	International Conference on Population and Development	UNICEF	United Nations Children's Fund
IDA	International Development Assistance	URD	Upper River Division
IEC	Information, Education and Communication	USA	United States of America
IMR	Infant Mortality Rate	WD	Western Division
LDC	Least Developed Country	WEC	World Evangelical Church
LRD	Lower River Division	WHO	World Health Organisation
MIS	Management Information System		

ACKNOWLEDGEMENTS

We wish to express our most sincere appreciation to the Government of The Gambia and the United Nations System for the opportunity of conducting this study.

In particular, we wish to thank: the Honourable Secretary of State for Health and Social Welfare, Dr. Yankuba Kassama; the Permanent Secretary, Mr. Abdoulie Mam Njie; the Director of Health Services, Dr. Omar Sam; the Director of the National AIDS Secretariat, Mr. Saihou Ceesay; the National Technical Committee; and all Task Force members, especially Mr. Alieu Sarr, for their unstinting support and many useful contributions.

Our special gratitude is extended to: the Resident Co-ordinator of the UN System in The Gambia and Chairman of the UN Theme Group on HIV/AIDS, Dr. John O. Kakonge; WHO Representative, Dr. James Mwanzia; and the heads of other UN agencies and development partners; for their foresight, overall support and cooperation.

We also wish to thank the heads of the following institutions, whose representatives form the Task Force: the Directorate of Planning (DOP); the Epidemiology and Statistics Unit (ESU); the Health Education Unit (HEU); and the National AIDS Control Programme (NACP); the Department of State for Health; the National Youth Council (NYC); the Central Statistics Department (CSD); The Gambia Family Planning Association (GFPA); the Medical Research Council (MRC); and the Santa Yalla Support Society (SYSS).

The untiring support and commitment of the Manager of the National AIDS Control Programme at the Department of State for Health, Alhagie Kolley, and his dedicated staff and team of interviewers and supervisors deserve special mention and credit for ensuring operational efficiency and hitch-free field work at district and community levels, where we were so warmly welcomed by the people of The Gambia. This study could not have been undertaken without you.

Last, but by no means least, we wish to thank Ms. Lizabeth Forbes, UNDP Assistant Resident Representative, and all the wonderful staff at the UNDP office in The Gambia for their patience in facilitating the mission's activities.

Final synthesis and desk top publishing by David Bourn of the Environmental Research Group Oxford Limited.

1. COUNTRY BACKGROUND

1.1 Introduction

The Republic of The Gambia in West Africa is surrounded by Senegal to the north, east and south, with an Atlantic seaboard to the west. The country occupies a total area of 10,689 square kilometres of land on either side of the River Gambia, which flows through the entire length of the country from the Futa Jallon highlands in the Republic of Guinea. Located within the Sahelian and Semi-Arid zones, The Gambia experiences irregular rainfall, periodic droughts, soil degradation and marked fluctuation in agricultural output.

After gaining independence in 1965 and republic status in 1970, The Gambia maintained a system of parliamentary democracy until military intervention in 1994. Presidential elections were held in 1996 and democratic rule was restored the following year. There are two municipalities – the Banjul City Council and the Kanifing Municipal Council. The country has five administrative divisions, composed of thirty-five districts, sub-divided into village areas, each headed by an Alkalo.

Based on the 1993 census projection, the estimated population of The Gambia in 2001 was 1.4 million, increasing at 4.2% per annum, the highest rate of growth in the world. The population has a very youthful structure, with 45% under 15 and 19% in the 15-24 age group and, thus, a high dependency ratio. Population density is also relatively high for the region, at 121 people per square kilometre (UNDP, 2001).

1.2 Health

Despite numerous development programmes to improve the quality of life, the health profile of The Gambia leaves considerable room for further improvement. With a total fertility rate (TFR) of 6.05 children born per woman, the crude birth rate (CBR) has remained high at 46.2 per 1,000. Contraceptive prevalence rate (CPR) is very low at 12% (6.7% for use of modern methods and 5.1% for traditional methods). Maternal mortality rate (MMR) of 1,050 per 100,000 live births is still one of the highest in Sub-Saharan Africa. Infant mortality rate (IMR) increased from 92 per 1,000 for both sexes in 1993 to 144 for males and 122 females in 1998. Life expectancy at birth is low at 55 years overall, 54 for males and 57 for females.

The relatively poor overall health profile, is attributed to various factors, including: rapid population growth, high illiteracy level, limited accessibility to services in terms of affordability, availability and quality, and the position of women (GOTG, 2000).

Nevertheless, The Gambia was ranked first in national immunisation coverage (76.6%) in UNICEF's 1999 State of the World's Children report, which is a positive indication for child survival in The Gambia.

1.3 Education

The general level of literacy in The Gambia is quite low at 37%, with gender disparities in both enrolment and drop out rates favouring males. For instance, the Education Sector Public Expenditure Review of 1998 showed that only 61% of girls of primary school-going age enrolled in primary schools, compared to 79% of boys (UNDP, 2001). More girls also drop out later because of socio-cultural barriers, early marriage and adolescent pregnancies. According to the 1998 National Household Poverty Survey, the illiteracy rate among women aged 15 years and above was 81%. Madrassah (Arabic) schools, which do not offer western education, provide an alternative system of education that costs less than other schools. Some parents prefer to send their children to Arabic school "especially so for the girl child for moral and religious reasons" (GOTG, 2000: 109). Thus, girl children tend to miss out on formal education, although revised education policy aims at address some of these issues.

1.4 Gender Issues

Women appear to have a high profile in the development process in The Gambia. For instance, the Vice-President, Deputy Speaker of the National Assembly and four appointees of cabinet rank with portfolios are women. A National Women's Council that acts as an advisory body to the Government was set up as far back as 1980, and a Women's Bureau has also been established. In addition, a National Policy for the Advancement of Women has been adopted, although it has yet to be implemented.

From a gender analysis perspective, however, the real situation is one far removed from equal opportunity. For instance, although women make up about 50% of the population, they constitute only 4.9% of the skilled labour force, and at managerial level they occupy only 12.8% of positions. This is due to their generally low attainment of education and qualifications and limited access to training.

As a result, women are under-represented in the formal sector, but are much more involved as unskilled workers in agriculture (70%) and in the tourism industry. Structural and institutional barriers generally exclude women from the decision-making process, and the tripartite system of laws (Statutory, Customary and Sharia) interact to frustrate, if not, impede Government's efforts to improve gender relations (Women's Bureau, 1999).

1.5 Economy and Poverty

With a predominantly agrarian economy, The Gambia is ranked among the low income and least developed countries (LDC). The main export is groundnut products, which has experienced mixed development. Agriculture has been a rather unstable source of livelihood for over 80% of the population, though it contributes to only 20% of gross domestic product (GDP). The industrial manufacturing sector accounts for 11% of GDP, while tourism remains a main feature in The Gambia attracting foreign exchange and contributing about 10-12% of GDP.

With the country's limited resource base, irregular rainfall, periodic droughts and erratic agricultural output, the economy has performed poorly, culminating in an increase in poverty by 31% between 1993 and 1998. In addition, tidal salt water penetrates as far as 180 kilometres inland along the Gambia River, salinating large swampy areas and depleting further the country's productive base, particularly in growing rice, which is a staple food.

In urban areas, 11% and 13% of economically active individuals in the 15-19 and 20-24 age groups, respectively, are unemployed, with no social security safety net. The 1998 National Household Poverty Survey reported that the poor constitute 55% of households and 69% of the population, while 37% of households and 51% of the population are extremely poor and are unable to sustain a minimum standard of living financially. This situation is more pronounced in rural areas, especially in the Lower and Upper River Divisions and amongst urban, informal sector households.

In addition, the feminisation of poverty and widespread internal trafficking of children for child labour are evident, especially among extremely poor households, with a higher proportion of girls than boys (GOTG, 2000:ii). Government has introduced various institutional reforms and interventions to improve food security, such as the Strategy for Poverty Alleviation (SPA I) in 1994 and SPA II, the Poverty Reduction Strategy Paper (PRSP), in 2002. However, their impacts have yet to be felt by Gambians, as "44.8% of the population suffer from combined deprivation along the three broad dimensions: vulnerability to death at an early age, exclusion from the world of reading and communication, as well as deprivation in terms of overall economic positioning" (UN/GOTG 1999: 65). Human Development Index for The Gambia in 2001 was 0.405.

1.6 Socio-Cultural Characteristics

There are five main ethnic groups in The Gambia: Mandinka (39.5%), Fula (18.8%), Wolof (14.6%), Jola (10.6%) and Sarahuleh (8.9%) and a further half dozen smaller groups, including the Serer and Creole (2.8%). The Wolof language is freely spoken

and understood in most parts of the country, but English remains the official language. The country maintains a monolithic religious practice, with Muslims constituting 95% of the population. Christians constitute about 4% and practitioners of traditional religion 1%. Thus, there is a mix of western and Arab-Islamic cultural patterns and practices. Imams form part of the power constellation and, through the bidding force of Islam, in a unique way, ethnic differences seem not to have generated the tension observed in some countries, where national unity is threatened by periodic outbursts of ethnic violence.

Features of Gambian society include: patriarchal domination, low status of women, early marriage, polygamy and a pronatalist culture, which subscribes to patrilineage. The prevailing "Kabilo" (clan) and "Kafoo" (community groups) present a rather closely-built community that makes the country, with its relative small population size, appear as an amalgam of kith and kin, which readily provide support in times of sorrow and joy to their members. This unique structure seems to have insulated society from extreme social disorganisations observed in other developing countries. Social network relationships, in which everyone seems to know to each other, cements bonds and discourages violent episodes, or much criminal behaviour among Gambians.

The captivating scenery of the beaches, the cool sea breeze and the sunny weather interact to attract tourism. This has facilitated the establishment of multiplicity of hotels of all grades. There are also numerous of restaurants, video clubs and drinking "joints," all of which present conducive avenues for sex work and clandestine liaison.

The Gambia has porous borders all round, though only five entry/exit points to and from Senegal are officially approved. The River Gambia provides an illegal entry route to immigrants. The country also has an international airport and a seaport with a fast sea link to Europe. The bustling life of the seaport provides a facilitating environment for drug abuse and prostitution, which are implicated in the spread of sexually transmitted infections (STI), Human Immuno-deficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

With poverty prevailing in rural areas, there is a major drift to urban areas. A third of the country's population reside in the Greater Banjul and Kanifing Municipal Areas. Young people from the divisions often move to urban areas in the hope of securing better prospects but, more often than not, their expectations are frustrated. Population mobility, migration (both internal and international) and trans-national prostitution create conditions conducive to the spread of STI/HIV/AIDS, exacerbated by refugees from neighbouring countries, particularly Senegal and war torn Liberia and Sierra Leone.

1.7 Background to the Study

In the United Nations Declaration of Commitment on HIV/AIDS of 27 June 2001, the international community affirmed that HIV/AIDS had become a global emergency and called for a global alliance to fight the scourge. By the end of 2001, an estimated 40 million people around the world were living with HIV/AIDS, 28.1 million of whom were in Sub-Saharan Africa. During 2001, an estimated 2.3 million Africans died of AIDS and a further 3.4 million became infected with HIV (UNAIDS, December 2001:2). For a summary of current views of what drives the spread of HIV/AIDS in Africa, see Box 1.

The Food and Agriculture Organisation (FAO, 2001) has also alerted the global community to ominous signs that in the 25 most severely affected African countries HIV/AIDS has already killed some 7 million agricultural workers since 1985 and that a further 16 million might die in the next 20 years. In Botswana, Namibia, Swaziland and Zimbabwe, 20-26% of the population aged 15-49 live with HIV/AIDS.

At the regional level, Botchway (2000:9) in his paper at the African Development Forum highlighted the fact that not only was Africa the worst HIV/AIDS infected continent, but it was also the world's poorest region, with the lowest access to any quality of health care.

In its concern over the possible impact of HIV/AIDS on its younger generation, the then Organisation of African Unity (OAU) had, early in 1992, called for the necessity of providing to the youth, frank information about the disease, access to condoms and appropriate management of sexually transmitted diseases (STDs).

A decade later, alarmed at the havoc AIDS had already created in the sub-region, the African Heads of States and Government at their special summit in Abuja in April 2001 made a further declaration with a framework for action and pledged 15% of their respective annual budgets to the health sector to help address HIV/AIDS.

Box 1: What Drives HIV/AIDS in Africa?

No single factor, biological or behavioural, determines the spread of HIV infection. Most HIV transmission in sub-Saharan Africa occurs through sexual intercourse, with unsafe blood transfusions and unsafe injections accounting for a small fraction. While sexual behaviour is the most important factor influencing the spread of HIV in Africa, that behaviour varies greatly across cultures, age groups, socio-economic class and gender. Sexual behaviour is itself influenced by a host of factors, ranging from the daily and pragmatic (such as economic and social circumstance), to the complex and abstract (such as culture).

For example, higher numbers of sexual partners has consistently been found to be associated with greater likelihood of HIV infection, but the chances of individuals engaging with commercial sex workers, and thus having more partners, is clearly enhanced when large numbers of single, migrant men live together. These communities of single, male migrants (such as those in the mining communities of southern Africa, for example) have been established as a result of a complex interplay of economics and history. And this is only one example. Forced migration due to war, long-term travel along transit routes for commercial reasons, and the lack of secure livelihoods are other factors.

The interplay of multiple factors obscures causal linkages and prevents categorical conclusions. A study in four African cities (Cotonou, Kisumu, Ndola and Yaounde) revealed that the most common behavioural and biological factors in those cities with the highest HIV prevalence were: young age at women's first sexual intercourse; young age at first marriage; age difference between spouses; the presence of HSV-2 infection and trichomoniasis (a sexually transmitted infection); and lack of male circumcision. There is substantial evidence that sexually transmitted infections enhance the risk of sexual transmission of HIV, while other analyses suggest that male circumcision may be associated with reduced risk of transmission.

Young women have been consistently found to have higher prevalence rates of HIV infection than men of the same age group. The assumption that this results from women having sex with older men suggests a possible inter-generational driver of the infection from men to women. Young women are also physiologically more susceptible to sexually transmitted infections than young men. For instance, in Kisumu, Kenya, in 1998, the prevalence of HIV infection in women aged 15-19 was 23%; among young men of the same age, it was 3.5%. Socio-cultural systems in many cases also limit women's control over their sexual lives.

In addition, a large share of sub-Saharan Africa's population is young and, therefore, more likely to be sexually active. This helps explain the higher incidence of HIV and other sexually transmitted infections.

Where these facilitating factors are absent, HIV infection can remain 'hidden' for many years. In the presence of social, socio-economic and biological factors that facilitate spread, however, the epidemic may grow at a rapid rate. While the complex interplay of factors makes it difficult to estimate the likely growth of the epidemic, evidence from the past decade shows that HIV can spread rapidly and widely from very low general sero-prevalence levels. All countries with risk factors must employ the range of policies and programmes available (detailed in the source report identified below) so as to avoid a high-prevalence epidemic.

Source: UNAIDS (July 2002). Report on the global AIDS epidemic 2002. Geneva: Joint United Nations Programme on HIV/AIDS.

The HIV/AIDS situation in The Gambia may not appear as serious as obtains elsewhere, but has shown progress in that direction. According to the National AIDS Control Programme (NACP), the first case of AIDS in The Gambia was reported in 1986 and since then over 2,000 cases of AIDS have been reported, although there is a strong possibility of under-reporting (NACP, 2000:1).

HIV prevalence from sentinel surveillance at antenatal clinics in 2000-01 was 1.2% for HIV-1 and 0.9% for HIV-2 (NACP, 2001).

In its efforts, to combat the HIV/AIDS menace, the Government adopted a national policy and guidelines on HIV/AIDS in 1995. It also established the National AIDS Control Programme (NACP), which is charged with the responsibility of preventing HIV/AIDS and other sexually transmitted infections (STIs), and the reduction of personal and social consequences of HIV/AIDS infected persons. Since then, the programme has: been involved in advocacy, awareness creation and a series of sensitisation workshops on HIV/AIDS for different target groups; facilitated the establishment of Anti-AIDS Clubs in Schools; supported the Association of People Living with HIV/AIDS (PLWHA); trained peer counsellors; and supported HIV/AIDS related NGO activities.

In collaboration with other arms of Government, NACP is involved in condom distribution, provision of STI services and safe blood at central and divisional levels. As part of the national response to the scourge of HIV/AIDS and further demonstration of its commitment, Government has secured a credit of \$US15 million from the World Bank for the HIV/AIDS Rapid Response Project (HARRP).

Additional credit of \$US18 million has been secured from the International Development Association (IDA) for a Participatory Health, Population and Nutrition Project, which has components for a campaign against Female Genital Mutilation (FGM); Information Education and Communication (IEC) activities on HIV/AIDS prevention; and a social marketing programme on promotion of contraceptives, including condoms to prevent unplanned pregnancies and reduce the transmission of STIs and HIV.

While seeking to access the Global Funds for HIV/AIDS, The Gambia is part of a sub-regional Health for Peace Initiative (HPI), which seeks to coordinate development in the field of health to serve as an entry-point for confidence building and a strategic process to achieving peace in the sub-region.

Other member countries in the HPI project include: Guinea Bissau, Guinea Conakry, and Senegal. Under the initiative, common health problem areas, such as HIV/AIDS, malaria, polio eradication, management of complex emergencies and surveillance of

cross border activities are addressed. The Gambia co-ordinates efforts on malaria control and treatment of eye complications, while Senegal serves as the focal point for the co-ordination of sub-regional activities in HIV/AIDS prevention and control. Furthermore, a National AIDS Council under the Office of the President has been established as an advisory body on policy and to proffer strategic directions.

Related and supportive policies have also been enunciated, including: the National Health Policy, Population Policy and National Family Planning Policy, all of which aim at addressing overall health issues, population concerns, sexual and reproductive health (S/RH) and responsible parenthood. Cognisant of the crucial role of youth in national development, a Youth Policy has also been adopted and a National Youth Council established.

To supplement Government efforts, the United Nations Development Programme (UNDP) through its support to the National AIDS and Malaria Programme, aims at ensuring that HIV/AIDS and malaria become a developmental issue. It has also contributed to strengthening the capacity of the medical laboratories for continuous provision of safe blood for transfusion and has been supportive to the Association of PLWHA, Non-Governmental Organisations (NGOs) and grassroot involvement in HIV/AIDS activities.

The joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organisation (WHO) support NACP in capacity building, institution strengthening and through its projects on commercial sex workers (CSWs) and youth awareness on HIV/AIDS prevention and control. Also, in collaboration with the Medical Research Council (MRC) laboratories and the country team, a national HIV sentinel surveillance of pre-natal women was conducted.

From the perspective of population dynamics, sexual and reproductive health (S/RH) and HIV/AIDS prevention, the United Nations Population Fund (UNFPA) is providing support for advocacy, management and prevention of HIV/AIDS. It assisted the Women's Bureau in promotion of positive gender relations and women empowerment to prevent and control the spread of HIV/AIDS. In collaboration with the United Nations Educational, Science and Cultural Organisation (UNESCO), UNFPA supported the development of a curriculum on population and family life education (POP/FLE), which has been introduced to secondary schools.

Through the integrated Basic Services Programme and such projects as the Girls' Education Project, UNICEF is assisting in awareness creation on sexual harassment, teenage pregnancy and HIV/AIDS prevention. In addition, through the new United Nations Development Assistance Framework (UNDAF) Programming 2002-2006, the UN System in The Gambia has embarked on a much more streamlined, coordinated

and reinforcing effort to provide the synergy needed for effective impact on the spread and control of HIV/AIDS. It has also incorporated gender issues and HIV/AIDS as cross-cutting concerns under UNDAF programming.

Other stakeholders, such as the World Evangelical Church (WEC), have been involved in the provision of STI/HIV/AIDS related medical services and is to embark on community based care for PLWHA.

An encouraging development is the support of the private sector, such as the Shell Company, Trust Bank Limited and Chartered Standard Bank in HIV/AIDS support activities. A number of NGOs are also quite active in HIV/AIDS activities. For instance, The Gambia Committee on Traditional Practices (GAMCOTRAP) and the Foundation for Research on Women's Health, Productivity and the Environment (BAFROW) focus mainly on issues relating to harmful traditional practices and eradication of female circumcision. The Gambia Family Planning Association (GFPA) provides counselling services, non-prescription contraceptives, awareness creation and treatment of STIs. Also, the Youth Networks, under the leadership of The Gambia Red Cross Society, concentrate on the dissemination of information on STD/HIV/AIDS to peer groups. The Santa Yalla Support Group itself has taken up advocacy for PLWHA and is attempting to address the barrier of denial and silence.

Notwithstanding the array of HIV/AIDS activities outlined above, there are gaps in the services offered and IEC initiatives appear to have had only limited impacts on the spread and control of HIV/AIDS.

1.8 Justification for the Study

Sentinel surveillance data obtained in 2001 from antenatal clinics in four locations in The Gambia: Serrekunda, Sibanor, Farafenni and Basse, pointed to a disturbing trend indicating that HIV-1 had almost doubled from 0.7% to 1.2%, suggesting that as many as 8,000 adults might have been infected (NACP, 2001). A surprisingly steep increase in HIV-1 prevalence was found in rural Sibanor, compared with only a marginal rise in urban Serrekunda, in marked contrast with most other sub-Saharan Africa countries, where the opposite situation prevails. No immediate explanation for this anomalous increase in HIV prevalence in Sibanor was evident and provided specific impetus for this study.

In a more general context, one of the priority development issues for UNDAF programming in The Gambia is to support the control of HIV/AIDS and STIs through effective and improved IEC tools and methodology. It is widely acknowledged that good policy and sensible government actions should be built on a base of strong data that make analysis and intervention meaningful and effective. Suffice it to mention

that successful implementation of these strategies, needs to be based on a foundation of comprehensive baseline socio-cultural data for meaningful result-oriented outcomes and impacts. Furthermore, the 2001 UN Declaration of Commitment on HIV/AIDS specifically calls for improved understanding of factors that influence the epidemic and actions that address it.

In addition, one of the targets of the International Conference on Population and Development plus 5 (ICPD+5) relates to persons between the ages of 15-24 and called on Governments, with the assistance of UNAIDS and other donors, to ensure that by 2005 at least 90%, and by 2010 at least 95% of young men and women have access to the information, education and services necessary to develop the life skills required to reduce their vulnerability to HIV infection.

Through implementation of this study and dissemination of its findings, The Gambia has sought to obtain baseline socio-cultural and other information on the patterns of sexual behaviour and knowledge of HIV/AIDS amongst youth and other populations to assist in the targeting and provision of appropriate IEC and related services.

1.9 Objectives of the Study

The overall purpose of the study was to gather and collate basic socio-cultural information concerning key problems and issues in HIV/AIDS prevention for various socio-demographic groups, whilst the specific objectives were to:

- Identify the sexual behaviour trends among the socio-demographic and major ethnic groups;
- Provide an indication of the acceptability of condoms and other preventive measures by the various population groups; and
- Make appropriate recommendations.

It was envisaged that the achievement of these objectives would assist in developing appropriate HIV/AIDS/STD awareness strategies and contribute to improving other health related programmes and services.

Previous studies, reviewed in the following section, have been limited in scope and sample size and have been insufficient for strategic planning and comprehensive holistic intervention. Moreover, it was generally recognised that the collection and assessment of such basic data on awareness, attitude, behaviour and practices would facilitate an early evaluation of existing programme activities.

2. LITERATURE REVIEW

In an exploratory investigation such as this, it is instructive to review previous investigations of socio-economic aspects of HIV/AIDS to provide both contextual background and useful insights for interpretation of findings.

2.1 Related Earlier Studies

2.1.1 Sexuality and STI/HIV/AIDS

Sexuality has in recent times become a critical social, political and health issue, as well as an individual concern. It is recognised that about 85% of HIV/AIDS transmission occurs through sexual intercourse (Soyinka, 2001:17). The first few studies in sexual behaviour in sub-Saharan Africa (Romanuik, 1967; Laurentin 1974; and Evina, 1990) were conducted to determine the cause of widespread infertility and sterility, especially in central Africa. The major conclusions reached pointed to the relationship between these conditions and decreased control of the elders over the young, economic hardship and the presence of societies with permissive sexual customs. Murdock (referred to in Manners, 1964) had previously observed a similar correlation between sexual permissiveness and certain ethnic groups.

These factors were also contributed to the spread of sexually transmitted diseases (STDs), such as gonorrhoea and chlamydia, which cause infertility, or as in syphilis disrupt pregnancy. With the entry of HIV/AIDS into the health arena during the 80s, some STDs were also found to increase the probability of sexual transmission of HIV (Laga *et al.*, 1991 and 1993; Grosskurth *et al.*, 1995).

In a recent socio-cultural study of HIV/AIDS in Lesotho, it was concluded that the range and patterns of sexual relationships taking place before, within and outside marital union by both sexes, presented disturbing elements in the spread of STIs and HIV/AIDS that would frustrate prevention efforts (Otti, 1998:55).

There is a high prevalence of sexually transmitted infections (STIs), such as gonorrhoea, chlamydia, trichomoniasis and syphilis in The Gambia (UN/GOTG, 1999). These conditions are known to increase not only the risk of cervical cancer, one of the commonest cancers among women in The Gambia, but are also risk factors for the spread of HIV/AIDS.

In recognising the possibility of an HIV/AIDS epidemic and the need to control the disease, the Government of The Gambia has stressed that sensitisation of the public

should include discussion of related issues of sexuality and other sexually transmitted infections (GOTG, 2001:11).

In this regard, it is pertinent to mention Enel's (1995) study that examined the issue of sexuality and STDs in an attempt to determine the types of sexual behaviour that would explain the high rate of STDs and HIV in the Foni area of The Gambia. The findings noted the migration into the area each dry season, both from within the country and from neighbouring countries: Guinea Conakry, Mauritania and Senegal. Both married and single men leave their families for some months to work as traditional healers, wood cutters, blacksmiths and others. During this period, multi-ethnic liaison and sexual networks are established, facilitating unprotected sexual practices that have implications for the transmission and spread of STI/HIV/AIDS.

The author asserted also that the major host ethnic group, the Jola, hold regular festivities and annual initiation ceremonies, which last for days. Sons and daughters residing elsewhere return to their respective villages to participate in the celebrations. These events provide occasions and ready opportunities for pre and extra-marital relationships. *"When they are away from their regular partner(s), Jola men and women do not hesitate to use all available opportunity for having extra-marital partners, enjoying a high rate of life style"* (ibid. :23).

The reasons for this behavioural pattern were rationalised from three perspectives. For the men: *"long absences of the wives as long lactation, abstinence and habit of high frequency of sexual intercourse; pleasure of being loved and taken care of; challenge of "stealing" somebody's wife; family planning method that encourage women to have extramarital affairs"* (ibid. :23).

While for the women: *"husbands being reluctant to give money; being married to a man not loved; pleasure of being loved and taken care of; some kind of revenge for multi-partner relationships permitted to men through polygamy"* (ibid. :24).

On the other hand, to the moralizing individuals, the following reasons were advanced for the observed risky behaviour, thus the *"effect of generation changes; young people living in urban areas and hanging around; promiscuity and prostitution, multi-ethnicity within the area; tourism with the European women coming to The Gambia for sex with Gambian men; effect of money economy, effect of strangers attending initiation festivals"* (ibid. :24).

These findings are related to the observations made earlier by Murdock and others and have relevance to the present study. Suffice to mention that for whatever reasons, such sexual patterns do facilitate the spread of STI/HIV/AIDS.

One of the limitations of Enel's study, however, is the absence of quantifiable measures of sexual behaviour based on a structured questionnaire survey, which this study has attempted to achieve. Also, being localised the study needed to be replicated elsewhere in other parts of the country, for comparative analysis and an understanding of behaviour patterns of other ethnic, demographic and social groups, as they relate to the spread of STI/HIV/AIDS.

2.1.2 Mother to Child Transmission

Another major mode of transmission of HIV in SSA is from mothers to their children during pregnancy, delivery or breast-feeding. In developing countries, 25-35% of infants born to HIV infected women become infected themselves (UNAIDS, 1998). Tragically, children who escape infection from their HIV positive mothers are likely to be orphaned sooner or later by their parents dying of AIDS.

A nationwide study of 29,670 women in eight major health centres found mother-to-child infection rates of 25% for HIV-1 and 4% for HIV-2 (O'Donovan, 1994).

Besides the potential medical risk factors, such as positive syphilis serology, or last baby dying, the behavioural risk factors for HIV-1 infection were: having had more than one sex partner; and having received money, or gifts for sex. Risk factors for HIV-2 infection included: having had more than one sex partner.

The main risk factors for syphilis were: age 14 or less at first sexual intercourse; having received money, or gifts for sex; living in a rural area; lack of formal education; travel outside The Gambia; and female circumcision (NACP, 1999:10). Other important risk factors for syphilis transmission included: a history of genital ulceration or discharge in partner and history of genital ulceration in the woman.

These findings are generally consistent with those from elsewhere. It is important to note, however, that although only those women who requested to know their HIV status after testing would have been informed, very few individuals actually came for their results (NACP, 1999:9). This has serious implications for STI/HIV/AIDS control in the population at large, where unsafe sex is commonly practiced.

2.1.3 Young People and Vulnerability to STI/HIV/AIDS

Although over half of all new HIV infections occur in young people aged 15-24 (WHO, June 2001), adults have often found it difficult to see young people as sexual beings and, thus, sexual and reproductive health information and services are seldom made available to them. Yet young people in general have been considered to be often at high risk for the transmission of HIV/AIDS. In an attempt to explain this tendency,

based on their findings in Uganda, Caldwell (1993) and Twa-Twa (1997) argue that young peoples' sexual risk behaviours are influenced by both cultural and economic factors, and point to young people's environment and living conditions as being extremely important.

Focussing on young girls in particular, Gyeye, Castle and Konate (2001) also noted from their studies in Mali that: '*... the majority of (unprotected) sexual encounters among unmarried young people in Mali involve financial recompense of female partner by the male...*' (p.56)

They further observed: "*Changing family responsibilities for the economic needs of adolescent girls appear to drive them to engage in sex for cash, particularly those in urban areas, being required to be financially independent rather than relying on family support*" (Ibid).

This portrays an emerging trend in the urban setting.

An added concern over risky behaviour by young people is the problematic issue of "age mixing," which has been raised by UNAIDS (2000), in the realisation that, as more older men infect younger women/girls with STI/HIV who then transmit the disease to their partners or children, a vicious cycle of infection and disease is established.

Another factor that involves youth in HIV transmission is substance abuse, especially, when it entails unsafe drug injection practices, particularly amongst needle sharing users (UNAIDS, June 2000:18). In many countries, young people are more vulnerable to substance abuse and injecting hard drugs.

The challenge of growing up and transition to adulthood and responsibilities, and peer pressure to experiment are some of the reasons adduced for the involvement (Otti, 1991). A survey in 1996 by the Department of Social Welfare (DSY&S 1998:3) alerted the country to the fact that drug abuse was becoming widespread among youth in The Gambia and revealed that the same under-18s were using both alcohol and harmful drugs. This study, therefore, made efforts to assess the knowledge among the population, of the risk of contracting HIV from sharing of syringes and needles.

The 1994 International Conference on Population and Development (ICPD) and ICPD + 5 have provided impetus for improving adolescent and youth sexual and reproductive health in The Gambia, which is a government priority. As advised by UNAIDS during the 1998 World AIDS Day, young people face enhanced risks and should be specifically identified as a group for HIV/AIDS related prevention programmes.

A baseline survey of 14-24 year olds was undertaken in 2000, as a basis for strengthening family life education programmes and to improve access to reproductive health services and counselling programmes for adolescents and youth. The respondents indicated that their ideal ages for first sex, marriage and child bearing were 11.9, 15 and 16.9 years, respectively, for females, while higher ages of 12.3 years for first sex experience, and 18.5 for marriage were indicated by boys. Such views seem shaped by socio-cultural, gender norms and values. Exposure to the risk of unwanted pregnancy at a tender age was found to be high. The respondents' knowledge of modes of transmission and prevention of HIV was also high (80%). An aspect of particular importance calling for further investigation was that respondents attributed their non-use of contraceptives to lack of access (GOTG, 2001).

There is no doubt that the Adolescent and Youth Study was an important one, particularly in the absence of a demographic and health survey, which has never been undertaken in The Gambia. However, while offering valuable and insightful information, the study covers only one segment of the population and points to the need for a more inclusive study, involving adults as well as adolescents and youth.

2.1.4 Commercial Sex Work

Sex work has been generally implicated in the spread of HIV infections thus, Piot *et al.* (1992), Patton (1994) and Doyel (1995) all stress that the poor socio-economic position of some African women leaves them no option but to sell sex to survive.

In this situation, as Maduna-Butshe (1997:8) asserts: *'Holding women responsible for sexual safety in the time of AIDS seems like a joke. Decisions pertaining to sexual behaviour cannot be separated from the wider social and cultural influences that combine to keep women subordinate to men.'*

Also aptly expressed by Mwale and Bernard (1992) is the opinion that *"cultural and socio-economic factors have made it impossible for women to be independent. This is evidenced by the high number of female sex workers in countries like Kenya, Uganda and The Gambia"* (in: Maduna-Butshe, 1997:9).

'Some of the traditional mechanisms to ensure widows access to land contribute to the spread of AIDS, for example, levirate, the custom that obliges a man to marry his brother's widow. In several countries, studies have found that rural women whose husbands had died of AIDS were forced to engage in commercial sex to survive because they had no legal right to their husband's property' (FAO, 2001).

Studies by Stock (1998) and Loum (2000 a&b) highlight commercial sex work (CSW) as a rather flourishing trade in The Gambia, with much mobility of the

population in lumo (on market days) and a booming tourist industry. Various nationalities are represented but most come from Senegal (80%), with Gambians forming the minority but are involved more in clandestine and male sex work (Loum, 2000b). The majority of CSWs have little or no education and are either single, divorced or widowed (95%). They operate at hotels, brothels and or move about at night. However, *"A lot of sexual exchange takes place by women and men from their homes at their work places, in schools, and so forth. This is an area far further empirical study as these types of sexual exchange evade normal intervention efforts"* (Ampofo, 2001:6).

Such forms of sex work present a worrisome angle in the spread of HIV and the efforts being made to prevent transmission, more so, if unprotected sex is being practised. This study, therefore, explored the perceptions of condom usage, so as to inform the planning of future education and communication strategies.

The above review brings to the fore the gendered nature of forced prostitution, occasioned and anchored in the low position of women. In The Gambia, the prevailing situation of women as summed up by Government is as follows: *'Cultural, social and customary norms and practices mean that women continue to have a lower social status than men; they have an unequal access to education, control over assets and decision-making. Women cannot own land in rural communities and forsake family properties in the event of the decease of their spouses'* (DSF&EA 2002:24).

In its summation of the pandemic as it pertains, not only to SSA but also globally, UNAIDS (Dec. 2000:8) has identified a variety of behavioural and social factors which play a key role in kick-starting sexually transmitted HIV epidemic and driving it to higher levels, thus:

- Large proportion of the adult population with multiple partners;
- Overlapping, as opposed to serial sexual partnership;
- Large sexual networks;
- "Age mixing," typically between older men and younger women;
- Little, or no, condom use;
- Women's economic dependence on marriage or prostitution, robbing them of control over the circumstances or safety of sex.

The above further illustrates the complex web of social, cultural and economic factors involved in sexual behaviour and the spread of HIV/AIDS. This study attempted to examine to what extent this mesh of issues exists in The Gambia.

2.1.5 Female Circumcision

An overview of the practice and harmful effects of female genital mutilation (FGM) has been published by WHO (1998).

A survey by the Department for Community Development in the late eighties (DCD, 1989:14 & 15) found that about 80% of the families interviewed in The Gambia undertook female circumcision and that the practice was highly entrenched amongst Mandinka, Fula, Jola and Sarahule communities, but minimally practised by the Wollof. Enel (1995:28) has reported the compulsory practice of FGM in children aged 3-14 years amongst Jola and Mandingo in the Sibanor area. BAFROW's (1999) study, cited in UNDP (2001:25), indicated that at least 65% of girls in rural areas of the country undergo FGM.

Besides other reproductive health hazards, the possible facilitating role of FGM in the spread of STI/HIV/AIDS, especially where unsterilised instruments are used, must be recognised. It is noteworthy that that 87% of the circumcisors questioned in Lower River Division indicated that they would be willing to abandon FGM, if assisted with alternative income generation activities (BAFROW, 2000:53).

2.1.6 Religion and HIV Prevention

Since all religions emphasise abstinence and faithfulness to the spouse, religion must have played some part in HIV prevention. The Catholic Church has generally opposed the use of contraceptives, including condoms, except in Brazil, where Catholic Bishops have moved away from the official Vatican position and opted to allow congregates to use condoms; their stance being that: *"the use of condoms is less serious morally speaking than getting infected or infecting other people with the AIDS virus"* (<http://report.kff.org/hiv/aids>).

Islamic states or countries with a high proportion of Muslims, such as Egypt, Iran, Jordan, Senegal and Turkey, have adopted AIDS prevention measures, including condom use, whilst The Gambia has yet to be more specific.

A model developed for UNAIDS estimates that in any country where 15% or more of adults are currently infected, at least 35% of boys now aged 15 will die of AIDS (UNAIDS, June 2000; 25).

2.1.7 People Living with HIV/AIDS

An important direction advocated by UNAIDS (June 1999:23) is the unmasking of the HIV/AIDS epidemic and giving it "a human face" by greater involvement of people living with HIV/AIDS (PLWHA). In this regard, the African Development Forum has issued the following important guiding statement: *"People living with HIV/AIDS stand at the centre of any community efforts to overcome the pandemic and to change attitudes to overcome denial, stigmatisation and discrimination. Their rights must be respected in full and their leadership potential recognised"* (ADF, 2000: 2-3).

This statement acknowledges PLWHA as the central moving force in checking the spread of HIV/AIDS and, in effect, recognises that they hold the key to prevention and control.

However, a community survey by Schneider and Jallow (2001) on the attitude of 295 respondents in the Manduar Tundo Western Division in The Gambia, provided indications of a negative attitude of the community towards PLWHA, particularly with respect to home care and close contact with them. In view of the relatively small sample size in their study, it was deemed appropriate for this work to explore attitudes to the care of PLWHA on a national basis.

This section of the report has attempted to acknowledge the efforts made by others in unravelling the complexity of the situation into which the scourge of HIV/AIDS has thrown human society. The review is by no means exhaustive, but the studies provide the building blocks for further understanding of the inter-linkages of human behaviour and practices, survival and life threatening consequences, which have also contributed in part to the paradigm and motivation for undertaking this research.

2.2 Content Analysis

Until the late 1980s, there was no significant presence of newspapers and magazines or radio stations in The Gambia, and television was not available until the mid 90s. The government paper was the main newspaper in circulation as there was no "popular" newspaper, as such. The only two radio stations were the government-owned Radio Gambia and a private station, Radio Syd. Radio Gambia, commonly known as "Radio Kombo" covered the western half of the country, whilst Radio Syd had even more limited coverage. Radio Gambia was the Government's mouthpiece, broadcasting the news and entertainment, as well as informing and educating the public about government sectoral programmes, e.g. health, education and agriculture; whilst Radio Syd carried mainly musical entertainment and commercials, although it linked up with Radio Gambia for news broadcasts.

Nowadays, there are several commercial and community FM radio stations. The commercials are all within the Greater Banjul Area, whilst the community FM stations are in four provincial divisions, though not functioning at the time of the study. The fifth provincial division has an AM station run by Radio Gambia.

An independent press and media emerged in the 1990's. The first "daily" newspaper started with three publications per week and later expanded to six issues per week. The initial circulation was limited to Banjul and the Kanifing Municipality. However, the coverage now reaches the major towns in the country. Other newspapers, though not daily, also followed. Their combined readership is, however, very limited as the country's literacy level is relatively low.

Due to the increase in the number of radio stations and newspapers, Government no longer has a monopoly over news. Controversial and sensitive matters are now discussed over the airwaves through phone-in programmes and panel discussions. Government sectoral programmes have also used these outlets to inform and sensitise the populace on issues of the day, including HIV/AIDS. Besides the national news, popular radio programmes include music and drama programmes.

Both government and non-governmental organisations have used music and drama groups to compose songs or illustrate issues, including HIV/AIDS, as part of sensitisation and awareness raising activities. These channels have been employed by NACP in its IEC delivery strategies. The GOBGARR ("You Reap What You Sow") and FANSUNG-JAMANO ("Today's Society") groups, for instance, have been involved in HIV/AIDS related drama during the weekly radio programme on social and health concerns.

The Independent newspaper is circulated twice a week and carries features on the consequences of HIV/AIDS, "chagaya" (prostitution) and child care (including the exploitation and sexual abuse of children); while the Observer, which is a daily newspaper, discusses HIV/AIDS and related effects under its Health Forum page. Both newspapers widely publicise HIV/AIDS activities by students, such as an AIDS Quiz competition by the Serrekinda Lower Basic School and the HIV/AIDS Awareness Club, launched by the Bottrop Ex-Students' Association (BOSA).

Another daily, The Point, also has a column termed Your Health, which discusses sex education, sexual and reproductive health topics, amongst other health issues. The formation of the Association of Health Journalists in November 2001 marked a further encouraging development. Through its periodical: "The Gambia News," the association presents serious and comprehensive coverage of the AIDS pandemic, with emphasis on stronger leadership commitment and breaking the silence.

Overall, mass media support to the HIV/AIDS prevention campaign is amply demonstrated by the range of their outputs, but these tend to be of a general nature and do not reach all segments of the population.

2.3 Social Commentary

The popular forms of recreation and entertainment activities are similar across the ethnic groups, but slightly different in form between rural and urban. In the former the seven-month long dry season, which usually extends from November to May, is the period for recreation and entertainment. The "bantaba" (=meeting place in the village) is where men usually sit, chat, gossip, exchange stories or just run away from the family to be among "men." The adolescents and youths would be in their "attaya vous" - Chinese tea drinking sessions that can last from 30 minutes to a whole night. For females, their "bantaba" is the fireplace or kitchen and the wells.

The dry season is also the period for wrestling between ethnic groups or communities. Village wrestling is quite different from urban wrestling. Village wrestling happens at night and is free, though it is now being commercialised; whilst urban wrestling takes place in the afternoon and is a paid sport. Courtship and marriages often take place during the dry season when men's financial position is enhanced by the sale of groundnuts. Also, the dry period facilitates rural-urban migration in search of work, or visits to relatives in urban areas, or other communities.

In summary, the dry season is characterised by various social events and intense social interaction for all ethnic groups, which present numerous opportunities and contacts for unsafe sexual practices and the spread of HIV/AIDS; whilst in marked contrast, the rainy season, from June to October, is the period of hard farm work for rural communities.

In urban areas, the "grampalas" or "attaya vous" are favourite meeting places for friends, neighbours, peers and colleagues, or particular groups. It might be a compound, or a house, or under a tree, or on the roadside. Usually, one form of indoor game or another is played; the popular ones being drafts ("damiya"), cards, ("mariyass"), ludo and even the game of Scrabble. The usual Chinese green tea, "attaya" is brewed and sipped, while discussions take place, or jokes are told.

Social, religious and national, or topical issues are generally debated in the "bantaba," attaya vous," "grampalas" and during other socio-cultural gatherings, but are rarely of a violent nature. Gambians usually exhibit more passivity over events than mobilised collective behaviour and social movement. Moreover, with the high level of illiteracy, the majority of the population are unaware of their civic rights and responsibilities.

Consequently, citizen engagement is rare. Similarly, HIV/AIDS has yet to be understood and appreciated as a threatening and deadly disease.

2.4 Analysis of Social Trends in The Gambia

When The Gambia achieved independence in 1965, there were misgivings as to the sustainability of the country and whether it would survive as a sovereign nation state, given its size and poor economic profile. Virtually surrounded by Senegal on all sides except by the Atlantic Ocean, a pre-requisite for being granted independence was that The Gambia would work on its relationship with its much larger neighbour. Cognisant of this, the founding fathers tried to foster a spirit of self-reliance among the people. One of the popular songs, composed at the time and widely sung in schools, was a Wolof song: “Ligaye jotna Gambiya am na bopam,” meaning “It’s time to work as The Gambia has attained her independence.”

This immediate post independence period was followed in the 1970s by the philosophy of “tesito,” a Madingo word literally referring to tying one’s waist, but interpreted to mean hard work. The “tesito” philosophy was manifested in the rural communities during the rainy season. The more “donkeys²” a farmer had the more respect he commanded and consequently the more wives he was expected to marry, to a maximum of four. Social status was measured by the number of “donkeys,” cattle, wives and children an individual had. These values were common amongst all major ethnic groups. In urban and peri-urban areas, however, the ultimate status symbol was whether one was a government civil servant, or not.

2.4.1 Decade of Hope: 1965-1975

Development efforts during the first independence era, therefore, placed priority on agriculture through various rural development projects. This approach, however, failed to yield the desired impact on the lives of the people. In addition, although a Westminster type of parliamentary system was practised under the People’s Progressive Party (PPP), participatory democracy was in reality rather limited.

2.4.2 Era of Disenchantment: 1975-1985

Initially, the prospects appeared promising, which raised considerable hope for a better future for Gambians. Government continued with its agricultural policy, but

² Across all ethnic groups, the concept of the “donkey” in this context refers to two bags of groundnuts that may be converted for financial reward.

equally embarked on social sector improvement. It introduced a decentralisation process that brought health concerns nearer to the people. A primary health care programme was initiated, a revolving drug fund was established and the country’s health profile began to improve. Other sectors, including education were targeted and teachers training colleges were set up. A Women Bureau was created to address the plight of women. Donor assistance poured in, setting the stage and raising expectations for an improved quality of life.

However, the decade witnessed a military coup, which resulted in the short-lived Sene-Gambian Confederation that gave birth to the Gambian Army. It was also an era that experienced persistent drought. The economy soon went into serious recession and an Economic Recovery Programme (ERP) was introduced to address macro-economic imbalances. Mass unemployment ensued, as workers were made redundant and agricultural subsidies were removed. People became poorer and the quality of life plummeted. A policy of economic diversification was introduced and tourism was promoted, which led to an influx of foreigners and external influences with profound social consequences.

2.4.3 Re-Defining Years: 1985-1995

This period was one of proliferation of the mass-media, both print and electronic, with TV being introduced in 1995. Tourism flourished and trans-national commercial sex work became increasingly evident. The first HIV/AIDS case was diagnosed in 1986 and the NACP was set up the same year. Although the government of the day remained popular among the largely illiterate population, the seeds of dissatisfaction began to germinate, as accusations of corruption and malpractice were made, particularly by the educated urban population who had become apathetic to the political processes, while covertly opposing the Government.

In 1990, the Programme for Sustainable Development (PSD) was introduced to cushion the harsh effects of 1985 ERP and put the economy back on track. However, in 1994, a second military intervention brought another interim government and led to the withdrawal of much donor assistance (except from the UN system). With few natural resources to fall back on, The Gambia had to search for new friends, allies and development partners to support its ailing economy and rescue its international image.

2.4.4 Re-Positioning Period: 1996-2000+

With a clear national development policy vision to 2020 established and an approved poverty reduction strategy in place, The Gambia is re-positioning itself for further socio-economic development during the twenty-first century. Social sector revival and infrastructural development have commenced and tourism has become a major

foreign exchange earner. These positive signs, however, must be tempered by the mounting threat of HIV/AIDS associated with socio-economic change and increased population mobility.

Having reviewed its constitution and governance policy, the country is regaining some measure of confidence in the international arena. This has resulted in the normalisation of relations with United States of America and its recent election as Vice President to the Executive Board of UNICEF, representing the Africa region. Furthermore, the World Bank has granted a credit facility of \$US15 million to assist in developing a national response to the scourge of HIV/AIDS.

Notwithstanding these positive developments, the nation remains in an initial phase of “denial and secrecy” with respect to HIV/AIDS, which constitutes a formidable challenge to Gambian leadership that must be surmounted if the country’s primary resource of 1.4 million inhabitants are to be saved from the misery and havoc of an unchecked HIV/AIDS epidemic.

3. RESEARCH FRAMEWORK AND METHODOLOGY

Two observations from previous investigations gave encouragement and guidance to this study. The first being Enel's experience of working with the Jola: *"I did not meet strong reluctance to talk about sexual behaviour and sexually transmitted diseases; I believe that the topic of sexual relations is not terribly sensitive, quite the reverse, because interviewees appeared willing to discuss their own history"* (Enel, 1995:5).

And, the second was the wisdom of an old Jola man, who commented: *"The reason why you are asking all these questions is because you don't see what is going on. The reason why all these things are kept away from people is because people don't ask ... if you ask, however, the case might be that you'll know. If you don't ask, you'll not know"* (Ibid).

With these guiding words, research progressed smoothly without major hitches. Gambians responded positively to our enquires and proved willing to discuss a wide range of issues relating to their personal life, sexual behaviour, STIs and hygiene.

3.1 Theoretical Framework and Definition of Concepts

A key concept in this study is: "culture." Here it is used to refer to the shared understanding – a kind of pattern or organised disposition expressed in behaviours characteristic of each group of people. Although it is not physical, it embodies beliefs, attitude, a way of viewing the world and other dispositions that human beings manifest that are categorised under the label "culture." For the purposes of this study, it is the impact of these patterns and the power, influence and reality, which they exert on behaviours and practices – in this case sexual behaviour, that is important to this research.

As Durkheim states *"a sense of self is part of a broad reality, the society and culture"* (cited in Peacock, 1993:14-18). This introduces the second important concept in this study: "society" that embodies human relationships and the interlinked structural forms that provide the context of behaviour and makes man a social being – distinct and placed at the highest pinnacle or apex of the animal kingdom. Culture does not exist in a vacuum but is sustained by members of society, who individually have considerable freedom and "free will" to choose and to act. This comes, as Weber (1968) would remind us, from placement of one's acts in contexts, including culture and societal expectations. *"The cultural individual, therefore, exists in freedom but also embodies that cultural mould in which he is cast in his particular society and historical epoch"* (Peacock, 1993:46)

Relating this posture to this study, the process was guided by such questions as: what were the cultural and societal factors that guided, influenced or did not influence the individual and the personal choice to be involved in unsafe sexual practices, even with the knowledge of the health consequences?

Furthermore, The Gambia population being 95% Moslem, Islam provides a ruling religious ideology, source of information and doctrine that could influence individual behaviour and choices. This study was guided to examine some of these issues.

Youths face the most challenging period of personal development and growing up and, on the advice of the Technical Task Force of the UN Theme Group on HIV/AIDS and the investigators, were deemed to be between 13-24 years of age.

3.2 Research Design

3.2.1 Geographical Coverage and Target Population

The initial conception of the study, as reflected in the terms of reference was to conduct the exercise in four provincial divisions in the country, namely: Banjul Municipality; Kanifing Municipality; the Foni Districts in Western Division; and Upper River Division. These locations were selected on the basis of the 2001 HIV/AIDS sentinel surveillance data, which revealed a high prevalence in Western Division compared with other sites.

Subsequently, however, after arrival of the international consultant and discussions with the Technical Task Force of the UN Theme Group on HIV/AIDS, it was decided to extend the scope of the study to obtain sample coverage nationally. The main segments of society targeted were adolescents, youths and adults, in both urban and rural areas, and the six main ethnic groups:

Mandinka: Largest ethnic group found in all divisions of the country. Originally from Mali and mainly occupied in agriculture. Marriages are based on rural formation and are polygamous. Intermarriage with other ethnic groups is accepted. Female genital mutilation is compulsory. The Mandinka language is widely spoken.

Wolof: Widespread throughout the country, but originally from Senegal with numerous relatives still living there. Although predominantly farmers, they had early contact with female education by missionaries. Their language is widely spoken and understood in most parts of the country. Muslims, but FGM minimally practised. Marriage patterns and cultural practices very similar to other groups.

Fula: Although cattle rearers by tradition, much influenced by early colonial contact and education. There is less religious rigidity and patriarchy. Women are farmers and trade in dairy products, and tend to be more assertive, as husbands often away herding cattle. Marriages are arranged and female circumcision is practiced.

Jola: Found mainly in the Foni Districts in the eastern part of Western Division. Some Christians and animist, but mostly Moslems who share common language and geographical proximity with relatives in Senegal, reinforced by shared beliefs, values and social norms. Mainly crop farmers, but also own cattle and are involved in petty trading and processing of palm oil. Jola girls often work as maids in the Greater Banjul Area (GBA). Marriages are arranged and reinforce or create new linkages between families and villages. Initiation ceremonies are common and there are frequent celebrations and festivities. Literacy level is relatively low.

Sarahuleh: Live in isolated, rural communities in Upper River Division. Strict Muslims, closely-knit and conservative in nature. Patriarchal society with mainly polygamous marriages. Modern education is not a priority; female education in particular not encouraged. Early marriage and female circumcision widely practiced. Endogamy (marriage within ethnic group) is the general rule. Most men farm, but they are also renowned traders, travelling extensively both within the country and as far as Angola, Guinea, Liberia and Sierra Leone for diamonds and other goods.

Serrer: Fishing communities originally occupying the Kingdom of Banjul before colonial intrusion. Found in Nuimi Districts of North Bank Division. Have similar cultural practices as other main groups, but maintain their own language.

3.2.1.1 Study Areas

Focus Group Discussion Study Areas

The Greater Banjul Area (GBA) refers to the City of Banjul and the Kanifing Municipality and is the main urban area of The Gambia. In selecting specific places within the GBA, the assistance of certain institutions and groups was enlisted. Secondary schools and higher training institutions were selected for in-school target groups, whilst work places and business centres provided educated and un-educated target groups. The Islamic and Christian Councils assisted in the identification of religious leaders; “Yai Compins” and Area Councillors helped with the selection of married and single people; whilst ethnic group elders assisted in the choice of Mandinka, Fula and Wolof groups.

Within the five provincial divisions, namely: Western Division; Lower River Division; Central River Division; and Upper River Division; in-school and out-of school respondents were selected from major towns with senior secondary schools.

Sites for the ethnic group discussions were selected from villages comprised predominantly of one particular ethnic group. The three main ethnic groups, Mandinko, Fula and Wolof, are found in all divisions of the country. The other three, traditionally live in specific divisions or districts. The FGDs with the Jola ethnic group was conducted in Bantajang for males and Kalang for females, in the interior of Foni, off the main trunk road. The Serrer FGDs were conducted in Ndofan for males and Sam Mbollet for females in Lower Niumi District of North Bank Division, where they are found exclusively. Sarahuleh FGDs were conducted in Kumbija for males and Sabi for females in Upper River Division. A few Sarahuleh villages are also found in Central River Division.

Questionnaire Study Areas

A random sample was taken in which the Enumeration Areas (EAs), demarcated for the National Population and Housing Census in 1993, were used as clusters and a total of 42 EAs were selected across the country. In each of the divisions, the poverty status of the EAs were selected to include a range of “rich”, “middle-level” and “poor” areas, as defined by the Department of State for Finance and Economic Affairs. EAs were also selected to ensure inclusion of ethnic groups and districts identified for the FGDs.

3.2.2 Methodology

The study included collection and assessment of information from various sources and involved both qualitative and quantitative methodologies.

3.2.2.1 Data Collection

Secondary Data

A detailed examination of all available relevant documentation was undertaken, including: previous studies; published literature; unpublished reports; policy statements; project documents; and media publications. These provided much useful background material and insights into the problem and its inter-linkages, and a basis for comparative analysis that helped guide the research process.

(i) Stakeholders Analysis

The literature review aided the identification of stakeholders in HIV/AIDS prevention and control in The Gambia. A stakeholders analysis was developed that guided the identification of primary, secondary and key stakeholders, indicating beneficiaries, partners and allies, the uncommitted and adversaries. These categories relate to the issues involved, the expected impact of the study and the facilitating and constraining factors that have influenced efforts so far in HIV/AIDS prevention. Based on this analysis, tentative actions required to achieve further progress were proposed.

Primary Data

(i) In-depth Interviews

Further insight were gained from discussions and interviews with policy makers; representatives and programme officials of relevant arms of Government; key influential opinion; leaders and experts in the field; United Nations agencies other development partners; and Non-Governmental Organisations. They readily provided perceptive analysis of the study problem, involvement so far, and proffered future directions that should be considered.

(ii) Qualitative Methodology

The nature of the subject under investigation necessitated the adoption of a qualitative methodology as the main approach to the research. It was an attempt, which had the potential of capturing views representative of various segments of the Gambian population. The method emphasises the subjects' frame of reference, encourages fuller discussions and the emergence of unanticipated issues. With its flexibility, it allows personal expressions and individuality, to explore issues relating to the research question and understanding of people's behaviour and practices. The findings from the focus group discussions were insightful. Also, data from the quantitative methodology reinforced opinions held by the FGD participants.

(iii) Focus Group Discussion

FGDs were used to obtain primary data and to foster interactive and participatory involvement of community members who were the ultimate stakeholders. Themes for discussion covered the following: prevailing traditional practices; prevailing modern practices; gender relations; nuptiality and the family; sexual and reproductive health; sex education; HIV/AIDS; types of healing systems; PLWHA; and commercial sex workers.

Sub-themes were teased out from the main themes and lead questions outlined. Sets of questions and codes were developed to guide moderators and FGDs. The moderator's role was to facilitate discussion in an amicable atmosphere and ensure that participants had opportunities to express their views freely. Draft qualitative instruments were reviewed by representatives of the UN Theme Group on HIV/AIDS and discussed with field workers during training sessions. Transcription forms were designed to record divergent and convergent views and experiences of participants. Audio recordings of FGDs were made.

(iv) Quantitative Methodology

Qualitative methods may be criticised on grounds of subjectivity, so to overcome the deficiency of a single method of information collection, a protocol was developed as an instrument to obtain quantitative data from a representative cross-section of respondents.

It consisted of seven sections dealing with: respondent's background; awareness of HIV/AIDS; sources of information; knowledge of risks, behaviour and prevention of pregnancy and HIV/AIDS; sexual practices and risk behaviour; attitudes to condoms and their use; attitudes to people living with HIV/AIDS; and voluntary testing for HIV/AIDS. The instrument contained more pre-coded, close-ended questions with a few open-ended ones. Two versions were prepared to reflect the different socio-demographic backgrounds of adolescents/youth and adults.

The process of finalizing the questionnaire went through a number of inter-related steps especially because it contained a sensitive component relating to forms of sexual behaviour. An initial draft was subjected to the external scrutiny of the National Task Force of the UN Theme Group on HIV/AIDS. Their comments and suggestions were incorporated to make the instrument more country-specific, with respect to the education system, occupations and preferred format.

The draft was then presented and discussed during the training of 37 interviewers and their supervisors (nationals), responsible for administering the questionnaire in all divisions in the country. Minor adjustments were made reinstating certain questions contained in the original draft, previously deemed to be too sensitive.

Prior to finalisation, the protocol was pre-tested in urban, peri-urban and rural areas, the objective being to expose interviewers to actual data collection using the designed instruments; test their interviewing skills; identify sticky technical areas for re-consideration; and determine from respondent reactions if any revisions were required for clarity. Contrary to prior apprehension, the pre-test without a hitch.

Sampling

Participants of focus group discussions were not sampled, but purposely selected to include a broad range of individuals by age, educational level and gender in the following categories:

Demographic Groups: adolescents (13-18 years), including secondary school students for in-school adolescents; youths (19-24 years), including college and university students; young adults (22-30 years); and adults (31+ years);

Social Groups: religious leaders (both Muslim and Christian); married persons; and singles;

Ethnic Groups: Mandinka; Fula; Wolof; Jola; Sarahuleh; and Serrer;

Professional Groups: teachers; health workers; media practitioners; armed forces; police; and customs workers;

Special Groups: truck drivers; trained traditional birth attendants; traditional healers; commercial sex workers; PLWHA; maids; inter-country traders; and bumpsters.

Members of the National Task Force on HIV/AIDS assisted in the identification of locations for FGDs. Sites and communities for ethnic group discussions were selected purposely. The Mandinko, Fula and Wolof are found throughout the country in both urban and rural areas, while the Jolas are resident in the Foni Districts of Western Division, the Sarahulehs in Upper River Division and the Serrers in the Niumi Districts of North Bank Division. Where practical, ethnically homogeneous communities living away from major roads were chosen.

A total of 108 FGDs were planned: 56 in the Greater Banjul Area and 52 in the rural divisions.

The CDC/WHO STATCALC Programme in EPI Info 6.04d was used to determine sample size. In total, 2,400 semi-structured questionnaires were administered across the country, distributed proportionately between divisions according to population size, as shown in Table 1.

The Enumeration Areas demarcated for the National Population and Housing Census in 1993 were used as clusters and a total of 42 EAs across the whole country were selected to include rich, mid-level and poor EAs, as described in section 3.2.1.1.

Table 1: Sample Size as Drawn from Enumeration Areas

Division	1993 Population	Estimated Sample Size
Greater Banjul Area (Banjul & Kanifing MAs)	270,540	625
Western Division	234,917	543
Lower River Division	65,146	151
North Bank Division	156,462	362
Central River Division	156,021	361
Upper River Division	155,059	358
Total	1,038,145	2400

3.2.2.2 Data Analysis

Newman's typology facilitated the analysis of data from the FGDs. Analytical comparison and cultural analysis to synthesize the results were facilitated by the coding of values.

For the questionnaire data, after the additional coding of responses to the open-ended questions, EPI-INFO software was used for analysis to determine frequency distributions and cross tabulations and assess the relationships between variables.

3.2.2.3 Training of Interviewers and Supervisors

Thirty-four interviewers and eight supervisors recruited from health workers, youth workers, NGOs, the University of The Gambia and freelance enumerators used by the Central Statistics Department were trained for two weeks to ensure user-reliability for the study instruments. Some members of the Task Force of the Theme Group on HIV/AIDS participated in the training exercise.

The objectives of the training were to provide fieldworkers with the following skills:

Understanding and ability to use both qualitative and quantitative survey instruments;

Understanding of the basic principles of the study and the methodology;

Understanding and ability to apply recommended interview techniques;

Pre-test the survey questionnaire and make changes where necessary.

Training included the following topics:

Overview of the HIV/AIDS situation in The Gambia; objectives of the socio-cultural study; and objectives of the training workshop;

Introduction to the interviewing process/techniques and presentation of Focus Group Discussion Guide and Questionnaires;

Translation of survey instruments into Mandinka, Wolof and Fula;

Mock interview sessions;

Pre-test of the survey instruments;

Review of the pre-test experiences and constraints encountered;

Revision and finalisation of survey instruments.

This study acknowledges various gaps and limitations, which deserve further investigation. In particular, the attitude of health workers to PLWHA is a very pertinent area for future enquiry; and the finding that females (both young and adults) are less willing to undergo voluntary counselling and testing for HIV/AIDS, which has important implications for mother-to-child transmission, should be followed up.

3.2.2.4 Field Work

The thirty-four interviewers and eight supervisors were divided into:

Nine FGD teams of two, with four supervisors – one having 5 teams with one driver and the other 4 teams with one driver;

Six sample survey teams comprising four interviewers, one data entry clerk, one supervisor and one driver.

3.2.2.5 Limitations of the Study

Human behaviour is a complex phenomenon, especially with regard to sexuality, which despite its generally personal and private nature has become a subject of open discourse due to the HIV/AIDS pandemic.

No socio-cultural study of HIV/AIDS can ever be exhaustive and completely comprehensive because of the multiplicity of factors involved and limited time available for investigation.

Only the main findings of the study are presented and highlighted in this report. A substantial body of additional information was collected and has been compiled into electronic databases and lodged with the Department of State for Health and Social Welfare, the National AIDS Secretariat and the United Nations Development Programme for safekeeping and future analysis.

4. RESULTS

4.1 Background of Respondents

4.1.1 Number of Respondents

2,352 of the 2,400 people targeted (98%) responded to the questionnaire. Just over half (51%) were youths between 13-24 years of age and 49% were adults over 25, with males and females equally represented.

4.1.2 Ethnic Composition

Respondents reflected the national ethnic balance: Mandinka (35%); Wolof (19%); Jola (15%); Fula (11%); Sarahuleh (8%); Serrer (6%); and others (6%).

4.1.3 Marital Status

Just over half of the total sample population (52%) were single; 44% were married; 3% were divorced; and 1% (all females) were widowed.

Amongst youth, 82% were single (91% of males; and 72% of females). Amongst adults 25 years and above, 23% were single (32% of males and 12% of females)

The majority of married respondents were in monogamous unions (61%), more so for youth (77%) compared with adults (58%). Those in polygamous marriages constituted 39%, less so for youth (24%) compared with adults (42%). No significant gender differences were observed in the type of marriage.

A general trend towards monogamous marriages was noted by the study.

4.1.4 Religion

Almost all respondents (96%) were of the Islamic faith, reflecting national composition – age and sex notwithstanding, with Protestants and Catholics constituting 3% and 1%, respectively.

4.1.5 Residence

71% of respondents lived in rural areas (71% of youths and 70% of adults) and 29% lived in urban settings (28% of youths and 30% of adults).

4.1.6 Educational Status

Education in The Gambia may be broadly categorised into two forms: western oriented; and Islamic Madrassa Arabic schools. The form of education received by youth surveyed is summarised in Table 2. Overall, 62% of youth were in or had received some western education and 12% had attended Madrassa school, but more than a quarter (27%) had received no formal education. The table also reflects a gender imbalance, with higher proportions of males in all educated categories.

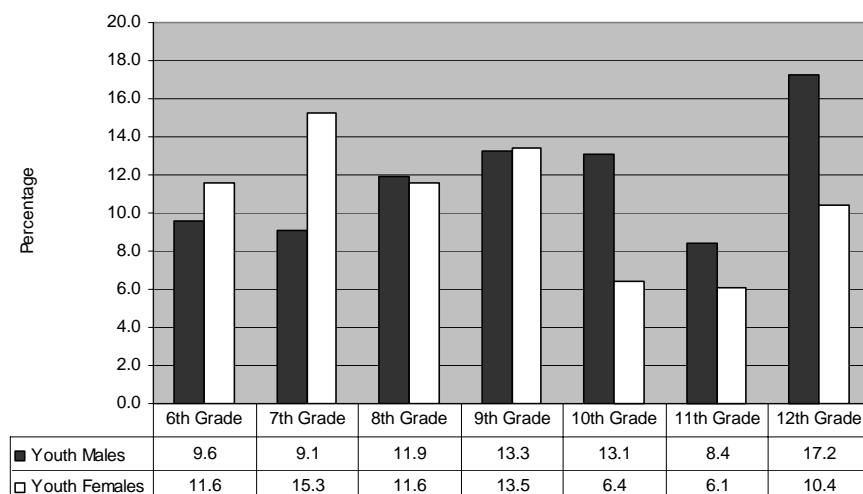
Table 2: Educational Status of Youth

Educational Status	Youth		Total
	Male	Female	
Currently in school (western education)	39%	30%	35%
Out of school (with some western education)	30%	23%	27%
Currently in Madrassa school (no western education)	6%	5%	6%
Out of Madrassa school (no western education)	8%	5%	6%
Never been exposed to any type of education	18%	37%	27%

Amongst adult respondents, 46% (52% of males and 40% of females) had had some form of western education, while 54% (48% of males and 52% of females) had had no formal education.

Female students tend to drop-out of school at an earlier stage than males, as indicated in Figure 1, which combines current grades of youth in school and highest grades attained by those out-of-school, and shows that the 7th Grade is the highest level achieved by most girls, compared with 12th Grade by most males.

Figure 1: Educational Grades Attained by Youth



4.1.7 Occupation

30% of respondents were farmers (28% of males and 31% of females); 14% were engaged in petty trading and shop keeping (17% of males and 12% of females); 12% were civil servants (17% of males and 8% of females); 10% were housewives; and 15% were unemployed (13% of males and 17% of females).

In education and economic pursuits, therefore, females are under represented, reflecting further the male dominated society, as mentioned previously and discussed in the next section.

4.2 Cultural and Religious Factors and HIV/AIDS

The nature of Gambian society is one in which cultural dictats and religious injunctions intertwine and reinforce each other, so that it is often difficult to distinguish their respective influences on attitudes and behaviour, particularly with regard to gender relations.

4.2.1 Patriarchal Structures

All focus groups participants, with the exception of Christians, held strong views on the subordinate position of women, with men having overall responsibility for decision-making, as reflected in the following statements:

“There is nothing that a wife should do without the consent of her husband. It is against religion and it is not accepted by our culture” (Madingo male – Kiang Jali, LRD).

“From the Islamic point of view, the man must lead the woman” (Female religious leader).

“The Holy Quran says a woman is made from a man’s rib, so they can never be equal” (Illiterate male adult – GBA).

“If even women are given positions they should always be behind men, not lead or be at the top. A man should always be above her” (Male Army Officer – Farafenni Army Barracks, NBD).

And in a more subtle way: *“Women should listen to their husbands, likewise husbands should consult their wives”* (Educated Christian male – GBA).

This range of views is indicative of society’s general stance on gender relations, as reviewed earlier, endorsed by both Islamic teachings and culture.

4.2.2 Inheritance Rights

The patriarchal outlook is reflected in inheritance rights, which allocate a greater proportion of assets to males than females. These rights are based on Islamic injunction, buttressed by cultural preference for males.

“Inheritance rights are very good. It is stated in the Holy Quran by God the Almighty that men should have two parts of any sharing while women should have one, because men and women are never equal” (Male traditional healer – GBA).

While males were emphatic on inheritance rights, factors such as age, education and gender appeared to be altering gradually the above held positions. Some focus groups, of youth in particular, raised doubts about the fairness of inheritance rights and were undecided on the issue. In expression of this doubt, one participant said:

“Women have limited inheritance rights and since it is traditional it is acceptable, but not fair” (Female health worker – LRD).

To an adolescent participant in a focus group of out-of-school youth:

“For property inheritance, extended family members sometimes secure the property left behind by the deceased for themselves, leaving the widow and her children to suffer” (18 year old male adolescent – NBD).

Some professional groups also held strong views against inheritance rights:

“Inheritance rights are unfair. Although more shares are given to men to enable them to take care of their sisters and wives according to the Quran, the men do not always fulfil this” (Female teacher – NBD).

“When husbands die, sharing should be done equally among the males and females” (Female police officer – GBA).

Married women have also begun to question inheritance rights.

“Women should inherit same share as men and not less as our culture states; because women are helpless, therefore, equal or more shares should be given to them” (Wollof female – Bundung, GBA).

And echoed by participants in the female in-school youth focus group:

“Females should have equal proportion with males in inheritance” (Young female – GBA).

Overall, no consensus emerged on the issue of inheritance rights.

4.2.3 Female Circumcision

The issue of female circumcision evoked much more discourse than any other subject, indicative of widespread controversy and contradictory interpretations related to this subject, reflected in the following statements:

“As for circumcision, Sharia orders men to be circumcised, but as for women it is not obligatory” (Muslim male religious leader – Farafenni, NBD).

Both in-school female adolescents in Banjul, GBA, and out-of-school female adolescents in Barra, NBD, expressed strong opposition to female circumcision and stressed that it was not obligatory under Islam.

To the former: *“Circumcision, gum beating, scarification and tattooing are all uncalled for ... The unsterilised instruments used from one person to another could lead to the spread of infection, including HIV/AIDS”*.

While to the latter group in predominantly village based Serrer and Wollof communities, there was general agreement that:

“FGM is not practised in this community. It is the Mandinka who do it and they are in the minority here. The affected girls experience a painful process and have difficulties in childbirth” (23 year-old young female rural based, Serrer participant – NBD).

However, at Basse, URD, where “notta” or “nottagol” (=infibulation - sealing of the vagina) is practised, Muslim males maintained that:

“Female circumcision was “sunnah” and should, therefore, be practised by all Muslim women” (Muslim male religious leader – Basse, URD).

“If a female is circumcised, she gains respect in society. Although much blood is lost during the process, and also there is difficulty during delivery, we must do it since Islam supports it” (Female college student – WD).

“Circumcision and the ceremony are good and belong to our culture. It is when they teach the young: how to behave; how to speak; when to speak; where to speak; and to know what is good, or bad. We inherited circumcision from our ancestors and it is part of Islam and should not be left behind” (Mandingo market woman).

“Female circumcision is very good and important, and is in line with Islam. If you are not circumcised you are not accepted in our community” (Sarahuleh female – Sabi village, URD).

“Our traditional practice of “nottagol” (=infibulation – sealing of the vagina) is to protect virginity, because when a girl gets married and is found not to be virgin there is shame for her family” (Fula female – Wellingara Samba Tacko village, URD).

In a more qualified way: *“Circumcision is tradition and Islam has accepted it. It cannot be abandoned easily. The safe way is to use a different blade for each person and using gloves during the cutting. These will prevent the spread of HIV/AIDS”* (Out of school male youth).

To another youth: *“Female circumcision is too traditional and not appreciated – it should be modernised. The practice is harmful, though it is said to reduce the sexual desire of women, which should be controlled”* (Male out-of-school youth – Kafuta WD).

No consensus was reached in group discussions about FGM, particularly as to whether it was Islamic, or culturally based. On balance, more participants were in favour of the practice than not, irrespective of gender and literacy, and a general preference for the use of sterile instruments was expressed to avoid the spread of HIV/AIDS.

4.2.4 Widow Inheritance

Most focus groups, particularly the educated male participants including armed forces personnel, referred to widow inheritance as a traditional practice, which had both positive and negative implications.

“This is not Islam, it is culture” (Serrer male – NBD).

Those who considered the practice ideal and should be retained argued that: *“Wife/widow inheritance is to secure the deceased’s wife, property and family and protect the wider family bond and kinship”* (Mandingo female – Bakau).

Others, however argued that: *“Wife/widow inheritance is a cultural and Islamic duty, which cannot be abandoned. This is done for the security and well-being of the children and the respect that the widow has for the family of her late husband”* (Wolof male – Tallinding Buffer Zone, GBA).

Female groups, in particular, were uncomfortable about the practice because of the risk of an infected, inherited widow spreading HIV/AIDS to her new spouse and felt that the widow should be offered a choice.

“Wife/widow inheritance is not good now because of HIV/AIDS. Without testing, no one knows the cause of the husband’s death and if you inherit without knowing you could be inheriting fire!” (Illiterate adult female – Latrikunda market woman).

“Wife/widow inheritance should not happen. If it cannot be stopped, then people should be allowed to test for HIV/AIDS before marriage because you never know what killed the husband!” (Urban based illiterate male – GBA).

“Wife/widow inheritance should be revisited, because you never know what killed the man or woman. Before inheriting a spouse, the husband and all the wives should be tested for HIV/AIDS.” (Married woman – GBA).

In general, amongst ethnic groups, the Wolof and Mandinka were relatively more emphatic on the retention of widow inheritance, whilst demographic and social groups feared the implications of the practice on the spread of HIV/AIDS. Again, participants were not sure whether the practice was based on religious, or cultural expectations.

4.2.5 Access to Strategic Resources and Health Services

There was general agreement amongst focus groups that women should not be allowed access to credit, land and health/family planning services, without the consent of husband/guardian or relatives-in-law because such behaviour would be un-Islamic and against cultural norms, which might lead to divorce.

From the male perspective: *“No wife should access credit, or family planning without the husband’s consent. Otherwise, she could bring disaster to the family. Our religion and culture do not allow this”* (Adult male – WD).

And from the female point of view: *“It is the man who brought you to the compound, so whatever you do, you should seek his permission first. Also, if he says no to family planning, for instance, accept the situation as it is”* (Married woman – NBD).

4.2.6 Festivals, Ceremonies and Lumo

Many people are attracted to social events, including traditional ceremonies, initiation rites, weddings, wrestling, home-coming events and lumo (market days), some of which last for days. Most focus groups, especially male groups, considered such festivities to be necessary cultural components of ethnic/social identity, which reinforced relationships, kinship bonds and promoted social cohesion, as reflected in following remark:

“These feasts are both Islamic and cultural. They bring individuals, groups and villages together – creating and cementing family bonds and new relationships. They are our culture and should not be abandoned” (In-school 21+ male youth, GBA).

To Jola males: *“During festivals, you always get presents like money, rice, oil. Such events foster closer relationship and understanding between individuals and villages. It is the time for fun, enjoyment and remembering your culture”* (Adult Jola male – Jinoie).

While appreciating the positive output of village ceremonies, a few groups, however, pointed to various negative aspects of these festivals and lumo market days, which

provide opportunities for sexual liaison. This came out vividly during the discussions of Trained Birth Attendants (TBA), expressed in this way:

Members of the armed forces complained that: *“The manner in which these ceremonies take place makes it easy for people to engage in indecent behaviours”* (Army Officer).

Male and female police officers stated that: *“Initiation rites and other ceremonies bring high levels of intercourse among youths, married and unmarried men/women. People do what they like – sugar daddies follow young girls, much sexual liaison occurs and infections spread like fire!”* (Police Officer – Banjul).

These views were echoed in ethnic group discussions: *“During these ceremonies boys and girls, men and women have opportunities to engage in sexual intercourse and expose themselves to STIs”* (Male adult).

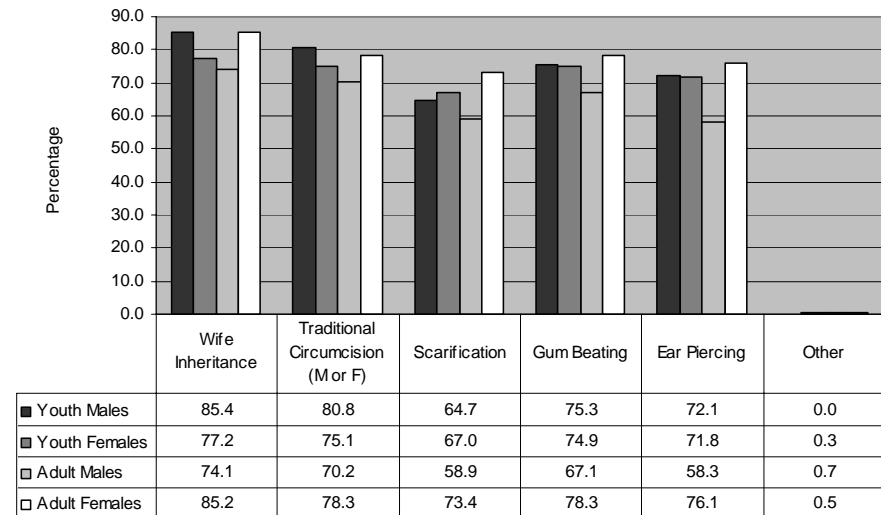
“A lot of things happen during these occasions, as both men and women mix together, and many temporary ghettos are formed where much of sexual acts take place and nobody minds whoever you have sex with. Normally, condoms are not used, as most women don’t allow us to use them” (Male adult).

Others, however, lamented that: *“Organising these ceremonies involve huge costs and at the end of the day we the women even end up with arrears, because sometimes we make loans during the ceremonies. When these cannot be paid, it can force us to follow men for money”* (Female cross-boarder trader).

4.2.7 Other Cultural Practices

Age, ethnicity, education and gender factors notwithstanding, focus group participants were divided in their opinions about the maintenance of traditional cultural practices, such as gum beating, ear piercing, scarification and tattooing. Some wanted these practices to continue, whilst others thought that they contributed to the spread of HIV/AIDS and should be discontinued. The great majority of respondents to the sample questionnaire recognised wife inheritance, traditional circumcision, gum beating, ear piercing and scarification to be risk factors in disease transmission, as indicted in Figure 2.

Figure 2: Practices Perceived to Contribute to the Spread of HIV/AIDS



4.2.8 Female Education

Contrary to expectations and the general subordinate role of women in Gambian society, the concept of promoting female education received widespread approval in all FGDs, except amongst the Sarahuleh, as reflected in the following quotations:

“Education is for all, as stated in the Holy Quran by Allah the Almighty and it is for both sexes. Female education is important – amongst other things, it will help the women take good care of their children and prepare females for effective performance of their roles in life” (A female Muslim religious leader, GBA).

Discussions with the Serrer ethnic group indicated that they had moved ahead on female education. As one participant proudly remarked:

“We believe that if you teach or educate the girl, you educate the nation. In our community, both boys and girls have equal access to education. Here, you see men

taking their children to attend infant welfare clinics, which is usually considered a female role” (Serrer male – Ndofan village, NBW).

On a rather more cautious note, the single adult male focus group in Borehole, GBA, conceded support for female education, but with the proviso that:

“Although equal access to education should be granted to males and females, as they are both human beings, females should read little (not be highly educated) in order to respect their husbands, because if a woman is well educated she would be disrespectful, or look down on her husband”

Only the Sarahuleh ethnic focus groups did not indicate positive support for female education: *“Woman should take care of the family and be good mothers”* (Sarahuleh woman).

These indications point to a cultural shift in attitudes about traditional practices. Fear of contracting HIV/AIDS, and the cumulative impacts of information technology, tourism, modernisation, globalisation and exposure to other cultures are having profound consequences and changing established patterns of behaviour.

4.3 Socio-Medical Factors and HIV/AIDS

4.3.1 Awareness of HIV/AIDS and Prevention Measures

From the qualitative data, it was found that participants in the FGDs held divergent views on HIV/AIDS. While some scapegoated outsiders by blaming them for the spread of HIV/AIDS; others believed HIV/AIDS was a curse from God; and a few doubted its existence in The Gambia.

“Our girls want to be westernised too much. Putting on short skirts or tight trousers with transparent blouses – all to attract men. They follow tourists to the beach and hotel rooms to engage in sexual relations. Most of the tourists come here with HIV and spread it through these girls” (Muslim female participants, GBA).

To the male Muslim focus groups, the consensus view was that: *“God brought down HIV/AIDS to tell the people that what they are doing is not good. This is why there is still no medicine to cure the disease”* (Muslim male – Farafenni, NBD).

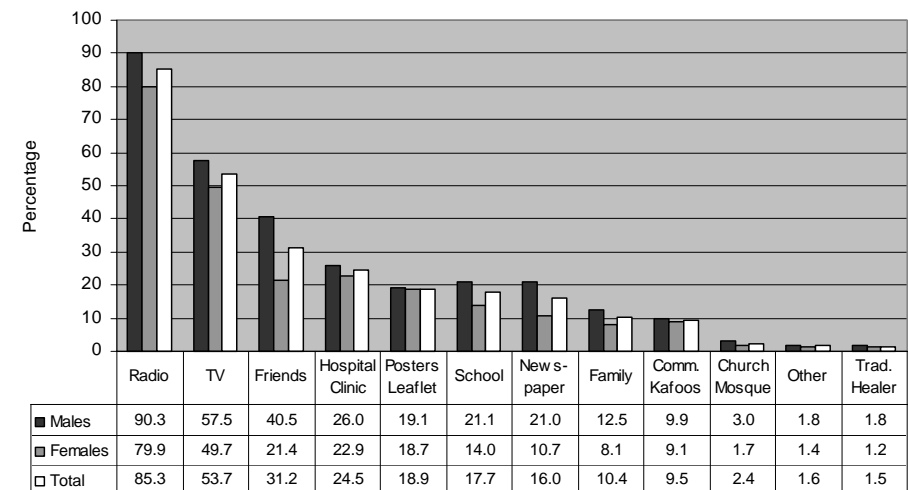
While some armed forces officers were sceptical about the existence of HIV/AIDS: *“People living with HIV/AIDS in The Gambia cannot be Gambians. Some of them have been paid to say that they are PLWHA”* (Military officer – Bakau, GBA).

Similarly, for some high school youth: *“AIDS is not in The Gambia. It is just a lab-make-up or sex propaganda of the West to control population growth in Africa”* (18-year-old college student – Farafenni).

However, the quantitative data showed that respondents’ awareness level to HIV/AIDS was quite high. Almost all (95%) respondents had heard of the disease, gender and age notwithstanding. The majority (83%) considered HIV/AIDS to be the most serious global health problem, followed by malaria (13%), indicated mainly by the youth. Only 1% of the adult population considered malaria to be a global threat. The majority of respondents were familiar with the signs/symptoms of HIV/AIDS.

81% of all respondents were aware that there was no cure for HIV/AIDS. As indicated in Figure 3, information about HIV/AIDS was obtained mainly from the radio (85%), followed by the television (54%), friends (31%), hospital/clinic (25%), posters/leaflets (19%) and school (18%).

Figure 3: Sources of Information about HIV/AIDS



Interestingly, among the youth, only 29% indicated that they had obtained information on HIV/AIDS from the school, and among all groups only 9.5% received information on HIV/AIDS from the community “Kafoos.” Mosques and churches

hardly featured in these responses, yet they provide moral ideologies to guide behaviour. Overall, 91% of respondents confirmed that they understood the information on HIV/AIDS from these sources.

On the most appropriate sources of information on HIV/AIDS, 67% of adults and 42% of youth indicated radio, followed by television, which was preferred by youth (32%) and adults (22%). There were no significant gender differences.

Radio was listened to every day by half the respondents, mostly adults, and a further 28% did so on most days. Only 15% listened to radio less often, whilst 7% had no access to radio.

Surprisingly, only 3% of youth and 2% of adults considered hospitals or clinics to be appropriate for information dissemination on HIV/AIDS, while less than 1% of both groups indicated newspapers, posters or leaflets, as appropriate. This may reflect the high rate of illiteracy and poor reading culture in the country.

Only 4% of youth indicated school as an appropriate source of information on HIV/AIDS. Mosques and church were not mentioned at all.

In general, respondents were aware of HIV/AIDS prevention and advanced the widely propagated “ABC” preventive measures, as illustrated in their responses to the three most effective preventive measures against HIV/AIDS. Both youths and adults in equal proportion (78%) ranked abstinence first, followed by “being faithful to one’s regular partner(s)” as indicated by 75% of young people and 76% of adults.

The “use of condoms” was considered the third most effective optional measure for preventing HIV/AIDS by 74% of youth and 67% of adults. Gender and age made no difference to these responses, as reflected in Figure 4, Figure 5 and Figure 6.

Figure 4: Most Effective Way of Preventing HIV/AIDS

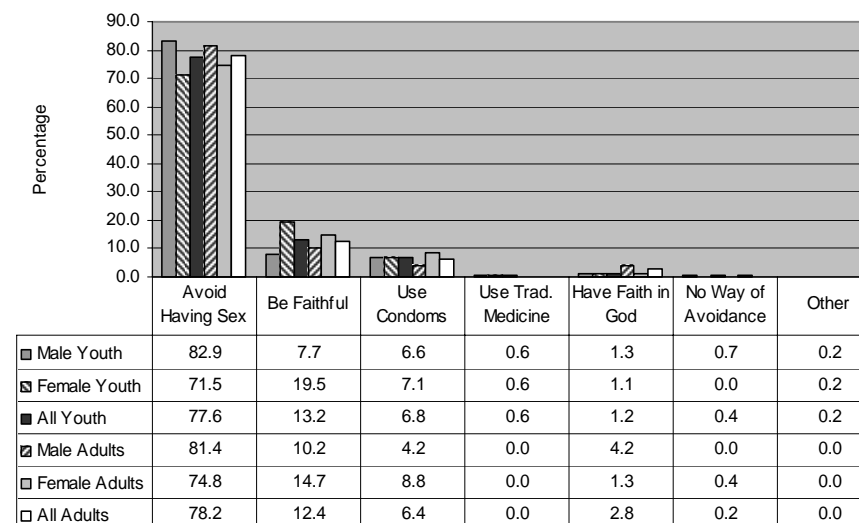


Figure 5: Second Most Effective Way of Preventing HIV/AIDS

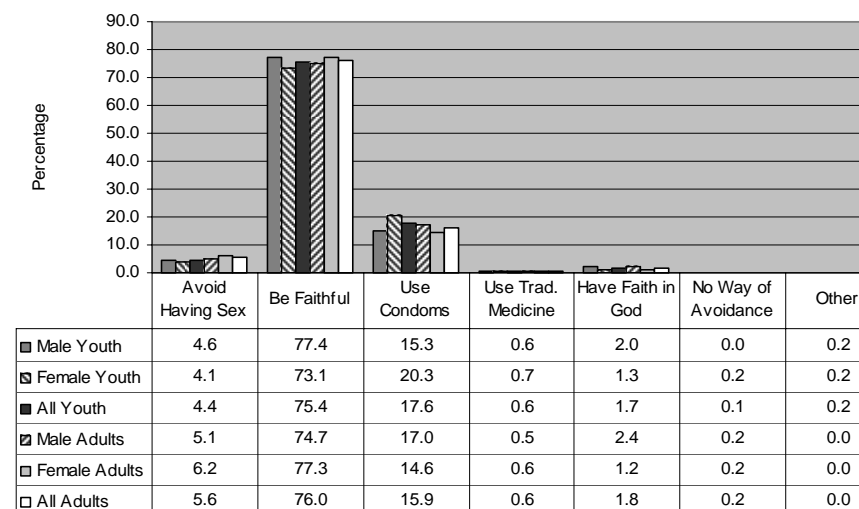
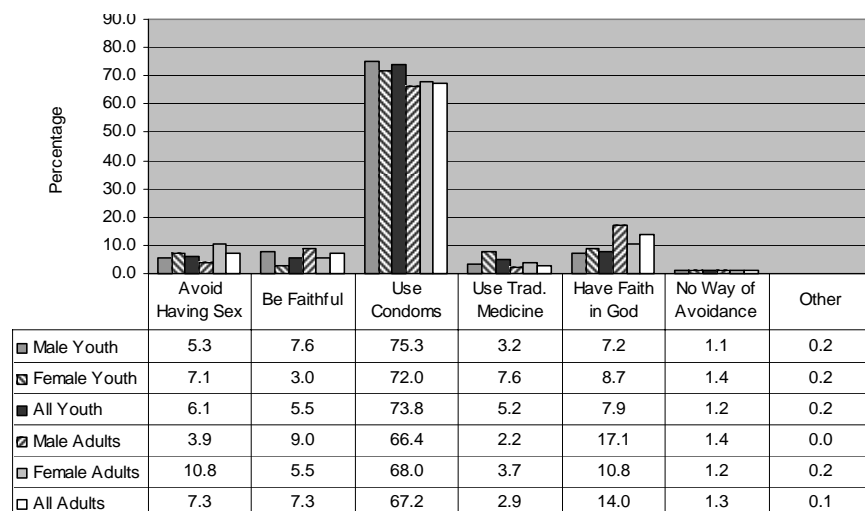


Figure 6: Third Most Effective Way of Preventing HIV/AIDS



4.3.2 Knowledge of Modes of HIV/AIDS Transmission

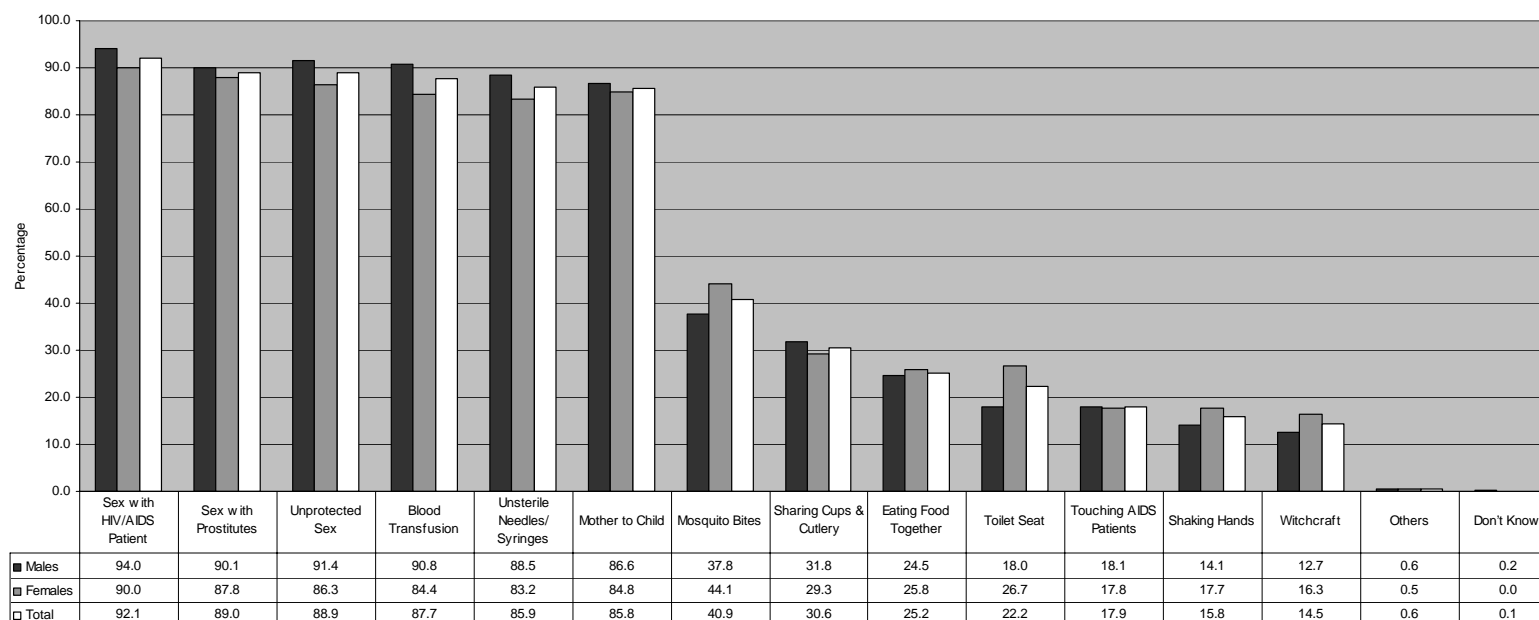
When asked to identify from 13 optional modes of HIV/AIDS transmission, respondents chose in descending frequency: “sex with HIV/AIDS patient”; “sex with prostitutes”; “unprotected sex”; “transfusion of HIV/AIDS infected blood”; “unsterile needles/syringes”; and “mother to child transmission”; as shown in Figure 7.

When probed further, “sex with foreigners,” “same sex practices” and “promiscuous way of living” were additionally selected as ways people could contract HIV/AIDS.

Knowledge levels were limited and pointed to various misconceptions that should be targeted; particularly amongst some youth and armed forces personnel who thought that anyone could have HIV/AIDS, irrespective of behaviour and lifestyle.

Nevertheless, significantly fewer youths (39%) than adults (64%) thought that anyone could have HIV/AIDS ($P < 0.005$), irrespective of behaviour and lifestyle, indicating that youth were better informed in this regard.

Figure 7: Perceived Modes of HIV/AIDS Transmission



4.3.3 Reproductive and Sexual Health

4.3.3.1 Awareness of Effective RH Preventive Method

Given eight listed options, the three most effective preventive measures against pregnancy chosen by respondents were in descending order: “use of condom;” “use of other modern family planning methods;” and “abstinence.” These responses are indicative of a high level of awareness of modern family planning methods as publicised by the IEC services.

In the FGDs, however, even though these modern methods were confirmed, participants also mentioned various other methods, including:

Relocating nursing mothers to parents home for a while;

Use of herbs and “nana” leaves;

Women praying behind the Imam during the morning prayers;

Turning shoes upside-down under the bed during intercourse;

Anal sex on women;

Women urinating immediately after intercourse;

Drinking paracetamol minutes before intercourse.

4.3.3.2 Abortion

From the questionnaire responses, 31% and 22% of female youth and adults, respectively, had had a voluntary abortion. As confirmed by participants in the focus groups, these were usually carried out at private clinics or drug stores and sometimes with traditional healers. Indeed, 15% of adult female respondents acknowledged using traditional healers for abortion. The sterility, or otherwise, of the instruments used could not be determined, but the possibilities for infection and damage to the reproductive organs is a distinct possibility.

FGDs also indicated that self-medication was also applied for voluntary abortion, particularly by young females, including: drinking “blue” detergent with water; drinking Chinese green tea without sugar; drinking “ataya” herbs; extracts of neem tree leaves and gum; and consumption of drugs, such as aspirin (12 tablets at a go) paracetamol and seprin (6 tablets at a time).

These practices are health threatening and were strongly condemned by Traditional Birth Attendants and health workers, not only because of their side effects, but also on religious grounds. Further public health education is required to address these concerns.

4.3.3.3 Sexually Transmitted Diseases

Further indications of limited sexual health knowledge emerged with respect to prevention of STDs, as illustrated in various statements by focus group participants, including:

“STDs occur when a female sexual partner halts her breath during sex, but by tapping on the chest the breathing continues and no STD will occur” (17 year old adolescent in-school - Farafenni, NBD).

“Palm oil can treat STIs” (Customs officer - Farafenni check point, NBD).

4.3.3.4 Virility

Both sexes go to extraordinary lengths to increase their sexual performance, including: application of mentholatum on male genitalia and inside vagina wall to increase sensitivity; eating raw cassava; or drinking “nim” leaves for enhancement of male performance.

“Women in particular go to any extent to secure and maintain their husbands attention by insertion of substances such as ‘safal’ (herbal mixture) in the vagina in an attempt to obtain muscle tone, and tighten the vaginal wall” (A high- school male student).

Some of these substances may be carcinogenic, e.g. raw cassava, and or otherwise detrimental to health; and if tissues are damaged they are more susceptible to infection by STDs and HIV.

These practices are both of general reproductive health concern and relate to the spread of STI/STD – HIV/AIDS and should be addressed in an integrated manner.

4.3.4 Sexual Practices and Risky Behaviour

Although the limited reliability of self-reported sexual behaviour is well known, particularly amongst adolescents, over 54% of young people and 94% of adult respondents admitted to being sexually active. Overall, 74% of the study population

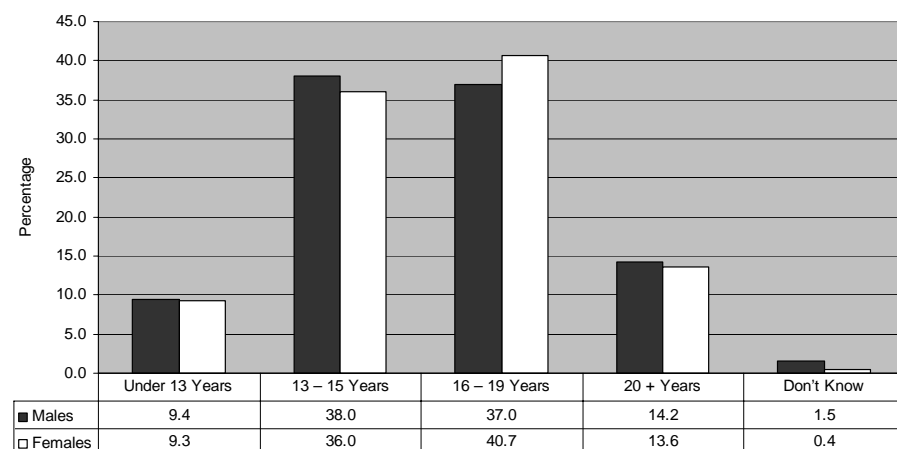
claimed to have had sexual intercourse, although this figure is likely to be an underestimate, as elsewhere in the questionnaire, 80% of youth admitted to having regular/sex partners.

4.3.5 Age at First Intercourse

The frequency distributions of age at first intercourse amongst youth and adults are shown in Figure 8 and Figure 9, respectively, and indicates a decrease in the average age of first sexual encounter, especially for males. 85% of all youth had had sexual intercourse by the age of 19, compared with 64% of adults.

Similar to some of the findings of the 2001 Adolescent Health Survey in The Gambia, almost 10% of youth in the study had experienced their first sexual intercourse before the age of 13, with no significant difference between the sexes, whilst only 5% of adult males and 8% of adult females had had similar experiences under 13.

Figure 8: Age at First Sexual Experience by Youth



As shown in Figure 10, the majority of all ethnic groups commenced sexual activity between 16-19 years of age, with the Sarahuleh, Jola and Mandinka predominating in this category. A small proportion of all groups had had their first sexual experience at less than 13, notably the Wollof.

Young rural females commence sexual activity at a significantly earlier age than their urban counterparts ($P < 0.0005$) and male youth, as shown in Figure 11.

Figure 9: Age at First Sexual Experience by Adults

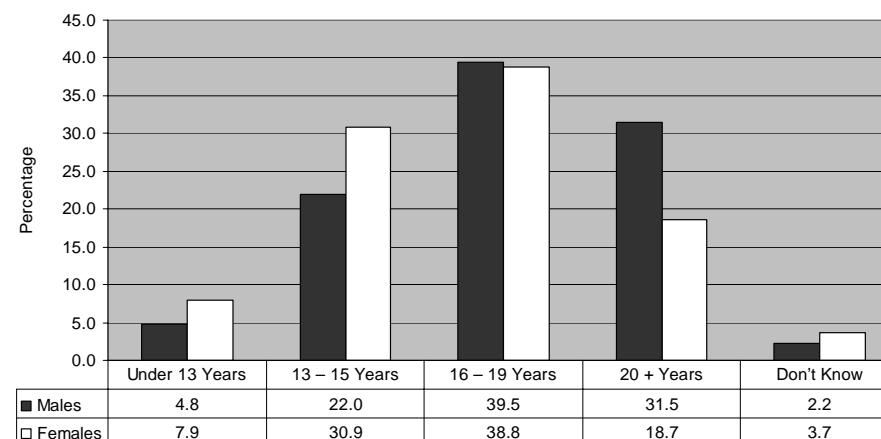


Figure 10: Age at First Sexual Experience by Ethnicity

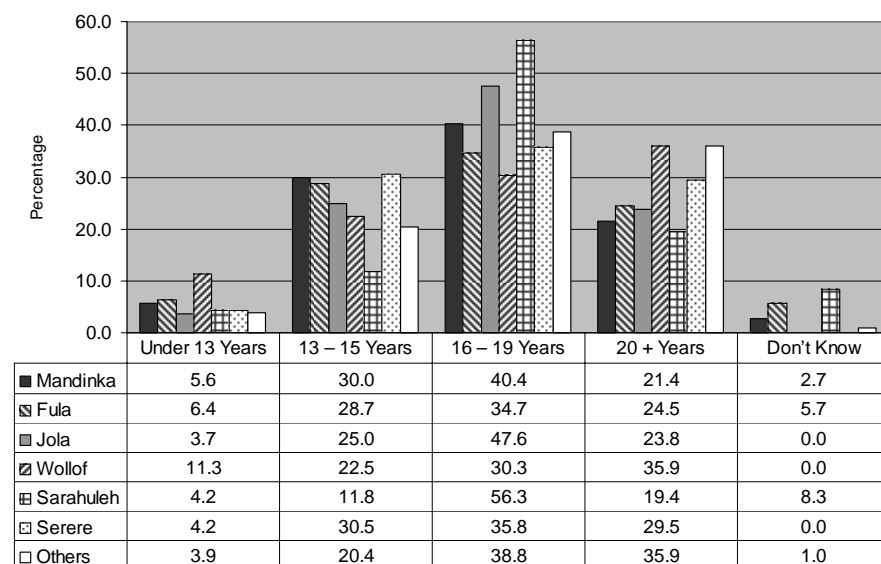
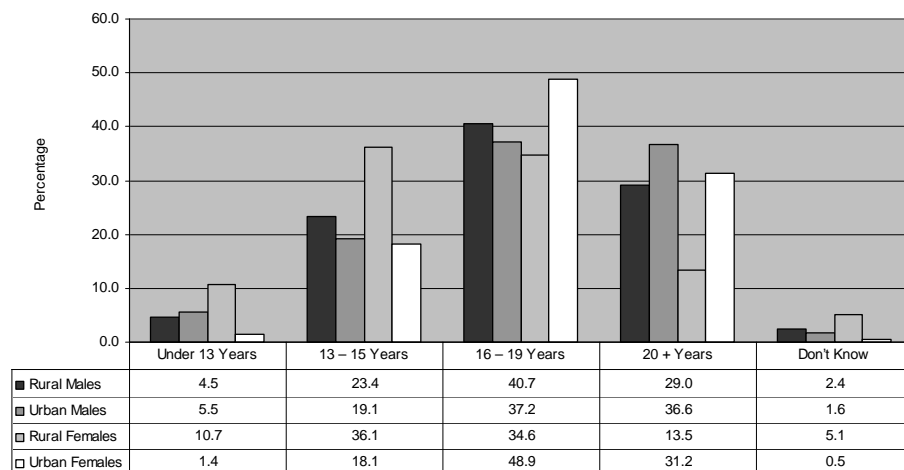
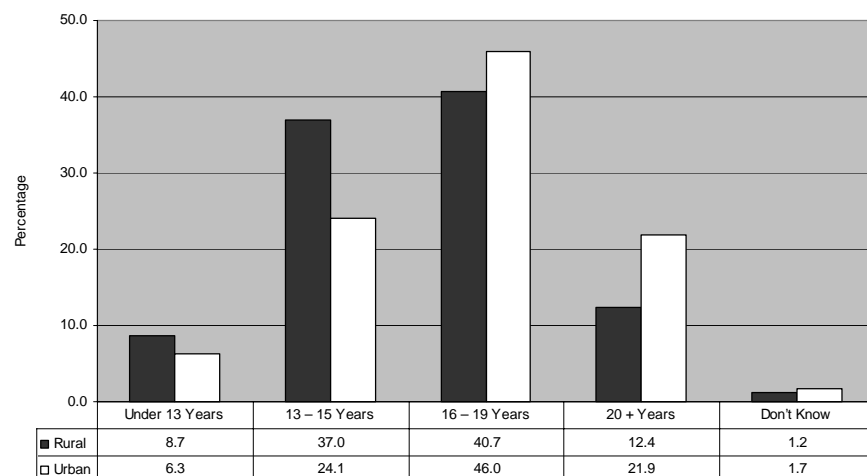


Figure 11: Age at First Sexual Experience of Rural and Urban Youth



First sexual encounters of unmarried young people tend to be at an earlier age in rural areas than in towns, as indicated in Figure 12.

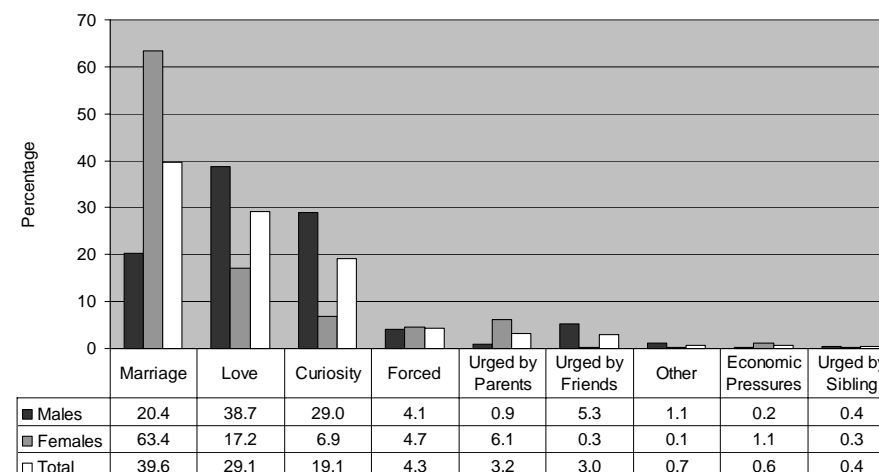
Figure 12: Age at First Sexual Experience of Unmarried Youth



4.3.6 Motivation for First Sexual Experience

Major differences between males and females are evident in the stated motivation for their first sexual encounters, as evident in Figure 13. Unlike the findings of a similar study in Mali (Konye, 2001), financial reward did not really feature as a reason for first sexual experience in The Gambia.

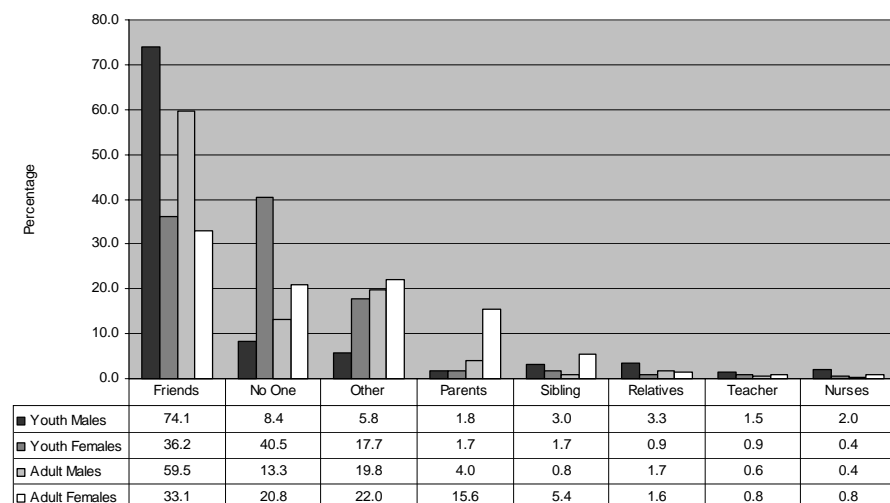
Figure 13: Motivation for First Sexual Experience



More than half the male youth (54%) gave “love” as the main reason for their first sexual experience, compared with 30% of female youth. Curiosity, “To know what it is like,” was the next most common response for just over a quarter of young males (26%), but only 9% of young females gave curiosity as a reason. Boys were, therefore, three times more likely to have sex out of curiosity than girls. Marriage was the main motivation for 51% of female youth, in marked contrast to only 6% of male youth.

In almost equal measure, adult males indicated curiosity (31%), marriage (30%) and love (27%) as motivating factors for first experience. For the great majority of adult females (69%), however, marriage was the foremost reason. Peer pressure and forced sex did not feature as much as expected: only 4% of young people and 3% of adults attributed their first encounter to these factors.

Figure 14: Discussion of Sexual Matters



Sexual experiences were widely discussed amongst young males Figure 14. In marked contrast and not surprisingly perhaps, given the issues relating to sexuality and the mores surrounding it in The Gambia, 41% of young girls did not discuss their experiences with anyone. It is important to recognise that this “bottling-up” of sexual experiences and potential problems may distort interpretations of reproductive and sexual health status and cause anxiety.

4.3.7 Casual Sexual Relationships

The great majority of respondents had had no casual sexual partners during the previous month, as indicated in Figure 15 and Figure 16. Nevertheless, the behaviour of a small proportion of the population, particularly young males, young females and adult males, with numerous casual partners, is a major cause for concern as far as the spread of STI/HIV/AIDS is concerned.

Figure 15: Frequency of Sexual Relations in Previous Three Months

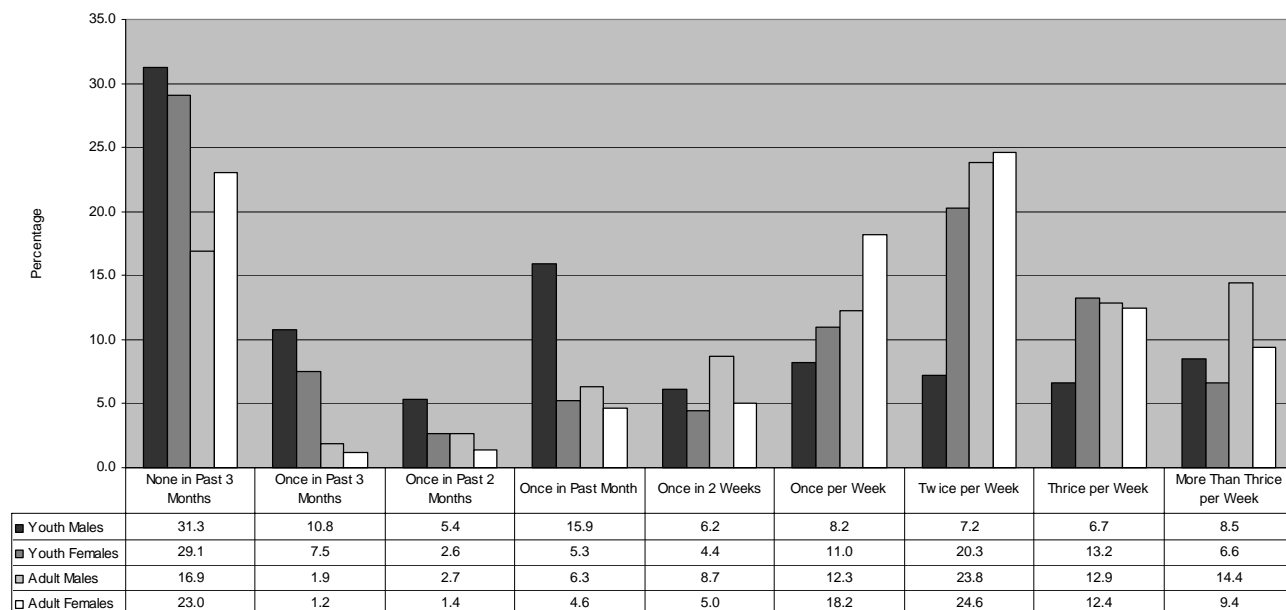
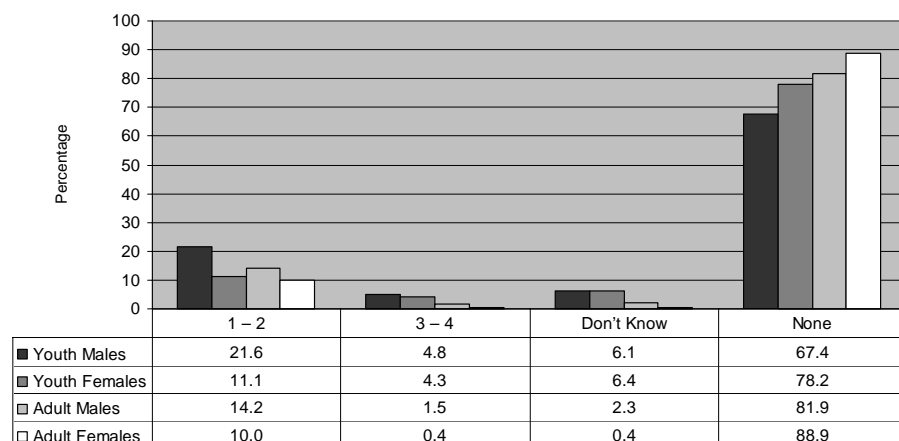


Figure 16: Number of Casual Partners in Previous Month

Of those who had travelled away from home during the previous month, two-thirds (66%) had had a casual sexual partner, with little variation between ethnic groups.

Not surprisingly, unmarried people were more likely to have casual sex than married individuals: 30% of all single respondents had had casual sex during the past month, compared with only 12% of married respondents.

Just over half (56%) of all unmarried respondents were sexually active, varying from 41% amongst the Sarahuleh to 61% amongst the Fula.

4.3.8 Extra-Marital Liaison

All focus groups expressed negative attitudes to pre-marital sex amongst the young. It was, however, the extent of extra-marital sex, particularly among married females, that was seen by all to be more problematic, both morally and health-wise in the spread of HIV/AIDS. More so, as those involved were considered to be clandestine sex workers, who, being in marital union, were generally considered safe for casual sex.

“Extra-marital affairs occur and are caused by greed, poverty and sexual dissatisfaction by either partner” (Male Adult – Western Division).

“Extra-marital liaisons are rampant during circumcision ceremonies and other festivals – one cannot avoid it due to temptation and sexually incompatible spouses.

They are unavoidable because either the woman does not get satisfaction from her husband, or the man does not get satisfaction from his wife, or wives. It happens too much during circumcision time and other festivals” (Male Adult – WD).

“Extra-marital affairs occur due to sexual dissatisfaction by women in polygamous homes, and HIV spreads as a result” (Female group – GBA).

“Forced marriages have made women engage in extra-marital affairs with the men they love and wanted to marry” (Civil servant – URD).

With reference to market days (lumo): *“People who attend festivals, ceremonies and lumo are more disposed to extra-marital affairs, because there is nobody to control them at these locations”* (Female – FG Participant, GBA).

While to the Serrer groups: *“Many women attending a programme, or lumo go from there to sleep with other men, having many casual partners. If you want to change them it is problem”* (Male adult – NBD).

The acknowledged extent of extra-marital liaison in virtually all groups was surprising, and indicated that the phenomenon was not uncommon.

4.3.9 Part-time Sex Work

Every focus group, regardless of age, sex, ethnicity and locality commented on part-time sex work:

“Part-time sex workers are our own sisters, married women and school girls” (Christian males – religious leader).

“Part-time sex workers are those married women who are not satisfied with what their husband provide for them and practice this profession from time to time to satisfy their needs” (Female Inter-Country Traders – Farafenni, NBD).

“Part-time sex workers are our sisters, and married women are most dangerous and are spreading HIV/AIDS. It is not easy for the public to identify them, but we know them” (Bumpsters Tourist Guides, GBA).

“Those in polygamous marriages whose husbands cannot make ends meet often have relationship with other men for economic reasons” (Female health workers – Some, LRD).

“Extra-marital affairs involve mainly women and they are the cause of this (HIV/AIDS) silent epidemic” (Female teacher – Kerewan).

“We know some of them. They are mostly married women and school girls” (Fula males – Nema Kunku GBA).

“Part-time sex workers are the worst, as they are our own wives in the house who do such acts in cities, villages and even on market days” (Jola male – Jinoie village).

“Part-time sex workers are married and unmarried women” (Sarahuleh females – Sabi, URD).

Pre-marital sex was also condemned: “Pre-marital sex is now rampant in our country with early pregnancies and baby dumping taking place. These practices spread HIV/AIDS. Also, sugar daddies shower money and gifts to influence women and young girls” (Mandingo male – Kanifing).

4.3.10 Commercial Sex Workers

Mixed views were expressed about commercial sex workers (CSW): “Sex workers are so engaged due to poverty, broken marriages and perhaps material minded people, but they help to reduce the rate of rape cases in our society. They should be re-habilitated” (A female high school student – WD).

“These women in the trade are rendering a social service and they will always have clients for their services. Otherwise, those in need will vigorously penetrate homes and who knows what might happen. Let us be positive to them. They may be motivated by money, but their roles are certainly very important” (Sailor).

There was general agreement amongst truck drivers that: “These women keep us company everywhere. Oh! Don’t worry; they are very safe to sleep with. We are also selective and the ones we deal with are not sick. So we are in safe hands” (Truck drivers spokesman).

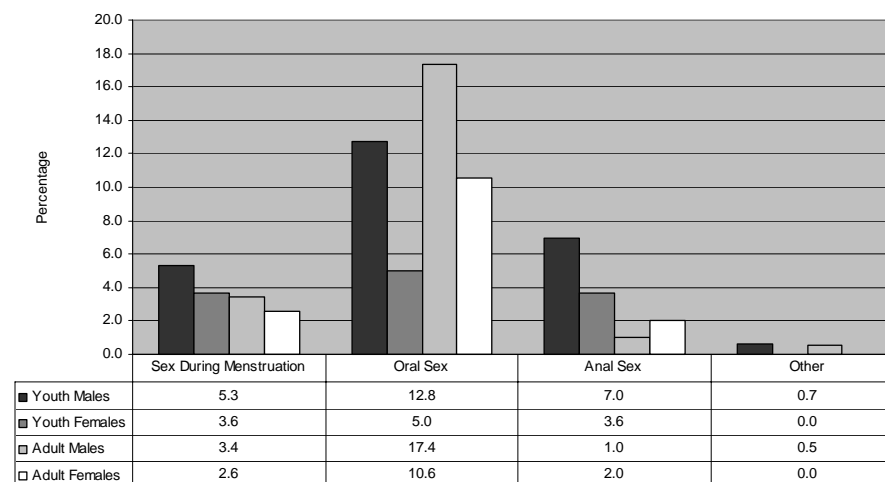
In general, however, CSWs were blamed for the spread of STI/HIV/AIDS, and evoked strong negative reactions in most focus groups, such as: “We have heard about prostitutes being given licenses and deplore the whole idea because it is against Sharia and un-Islamic. We hate to see CSWs and they will lose, both here and in the hereafter” (Islamic religious male participant – Basse, URD).

4.3.11 Forms of Sexual Behaviour

Responses to the questionnaire indicated the occurrence of various other forms of sexual behaviour in addition to vaginal sex, as indicted in Figure 17. A few single males in the Bundung area of GBA also mentioned anal sex with animals.

“Anal/oral sex, same sex relationships are on the increase gonorrhoea has crept in. We are referring them to the hospitals” (Pharmacist – participant GBA).

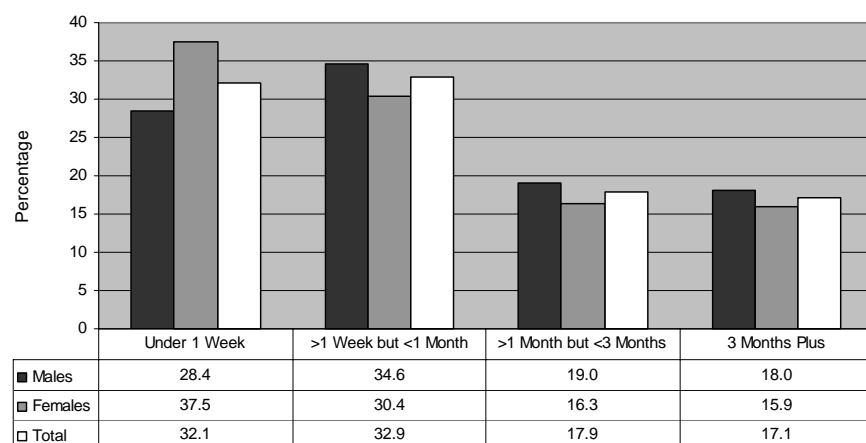
Figure 17: Different Forms of Sexual Behaviour



All focus groups condemned these practices and same sex relationships, as being un-Islamic and alien to the Gambian culture. The HIV transmission risks involved in these practices have yet to be appreciated. Suffice to mention that such practices facilitate the spread of STI/HIV/AIDS.

4.3.12 Travel Factor and HIV/AIDS

Over half (54%) of the study population had travelled away from home to other parts of the country, or beyond, during the previous year. Of these, approximately equal proportions had been away for less than a week (32%); between 1-4 weeks (33%); and more than a month (35%), as shown in Figure 18.

Figure 18: Duration of Journeys During Previous Year

The more time spent away from home, the greater the chances of pre- and extra-marital liaisons and the consequent increased risk of STI/HIV/AIDS transmission. Awareness of the travel factor in the spread of HIV/AIDS is reflected in the following statements:

“I sailed with cargo ships around West Africa and tripped to Europe, Asia and the Caribbean. At least I have girl friends in the countries I travel to. As sailors, wherever we anchored, off we went to town for women. We do know the places, sometimes with guides to take us to them” (Sailor – portside, Banjul).

“We know married people who, in the absence of their spouses at lumo (market days) or whilst travelling out of the country, engage in other man/woman relationships” (In-school male adolescent – Farafenni, NBD).

The practice of posting civil servants away from their usual place of abode and “trekking” on periodic short-term, outpost duties also presents opportunities for extra-marital liaison and other casual relationships.

“Some (civil servants) have other sex partners in the other towns where they go to work” (19 year old female out-of-school – Bundung, GBA).

“Women who go on business and trading trips are not the least reliable, they need money and can do anything to get what they need” (Illiterate 22 year old male – Sibanor).

There was general agreement amongst Islamic religious groups that: *“Travellers brought the HIV/AIDS to The Gambia, especially those who go to countries like Congo, Ivory Coast, Cameroon and East Africa to trade and come back with the disease”* (Muslim male – Basse, URD).

4.3.13 Sex Education

Opinions were divided on sex education and where it should take place.

“Parents should teach their young ones these things before they reach puberty. If this is done, there will be no problem within our communities. These young ones are going to be parents tomorrow” (Out of school female adolescent 16 plus – Basse, URD).

In agreement with the above views, Christian focus groups insisted that: *“Parents should be the first to teach children sex education at home. Teachers are also key players in doing their job to teach sex education at school”* (Female Christian mother).

“Fathers should talk to their sons and mothers discuss with their daughters on sex education, so that the children will know what to do and what not to do” (Father – Ebo Town, GBA).

An extreme view was expressed by Jola males: *“We will not discuss sexual matters with our children, or allow schools to discuss such things with our children. Rather, every responsible parent should show good morals and train the children to be good future parents”* (Jola father – Jinoie Village).

From the focus group of Serrer males: *“Sex education at home, school, T.V. or radio is not good because they make them practice sex before marriage. But if they do not know it they will not do it. It should be left a secret until marriage”* (Serrer male – Ndoan Village, NBW).

Despite the strong Islamic outlook in the Upper River Division, the focus groups of Muslim mothers from the Sarahuleh ethnic group said: *“As parents, we sometimes educate our children on sexual matters”* (Muslim Sarahuleh mother – Sabi Village, URD).

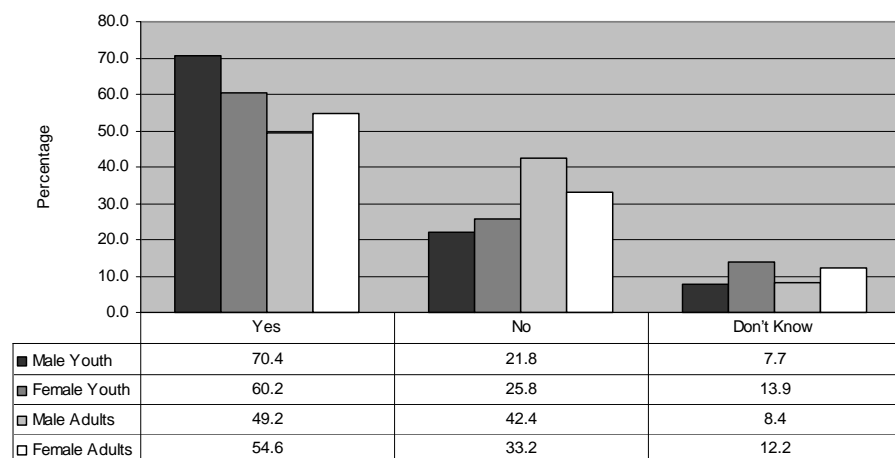
With the exception of the Jola, who were strongly opposed to sex education for young people, the need in principle for sex education was generally accepted, although there was no general consensus about where it should take place.

4.4 Condom Use

More than three-quarters (78%) of all respondents knew about condoms. 59% of males had used them, but less than half (47%) were currently using them at the time of the study.

Youth in general (67%) were more willing to use condoms than adults (51%), and adult females (55%) were more willing for males to use condoms than adult males were themselves (49%), as reflected in Figure 19.

Figure 19: Willingness to Use or Urge Partner to Use Condoms

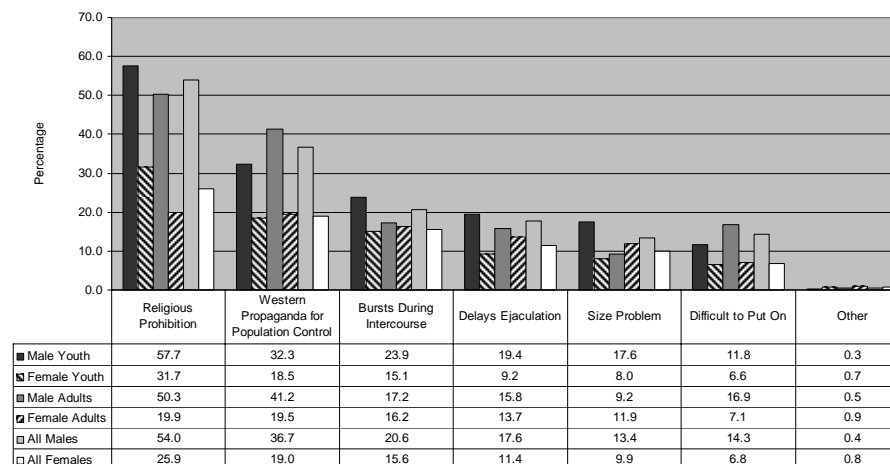


Irrespective of age and gender factors, the majority of respondents believed that condoms prevented pregnancy and STI/HIV/AIDS, but many also thought that intercourse was unsatisfactory using condoms and that they should be confined for use with casual sex partners.

Various others views are summarised in Figure 20, which reflects a marked dichotomy between the sexes in various respects: 54% of males but only 26% of females thought that it was against the tenets of Islam to use condoms; 37% of males but only 19% of females believed that condoms were a form western propaganda for

population control. Other minority views included that condoms burst during intercourse, delayed ejaculation, were the wrong size and were difficult to put on.

Figure 20: Beliefs About Condom Use



Focus group discussions on condom use yielded a range of comments and observations, including:

“Condoms increase promiscuity and should be condemned” (Fula male spokesman).

“We do not support the idea of condom use because when we use them, women are never satisfied. In addition, a man who uses condoms will not function properly in later years” (Illiterate 26+ male – Serekunda car park).

Pharmacists and sex workers said that they often had to explain how condoms should be used.

These views provide an insight on the relatively low rate of condom usage and the spread of STI/HIV/AIDS in The Gambia, and point to subject areas and public awareness issues to be targeted by IEC services.

4.5 Voluntary Counselling/Testing

The great majority of respondents (73% of youth and 70% of adults) expressed their willingness to undergo voluntary HIV testing. Most (71%) also indicated that they would prefer their girl or boy friends to be tested before contemplating serious relationship, or marriage.

Females, however, appeared to be generally less willing to submit to HIV testing than males: 68% of female youth and 63% female adults, as opposed to 78% of male youth and 77% of male adults. This difference in attitude warrants further investigation in view of mother to child transmission of HIV/AIDS.

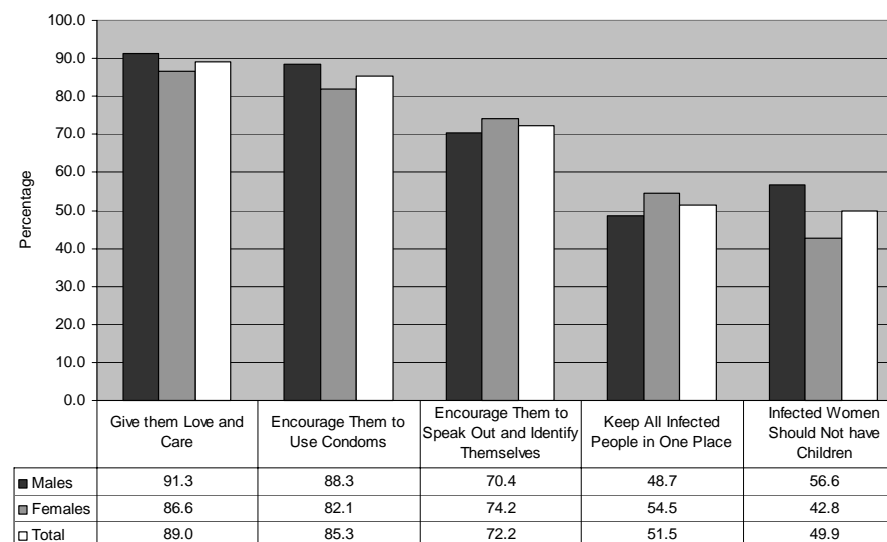
4.6 People Living With HIV/AIDS

Although 94% of respondents had heard about the disease, only 15% acknowledged that they knew people living with the HIV/AIDS (PLWHA), as neighbours (42%), relatives (20%), friends (12%), friend's relatives (7%) or other acquaintances (18%).

However, in all focus group discussions, participants were generally unwilling to admit knowing anyone with HIV/AIDS. This anomaly may be attributed to group dynamics and the stigma attached to HIV/AIDS, which compelled participants to deny such knowledge in the presence of other group members. This reluctance to discuss such a serious subject in public needs to be addressed as a matter of urgency.

Nevertheless, people were more forthcoming in answering questionnaires. In considering what society should do with PLWHA, the great majority of respondents indicated that they should be given love and care (89%); encouraged to use condoms (85%); and encouraged to speak out and identify themselves (72%), as indicated in Figure 21. Just over half (52%) indicated that PLWHA should be kept in one place, and 50% thought that infected women should not have children.

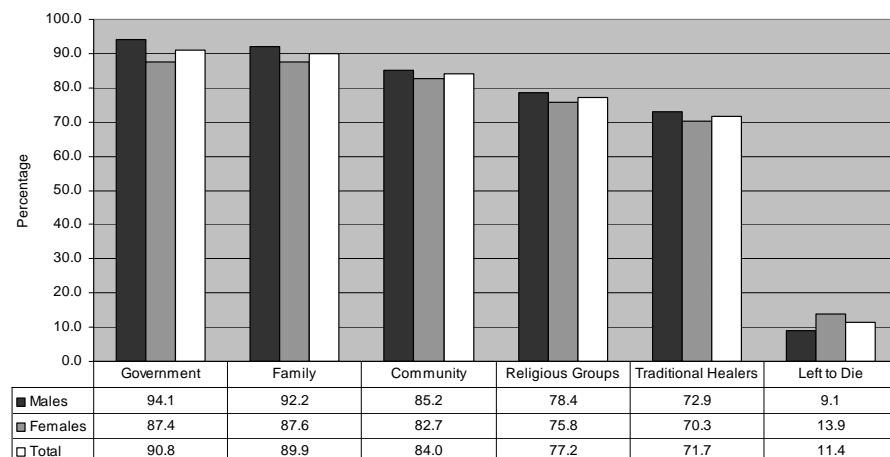
Figure 21: What Should Society Do with People Living with HIV/AIDS?



4.6.1 Care of People Living with HIV/AIDS

The great majority of respondents considered that government (91%), family (90%), community (84%), religious groups (77%) and traditional healers (72%) should be involved in caring for PLWHA, as indicated in Figure 22. Only 11% of respondents believed that PLWHA should be left to die.

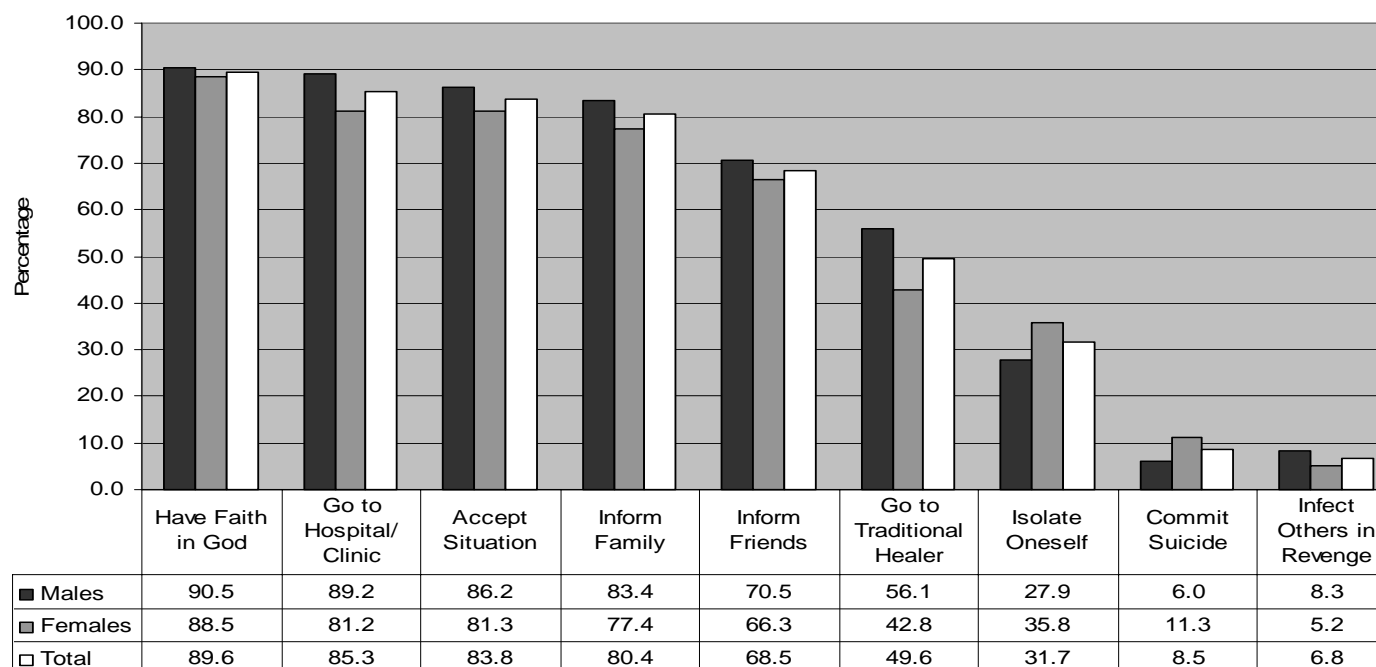
Figure 22: Who Should Care for People Living with HIV/AIDS?



4.6.2 Reaction on Testing Positive

If tested positive for HIV, most people would: have faith in God (90%); go to a hospital, or clinic (85%); accept the situation (84%); inform family (80%); and/or inform friends (69%), as indicated in Figure 23. Almost half would seek treatment from a traditional healer and a third (32%) would isolate themselves. 9% of respondents would commit suicide and 7% indicated that they would seek revenge by infecting others. Counselling is clearly required for the latter groups.

Figure 23: Reaction on Testing Positive for HIV



4.7 Media Influence

As an instrument of public enlightenment and education, the role of print and electronic media with respect to sexuality evoked much discussion among all focus groups. They were generally considered to have had a negative impact on morality and traditional values.

During focus group discussions with young males in an urban setting, one of the participants reflected the views of his colleagues in this way:

“Pornography in particular is watched by many youth of this generation. It is entertainment, but also exposes us to liberal sex” (Adolescent male – Farafenni, NBD).

Young females in their various focus groups also complained:

“Blue films are very bad, because they are spoiling our generations very much, teaching us love affairs, which are later put into practice” (Out of school 18+ female – Kafuta Village, WD).

Religious leaders demonstrated overwhelming condemnation of some discussions and films presented on radio and television.

“On videos and TV, the youth watch bad films, so some of them copy the lifestyle they see on the screens. Nowadays, even 7 year olds know about sex. These bad videos are ruining African and Islamic values” (Muslim adult male – Basse, URD).

To Christians also: *“Technology has brought video, video clubs and the internet – projecting bad morals, violating our homes and African values. In this regard, the media are doing more harm than good”* (Christian leader – Serekunda, GBA).

In general, across all groups, the media were considered to have had a negative influence on the sexual behaviour of young people. More detailed audience research on listener and viewer perceptions of specific programmes would be of interest in this regard.

5. DISCUSSION OF FINDINGS

The results of this study point to a complex interplay of socio-cultural factors, including religion, on sexuality and condom usage, and their impact on the spread of HIV/AIDS.

Respondents to the questionnaire and participants in numerous focus group discussions exhibited high levels of awareness and concern about HIV/AIDS, and knowledge of condom use as a preventive measure, but only modest changes in the patterns of sexual behaviour.

5.1 Gender Relations

The nature and extent of gender inequality in The Gambia are based upon patriarchal structures that are determined by religion and culture.

The Gambia has signed and ratified the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) and this convention is now in force. Acceptance and implementation of statutory changes to empower women, however, remains a Herculean task, as is mainstreaming gender considerations into socio-economic development planning.

Government's vision of year 2020 includes development of human capital and one of the priority-targeted areas of the United Nations Development Assistance Framework (UNDAF) for 2002-2006 is: "to build human capital to enable, the poor (and others) to take advantage of new opportunities, through improving their access to education, health and social services" (UN System, 2000:v).

Women are part of the human capital and the poor referred to. However, with female illiteracy at 81% and restricted access to credit and inheritance, as reflected in this study, women's opportunities to be fully involved in the development process, let alone partake in the world market to benefit from globalisation, are obviously limited.

The HIV/AIDS epidemic has created yet another dilemma in women's sexual relations. In matters relating to sexuality and reproductive health, men are more involved in the decision-making process.

Women are thus unable to control the type and frequency of their own sexual relationships, let alone those of their partners. Poverty and the low status of women make them more vulnerable to sexual abuse and sexual exploitation, and as a consequence they are more vulnerable to HIV/AIDS.

As Maduna-Butshe (1997:8) has stressed: *"When women are denied decision making, holding women responsible for sexual safety in the HIV/AIDS seems a joke. Decisions pertaining to sexual behaviour cannot be separated from wider social and cultural influences that combine to keep women subordinate to men."*

Furthermore, in general females are physiologically more vulnerable to HIV/AIDS. Not only are they receptive partners during intercourse, but they may also have pre-disposing conditions, such as cervical erosions or STIs that serve as "gateways" to HIV/AIDS transmission. It is not surprising, therefore, considering the nature of polygamous unions, the extent of pre-marital and casual sex and extra-marital affairs recorded in this study, with the resultant cross infections between spouses, and from and to other partners, that females account for the highest proportion of HIV/AIDS patients in The Gambia.

In effect, AIDS has also added to the problems of women in a double tragedy, not only for The Gambia, but also for other African societies. HIV/AIDS affects women in their multiple social and financial roles, as health care providers, educators, wives, mothers and providers of income. As more women become infected, more infants will be born infected, and more mothers will leave significant numbers of AIDS orphans, as well as additional dependents, without support.

The challenges posed by HIV/AIDS, thus, justify a more pro-active intervention to empower women. It is important that lessons learnt from the social fabric destroying pattern of HIV/AIDS should serve as a warning of what might happen if the country fails to undertake timely and far reaching measures needed to improve the conditions of women in The Gambia.

5.2 Poverty

Poverty is one of the underlying socio-economic factors contributing to the spread of HIV/AIDS, along with ignorance, illiteracy and general underdevelopment, which has been exacerbated by the sluggish performance of the economy in recent years.

With increasing globalisation and demand for scarce resources, there has also been an exodus of skilled personnel from The Gambia over the past decade (DSF&EA, 2002:33), which has lead to a general decline in social services, weakened family bonds and facilitated the spread of STI/HIV/AIDS.

5.3 Sexuality

According to the United Nations Convention on the Rights of the Child (CRC) and the Organisation of African Unity Charter on the Rights and Welfare of the Child,

both of which have been ratified by The Gambia, a child is anyone under the age of 18. From traditional perspectives within the country, however, a child's age limit is more of a diffuse social construct that varies according to circumstances and does not conform to the CRC definition (UNICEF, 2002:1)

Discussion of issues relating to the low age at first intercourse and at marriage for girls, teenage pregnancies, sexual abuse and exploitation of children can be problematic, especially as national youth policy indicates that most females reach sexual maturity at between 12-14 years of age (DSY&S, 1998:1).

These are complex and sensitive issues that clearly need further clarification when addressing the protection, promotion and development rights of young people.

5.3.1 Age at First Sexual Experience

The findings of the study indicate that young people in The Gambia (both single and married) experience sexual relationships at an earlier age and in a different social context from previous generations. Strong associations between age at first intercourse and subsequent sexual health have been established by clinical and behavioural research (Brabin, 1993; and Konings *et al.*, 1994).

Of particular concern is that early sexual intercourse is likely to lead to an increased lifetime number of sexual partners, an increased likelihood of multiple and concurrent partners, a lower probability of using modern contraceptive methods and an increased chance of infection with HIV, or other STDs.

First sexual experiences in The Gambia tend to occur at an earlier age in rural areas than in towns. This is an important finding, which may explain the higher HIV/AIDS prevalence found in rural areas and calls for a reorientation of IEC delivery to provide enhanced coverage of rural areas as well as urban areas.

In marked contrast to the great majority of male youth and adults who discuss sexual matters with their peers, 41% of female youth and 21% of adult females do not discuss sexual matters with anyone else. It is imperative that reliable information about reproductive health, STIs and HIV/AIDS and means of preventing infection is made available as widely as possible amongst all groups. IEC delivery needs to address this issue as a matter of urgency and include messages targeted at women in general and female youth in particular.

The promotion of improved communications between parents and their children is particularly important, where education, modernisation, urbanisation and exposure to western media are gradually eroding traditional values and influence.

5.3.2 Sex Education

No general consensus was reached amongst focus groups on the most appropriate setting for sex education. The content and purpose of such education was also unclear to some ethnic groups. With the spread of HIV/AIDS, the traditional social distance between parents and children in the discussion of sexual matters must be bridged. Adult education programmes are required to improve parents' knowledge of reproductive health, so that appropriate advice may be given to young people.

Further collaboration between that National Youth Council, the Department of State for Education and schools is required, to strengthen sex education programmes and to initiate further peer counselling and education activities.

5.3.3 Casual Sex Practices

Circumstances in which almost a third of young people admitted to having had casual sex partners in the month preceding the study, 24% did not use condoms and another 23% would not urge partners to do so, are indicators or "*flash points*" of looming disaster; the more so, if adult involvement in casual sex is also considered.

5.3.4 Non-Vaginal Sex

Focus group discussions indicate that involvement in non-vaginal sex is not derived from traditional cultural practices, but from external cultures, media influence and pornographic videos. Materials depicting pornography are readily available from various localities in urban and peri-urban settlements. Some measure of control by the Census Board is necessary. Non-vaginal sex may facilitate the transmission of STI/HIV/AIDS. Risks associated with these practices need to be incorporated in IEC messages.

5.4 Travel Factor

The association of travel with casual sex and the spread of HIV/AIDS in many countries has been well documented elsewhere. More than half the study population (54%) had travelled from home during the previous year, and two-thirds (66%) of those that had been away had exposed themselves to increased risk of HIV/AIDS through casual sex. An intensive and sustained IEC campaign is required to sensitise and inform the public of the risks of unprotected sex, especially those groups that travel frequently and extensively.

5.5 Condom Usage

The range of misconceptions about condoms has to be dispelled if their use is to be increased. Quality and reliability must be assured and best practice widely promoted. A communication expert should be engaged to develop a culturally sensitive strategy to dispel misconceptions and promote the marketing of condoms, possibly in partnership with the private sector. The willingness of female respondents to encourage their partners to use condoms is clearly a positive sign for the future.

Religious leaders, as scholars of religious texts, are well positioned to separate tradition from religion, and should be encouraged to participate as key stakeholders in HIV/AIDS prevention, as successfully demonstrated in Jordan.

5.6 Voluntary Counselling and Testing

The great majority of the sample population were willing to be tested for HIV/AIDS, but young and adult females were less willing than males. Further investigation is required because of the risk of mother to child transmission of HIV/AIDS.

5.7 Attitude to People Living with HIV/AIDS

The positive attitudes held towards PLWHA by respondents and the suggested caring options should facilitate the development of community-based care for PLWHA. It is also an indication that the denial phase of the country may soon be over, since a problem has to be recognised first, before suggestions and plans for dealing with the problem can be discussed sensibly and acceptable solutions found. The PLWHA themselves were anxious to enlist advocacy and survival support from all sectors, which should encourage them to speak out further and make their voice heard.

5.8 Information Education and Communication Activities

The range and scale of IEC activities in The Gambia, though encouraging, remain uncoordinated and uneven in coverage. Many initiatives promote awareness and prevention through health services, while others are one-off activities with no in-built sustainability. These efforts need to be harnessed and streamlined. Study findings indicate that the country now has reasonably high levels of awareness and should be facilitated to promote and attain changes in behaviour, through development and adoption of new models and strategies.

The NACP itself has few staff for the magnitude of the responsibility accorded to it of dealing with the growing trend of HIV/AIDS. In this regard, the establishment of a National AIDS Secretariat is a timely development. More staff members and

expertise are required for the task ahead, especially for implementation of an updated HIV/AIDS policy and a multi-sectoral National Plan of Action.

5.9 “Free Will” and the Spread of HIV/AIDS

The two theoretical perspectives, which provided the guiding frameworks for this study as indicated in section three were of particular relevance. The functional school of thought, as propounded by Durkheim (cited by Peacock, 1993) and others applies in the Gambian situation, in that to an extent any aspect of culture exists because it serves an important social function. While holding on to patriarchal structures to rationalise, uneven gender relations, the country has started generating relevant discourses on such issues as wife inheritance, scarification and even female genital circumcision, despite or perhaps because of the spread of HIV/AIDS. Culture can, therefore, be adapted to meet a specific set of conditions in a society, both physical and social.

Max Weber’s symbolic “interactionism” framework (Weber, 1968) has also been found applicable to The Gambia with respect to the choices available to and made by respondents, as discussed in section three: Culture does not exist in a vacuum but is sustained by members of society, who individually have considerable freedom and “free will” to choose and to act.

Freedom and free will allow Gambians to examine various courses of action, including: use, or non-use of condoms; assessment of the relative advantages and disadvantages; and choice of risky, or safe behaviour; despite the prevailing moral teachings and stipulations of both Islam (96% of the population) and Christianity (3%).

Future interventions should, therefore, be directed at exercising free will and targeting unsafe sex to effect positive behavioural changes at both individual and group levels.

5.10 HIV/AIDS is a Rural Problem in The Gambia

The findings of the study confirm that HIV/AIDS is a rural problem in The Gambia. With the exception of GBA and Kanifing municipality, the rest of The Gambia itself may be classified as mainly peri-urban and rural.

Transiting visitors, tourist and truck drivers, at the many exit and entry points to and from Senegal, provide additional exposure to young females in rural areas.

Most festivals, ceremonies, lumo (markets), wrestling and many other social events in The Gambia occur in rural areas. Many study participants alluded to the extent and

variety of sexual liaisons that take place during these events: cross-generational, extra-marital, part and full time sex work

Improved education for female youth and women in general, especially in rural areas but also in towns is a problematic issue in The Gambia, but nevertheless must be addressed as a matter of the utmost importance and urgency, not only for the control of HIV/AIDS, but also for the long term sustainable development of the country.

The education of the girl child is high on the social agenda of Government, which has introduced a range of commendable interventions with partners, such as UNICEF, to address the issue through various initiatives, including the establishment of scholarship schemes, free education and mothers clubs.

6. CONCLUSIONS AND RECOMMENDATIONS

The Gambia is gradually recognising the reality that HIV/AIDS is more than just a health problem, but still has to mainstream the disease and its widespread socio-economic consequences as a major development issue.

The circumstances of the national debate on HIV/AIDS have not been particularly conducive to the discourse. This is because of the often contradictory and juxtaposed perspectives of government, religion and culture for and against the promotion of condoms to prevent pregnancy and protect against STIs and HIV/AIDS, which have presenting unclear and confusing messages to Gambians. This is clearly evident from the statements of participants quoted in this study.

Islam is a vital force in The Gambia and Muslim leaders, as interpreters of Islamic principles and laws, are key sources of information and advice to many Gambians. The views of religious leaders, therefore, are a vitally important factor in HIV/AIDS prevention initiatives.

The findings of this study should be taken as a “wake-up call” to both Islamic and Christian leaders, particularly as social change and globalisation are impacting on sexual decision-making and behaviour.

Furthermore, there is a need to acknowledge that social equity, as widely recognised elsewhere, is linked to gender equity.

As has been reiterated in many fora and by many international institutions, including the World Bank and others, gender issues are not the same as women’s issues, in that understanding gender means understanding opportunities, constraints and the impacts of change as they affect both women and men.

In striving for sustainable development in The Gambia, it is imperative that a gender mainstreaming approach be pursued in the national interest.

Respondents and participants in this study, through their openness, responses and acceptance of the HIV/AIDS situation, have also taken the lead in pointing the way forward to community-based care for PLWHA.

These issues bring to the fore the contextual setting of HIV/AIDS activities in The Gambia, which are weakened by rather narrowly focused and outdated National Policy and Guidelines that are in urgent need of review and revision to incorporate emerging issues of the twenty-first century.

6.1 General Recommendations

The following recommendations emanate from the analysis contained in this report. Their scope of influence includes, but is not limited to: policy makers; planners; programme staff; and grassroots communities.

1. Mobilise support and resources (particularly grants) for the HIV/AIDS activities, especially at the grassroots level.
2. Equal property rights should be given to women to foster the establishment of sustainable livelihoods and discourage extra-marital sex for economic benefit.
3. Improve community awareness and understanding of the appropriate use of condoms and develop ways and means of making them more readily available in rural areas.
4. Voluntary HIV testing and counselling services targeted at women and youth should be promoted and made more widely available, particularly in rural areas.
5. Priority should be given to community based sensitisation campaigns, linking prevention and care.
6. Facilitate the establishment of a national network of PLWHA support groups, promote home based care for PLWHA and assist the incapacitated to attend clinics.
7. Establish formal links with traditional healers to sensitise them on HIV/AIDS.
8. Simplify information, education and communication (IEC) messages about HIV/AIDS and translate them into local languages for easy dissemination in local communities.
9. Target more aggressive media HIV/AIDS campaigns at youth groups.
10. Empower women to participate more effectively in family planning decisions.
11. Emphasis should be given to poverty-reduction programmes and initiatives to promote alternative sources of income instead of high-risk sex work.
12. Promote an aggressive awareness campaign to reduce stigma and discrimination, and promote positive attitudes towards PLWHA and those who care for them.

6.2 Specific Recommendations

- 13.** Review and update the 1995 National HIV/AIDS Policy and Guidelines to provide strategic direction, incorporate emerging issues of the twenty-first century and address youth and gender concerns.
- 14.** Develop a Strategic Action Plan for a renewed and reinvigorated national response as a matter of utmost urgency.
- 15.** Conduct an extensive analysis of current sectoral policies and strategies to mainstream HIV/AIDS concerns in poverty reduction, education, employment, youth and agriculture.
- 16.** Strengthen the National AIDS Secretariat and the National AIDS Control Programme to continue expanding their programmes at grassroot level.
- 17.** Establish a management information system (MIS) for a nationwide HIV/AIDS programme to provide routine information and geographically co-ordinated data on the status of HIV/AIDS and management.
- 18.** Develop an updated multi-sectoral plan of action to mainstream HIV/AIDS prevention and control as a development issue.
- 19.** Develop an advocacy and IEC strategy for a more focused approach to reduce risky sexual behaviour and in particular discourage casual sex amongst youth.
 - a)** Revive the National IEC Committee, or establish a broad-based National IEC Task Force under the National AIDS Secretariat, for a more coordinated and targeted effort.
 - b)** Promote peer group IEC delivery to address the silence on sex and sexuality, targeted at women in general and female youth in particular, through community based, participatory interventions, such as the Stepping Stones Project.
 - c)** Develop appropriate STI/HIV/AIDS prevention messages focusing on cultural practices, such as early marriage, wife inheritance, scarification and female circumcision, which may increase the risk to HIV infection.
 - d)** Intensify IEC campaigns targeting travellers in transit towns, lumos (market days) and boarder towns/villages.
- 20.** Encourage the wider use of radio as the most effective way of reaching the majority of the rural population, especially those who are illiterate.

REFERENCES AND BIBLIOGRAPHY

- ADF (December 2000). The African consensus and plan of action: leadership to overcome AIDS. Addis Ababa: African Development Forum Secretariat, Economic Commission for Africa.
- BAFFROW (1999). The BAFFROW report. Banjul: BAFFROW.
- BAFFROW (2000). Youth training manual on female genital mutilation. Banjul: BAFFROW.
- Botchway, K. (2000). AIDS and development. Theme paper for the African Development Forum 2000. Addis Ababa: African Development Forum Secretariat, Economic Commission for Africa.
- Brabin, L. (1993). Pelvic inflammatory disease. *Africa Health* **15** (3):15-17.
- DCD (1989). Report on the survey on methods of child rearing according to ethnic groups in rural Gambia. Banjul: Ministry of Local Government and Lands, Department of Community Development.
- DSF&EA (2002). Draft poverty reduction strategy paper (SPA11). Banjul: Department of State for Finance and Economic Affairs.
- DSH (2000). Adolescent health survey preliminary report. Banjul: Department of State for Health.
- DSY&S (1998). National youth policy: 1998-2008. Banjul: Government of The Gambia, Department State of Youth and Sport.
- Doyal, L., J. Naidoo and T. Wilton (eds) (1994). *AIDS: setting a feminist agenda*. London: Taylor and Francis.
- Enel, C. (1995). Societal and behavioural risk factors for STD and HIV transmission in the Sibanor area, The Gambia. Banjul: A report for Medical Research Council Laboratories.
- Evina, A. (1990). Infecondite et sous-fecondite: Evaluation et recherché des facteurs le cas du Cameroun, Cahiers de Institut de Formation et de Recherché Démographiques, No.1. Yaounde, Cameroon: Institut de Formation et de Recherché Démographiques.
- FAO (2001). AIDS - a threat to rural Africa. http://www.fao.org/focus/E/aids/aids2/_ehtm.
- FAO/UNAIDS. Sustainable agricultural rural development and vulnerability to the AIDS epidemic. Geneva: Joint United Nations Programme on HIV/AIDS.
- Finger, W.R. (1993). Seeking better ways to teach youth about AIDS. *Family Health International*. Vol. 14, No.2, October 1993.
- Flebenkamper, S. (2000). Knowledge of HIV/AIDS and attitude towards HIV testing and caring for people with HIV/AIDS in Brikama and Kombo District, The Gambia. Unpublished data.
- GOTG (2000). 1998 National household poverty survey report. Banjul: Government of The Gambia.
- GOTG (2001). National report to the United Nations General Assembly Special Session on HIV/AIDS. Banjul: Government of The Gambia.
- Gross-Kurth H. *et al.*, (1995). Impact of improved treatment of sexually transmitted diseases on HIV infection in rural Tanzania: randomised controlled trial. *The Lancet* **346**(8974): 530-536.
- Gyeye, M. S. Castle and K. Konate (2001). Timing of first intercourse among Malian adolescents: implications for contraceptive use. *Family Planning Perspectives* **27**, No.2. New York: Alan Guttmacher Institute.
- Kane *et al.* (1993) Sexual activity, family life education and contraceptive practice among young adults in Banjul, The Gambia. *Studies in Family Planning* **24**, 1: 50-61.
- Kelly, M.J., (2000). Challenging the challenger: understanding and expanding the responses of universities in Africa to HIV/AIDS. A synthesis report for the Working Group on Higher Education (WGHE) and the Association for the Development of Education in Africa (ADEA). Washington DC: World Bank.
- Konings, E. *et al.* (1994). Sexual behaviour survey in a rural area of north-west Tanzania. *AIDS* **8**(7): 987-993.
- Laga M., Nzila N & Geeman J., (1991). The interrelationship of sexual transmitted diseases and HIV infection: implications for the control of both epidemics in Africa. *AIDS* **5** (suppl.1) S55-S63.
- Laga, M. *et al.* (1993). Non-ulcerative sexually transmitted diseases as risk factors for HIV-1 transmission in women: results from a consultant study. *AIDS* **7**(1): 95-102.
- Lauretin, R. (1974). Infecondite en Afrique noire: maladies et consequences sociales. Paris: Maason.
- Legarde E, *et al.* (2001). Religion and protective behaviours towards AIDS in rural Senegal. *AIDS* **14**(13): 2027-2033.

- Loum, A. J. (2000b). Report on mapping and re-mapping of sex work sites for HIV/AIDS/STI prevention and control intervention in Rural Gambia, 18-30 September. Banjul: NACP/WHO Sex Workers Intervention Project.
- Loum, A.J. (2002a). Report on familiarisation and orientation of new field workers to intervention sites. 3-30 April. Banjul: NACP/WHO Sex Workers Intervention Project.
- Maduna-Butshe, A.C.Z. (1997). Women sex workers and the HIV pandemic: stigma and blame in context. *SAFAIDS News* March 1992. **5**(1)
- Murdock, G.P. (1964). Culture correlates of the regulation of premarital sex behaviour. In: Manners, R.A, (ed) (1964). *Process and pattern in culture*, pp 399-410. Chicago: USA.
- NACP (March 1999). Lessons from the Gambian study on mother-to-child infection with the AIDS virus. Report on a one-day workshop at the Atlantic Hotel. Banjul: National AIDS Control Programme.
- NACP (2000). HIV/AIDS situation in The Gambia. Paper presented at the National AIDS Forum (NAF) at the Kairaba Beach Hotel. Banjul: National AIDS Control Programme, November 2000.
- NACP (2001). National HIV sentinel surveillance. Banjul: National AIDS Control Programme.
- O'Donovan, D., Lloyd-Evans and K. Manneh (1994). World Bank Report: STD assessment in The Gambia, unpublished data, Banjul.
- Otti, P.N. (1990). The awareness and attitudes of prostitutes to AIDS in Jos, Nigeria. *Ghana Medical Journal* **23**: 149-153.
- Otti, P.N. (1993). The young substance abuser. In: A postgraduate doctor's changing world.
- Otti, P.N. (1996). Armed conflict in Africa and social dimensions and role of the media. *Nigeria Journal of Policy and Strategy*, **11**(1&2), June to December. Jos: National Institute for Policy and Strategic Studies.
- Otti, P.N. (1998). Socio-cultural study on HIV/AIDS in Lesotho. Maseru: UN Theme group on HIV/AIDS.
- Otti, P.N. (2001). A study on socio-cultural barriers to HIV/AIDS prevention initiatives in Monrovia and environs. Monrovia: Government of Liberia and UN System.
- Patton, C. (1994). *Last served? Gendering the HIV pandemic*. London: Taylor and Francis.
- Peacock, J.L. (1993). *The anthropological lens: harsh light soft focus*. New York: Cambridge University Press.
- Petros-Barvazian, A. and M. H. Merson (1990). Women and AIDS: a challenge for humanity. *World Health*: November-December 1990.
- Piot, *et al.* (1992). AIDS in Africa: a manual for physicians. Geneva: World Health Organisation.
- Romaniuk, A. (1967). *La fecondite des populations Congolaises*. Paris/la Haye: Mouton.
- SIP (2001). Trek to lumo sites. Report, 17-22 March 1998.
- Sock, D. (1998). Evaluation of sex workers intervention project - draft final report. Banjul: NACP/WHO.
- Soyinka, F. (2001). People with AIDS hold the key to its spread. Lagos: Federal Ministry of Information and National Orientation.
- Twa-twa, J.M. (1997). The role of the environment in the sexual activity of school students in Tororo and Pattisa District of Uganda. *Health Transition Review*, **7** (suppl.): 67-82.
- UN/GOTG (1999). Common country assessment. Banjul: United Nations System and Government of The Gambia.
- UN/UNDAF (2000-2006). The Gambia. Banjul: United Nations System.
- UNAIDS (1998). Report on the global HIV/AIDS epidemic. Geneva: Joint United Nations Programme on HIV/AIDS.
- UNAIDS (June 1999). A joint response to AIDS. Geneva: Joint United Nations Programme on HIV/AIDS.
- UNAIDS (May 2000). Ethical consideration in HIV preventive vaccine research: guidance document. Geneva: Joint United Nations Programme on HIV/AIDS.
- UNAIDS (June 2000a). Report on the global HIV/AIDS epidemic, Geneva: Joint United Nations Programme on HIV/AIDS.
- UNAIDS (June 2000b). A situational analysis on sex work in West and Central Africa. Abidjan: Joint United Nations Programme on HIV/AIDS.
- UNAIDS (June 2001). United Nations General Assembly declaration of commitment on HIV/AIDS. Geneva: Joint United Nations Programme on HIV/AIDS.

- UNAIDS (Dec 2001). AIDS epidemic update, Geneva: Joint United Nations Programme on HIV/AIDS.
- UNAIDS (July 2002). Report on the global AIDS epidemic 2002. Geneva: Joint United Nations Programme on HIV/AIDS.
http://www.unaids.org/epidemic_update/report_july02/english/embargo.htm
- UNDP (2001). The Gambia – human development report. Banjul: United Nations Development Programme.
- UNICEF (2002). Terms of reference for the study on sexual exploitation of children in the Senegambia region. Banjul: United Nations Children's Fund.
- Weber M. (1968). In: Roth, G. and C. Wittich (eds): *Economy and society*. New York: Bedminster.
- Whiteside, A. and C. Sunter (2000). *AIDS: The challenge for South Africa*. Cape Town: Human, Rousseau and Tafelberg.
- WHO (1998). Female genital mutilation: an overview. Geneva: World Health Organisation.
- WHO (June 2001). Fact sheets on HIV/AIDS for nurses and midwives. Vol. 3, No. 1 Supplement to African Journal Nursing and Midwifery, WHO/Geneva EIP/OSD/2000.5.
- Women's Bureau (1999). National policy for the advancement of Gambian women: 1999-2009. Banjul: Government of The Gambia.
- World Bank (August 2000). Exploring the implications of the HIV/AIDS epidemic for educational planning in selected African countries: the demographic question. Washington DC: World Bank.