



*The Ghanaian-Dutch Collaboration for Health Research and Development*

**COMMUNICATING HIV/AIDS  
PREVENTION MESSAGES THROUGH UNORTHODOX COMMUNITY-  
BASED MEANS**

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(On behalf of Leklebi Union)**

**2005**

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## EXECUTIVE SUMMARY

AIDS is a very common, familiar and dreaded name. It is often contended that awareness of the dreaded killer is not a problem in Ghana. Over 90 per cent of Ghanaians above 12 years are aware of the disease and some of the means by which the HIV virus is transmitted. However, risk perception of the epidemic among most Ghanaians, especially those in the rural communities, is very low. Accordingly, people continue to indulge in avoidable risk behaviours in contrast to the nationally proclaimed war against the epidemic.

It has been argued that the interventions targeting HIV/AIDS have generally been very formal in approach and not sufficiently localised to catch the attention and imagination of the ordinary people. Additionally, the general lack of involvement of members of the community in the awareness creation reinforces the impression in the local rural communities that the messages are remote and having to do with some remote people elsewhere. Awareness creation has, therefore, not been leading to any significant attitudinal or behavioural changes.

The study sought, therefore, to lift the HIV/AIDS campaign in the Hohoe-South constituency from an information-based approach to a skill-targeted approach through the experimentation of an indigenous communicating model. This model did not only use drama but also made use of brass band music with active community and audience involvement and participation, which is considered critical for effecting changes in the behaviour pattern of the people.

Accordingly, the study was designed to be an experiment of the pre-test post-test model. A baseline data was collected to establish the level/status of community awareness and disposition towards prevention methods as well as attitudes towards or stigmatization levels of HIV positive people and their relations. The intervention (information through drama accompanied by brass band music, punctuated with situational explanations by local resource persons) was introduced and, thereafter, an evaluation conducted, using the same instrument for a comparative analysis of the levels attained before and after the intervention.

Two communities each from four traditional areas were selected for the study. Six communities

from three traditional areas constituted the experimental group while two communities from a fourth traditional area constituted the control group. The communities were rated on a specially designed assessment instrument, HAAPIMAT, which is a five-point continuum rating scale of relevant indicators of knowledge/awareness of the HIV/AIDS epidemic, prevalence, prevention and protection as well as methods of mitigating the impact of HIV/AIDS on those infected and affected.

The results of the study indicated that the main instrument of this study, HAAPIMAT, is useful as a community-based assessment instrument for determining a community's level of attainment or progress on various aspects of HIV/AIDS issues including combating and mitigating the impact of the epidemic on the people.

The study has revealed that the use of music and drama as a medium of conveying HIV/AIDS messages to communities and in particular, using local and well known people in the community as communicating links on the very controversial aspects of HIV/AIDS information has proved to be an effective medium for getting to the people and influencing them to move beyond mere knowledge acquisition to a higher level of behavioural and attitudinal change.

The findings have confirmed the general prevalence of a number of misconceptions and speculations about some aspects of HIV/AIDS which were borne out of ignorance. These misconceptions and speculations tended to be a dividing wedge between the PLWHA and the very people who should show love and care and reach out to them. Once these misconceptions and speculations are convincingly explained, undermined and removed, it becomes much easier for the PLWHA to receive the sympathy, goodwill, acceptability and support of the people among who they live.

Some traditional beliefs and norms were found to place females at a disadvantage, apart from their natural physiological disadvantage which makes them more vulnerable to infection. If females should enjoy the same level of protection from infection, then there is the need to revise some of these norms and recognise their rights, especially their rights of choice or at least a say in when, where and how to

participate in sex as well as their refusal rights. Men will need to begin to respect females as equal partners in a relationship and not a subordinate or just an agent of sexual satisfaction.

A good number of people believe that given the required support, encouragement and recognition, the herbal medical approach could make a break-through in evolving a cure for AIDS. Finally, almost all the communities, even after the interventions, have been found to be virtually inactive and seemingly unconcerned as a group about the fight against the pandemic. One gets the impression that the communities have not yet begun to see the epidemic as their direct responsibility.

Finally, the study came out with the following recommendations:

1. The instrument HAAPIMAT can be used in other studies to assess community attainments especially in generating baseline information. The validity of the instrument for any particular purpose will however depend on the relevance of the specific questions used to generate the data for assessment.
2. The unorthodox approach to educating communities on HIV/AIDS issues has the potential of going beyond knowledge acquisition to effecting attitudinal and behavioural change. This is particularly so if the approach is combined with active community involvement and participation to fuse amusement, experience sharing, personal self appraisal and an unconscious learning.
3. HIV/AIDS is still shrouded in a number of misconceptions and speculative reasoning. This has been found to influence people's risk perception and affect their relation with people living with HIV or AIDS. As long as these misconceptions remain, people's attitudes and behaviour are unlikely to change for a more proactive approach to protecting self and others and reaching out to those infected and affected by the disease. It is recommended that HIV/AIDS education programmes should specifically target undermining and invalidating these misconceptions.
4. Related to recommendation 3 above, it is important that the beneficiary communities of HIV/AIDS programmes and messages do not see such programmes or messages as being brought by some people who probably have nothing at stake in the community. Organisations seeking to educate and empower communities, especially rural communities, against the HIV/AIDS epidemic should endeavour to involve some locally known people in the community in such programmes. It is worth starting such programmes by first spending some time to train some local potentials to perform some critical roles in the operation of the organisation in the community.
5. There is an urgent need to minimize the vulnerability of females, especially young girls, to HIV infection. This demands that the rights of females be protected and that the females themselves are assisted not only to know their rights but also feel empowered to protect and defend them. The legal system must be made to be more responsive to this need and more severe punishment meted out to those who violate the rights girls and women. This could serve as a deterrent.
6. The low level of community concern and protective action should be considered a serious flaw in the campaign against the epidemic. There is the need to put in place a mechanism to continually remind the various communities not only of the implications of the continuing spread of the disease but also of the community's obligations and responsibility to stem down the spread. In this regard, it is recommended that the concept of the workplace focal person be extended in scope and focus so that communities can also have people to look up to for continual reminder of their responsibilities. It might be useful to institute community focal persons for such a function. These could be agents of NGOs, the District Assemblies or the Ghana AIDS Commission.
7. There is no doubt that herbal medicine is proving its efficacy with a good number of medical problems. There are equally reports that some herbal centers are making tremendous strides in the area of treatment of

the opportunistic diseases of AIDS. One is inclined to think that with a little more support from both the orthodox medical practitioners, especially the scientific investigators and also from government, a lot more could be achieved through herbal medicine.

### **Acknowledgement**

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## ACRONYMS

ERNWACA	Educational Research Network for West and Central Africa
HAAPIMAT	HIV/AIDS Awareness, Prevention and Impact Mitigation Assessment tool
NGOs	Non Governmental Organisations
PLWHA	People Living with Aids
UNAIDS	United Nations Aids Agency
USAID	United States Aid Agency

## Chapter 1

### BACKGROUND

The HIV/AIDS pandemic continues to threaten mankind. Globally, more than 60 million people have been infected with HIV since it was first detected in the early 1980s. It has claimed the lives of more than 20 million people to date. In year 2002 alone, 3.1 million died of AIDS. At the end of 2002, there were approximately 42 million people living with HIV/AIDS. Each day, approximately 14,000 new infections occur. Young people, especially girls and young women, aged 15–24 are particularly vulnerable to infection. AIDS is reversing many hard fought development gains. Life expectancy in some countries is declining. The numbers of orphans is rising rapidly.

UNAIDS, in July 2002, reported that 70 per cent of the over 40 million HIV carriers in the world live in sub-Saharan Africa and that, without massive prevention and treatment, 55 million Africans could die prematurely by 2020 as a result of AIDS.

There is quite a lot of information on the HIV/AIDS epidemic in circulation in Ghana but there still is a paucity of data on country specific aspects, especially with regard to prevalence, impact, prevention and mitigating possibilities. The rural communities are, for instance, generally unaware that the life of an infected person could be prolonged to some extent by early detection and an early application of mitigating measures.

The ages of 25–29 and 30–34 for females and males respectively constitute the peak ages for AIDS cases in Ghana and nearly 90 per cent of all cases fall within the sexually active period (15–49). The disease is thus affecting most of the people in the reproductive age group (Awusabo-Asare *et al.* 1993)

The situation becomes more frightening when it is realised that there are modes of transmitting the virus other than sexual intercourse that could very easily be overlooked or ignored even though they relate closely to some life habits of especially the rural people: HIV infection could also be caused by vertical transmission and transmission through blood (15 per cent) and blood products (5 per cent).

There are very many people who, for instance, do not consider medical attention in clinics/hospitals to be complete without injections, These other modes of transmissions could turn out to be hidden dangers of the pandemic to such people. The same goes for people who patronise the barbers' shops which are not equipped to sterilise the tools of their trade. A simple cut by a contaminated tool in a barber's workshop could pose a serious danger without the victim least suspecting this.

The fact that the disease has no known cure is indeed frightening. But there is some hope in the knowledge that the transmission is mostly behaviourally induced, principally through sexual activities. Changes in HIV responsive sexual behaviours constitute the most potent protection against infection. It is known however that behavioural changes are never easy to achieve.

#### STATEMENT OF THE PROBLEM

AIDS is a very common, familiar and dreaded name. In a broad sense, awareness of the dreaded killer is not a problem in Ghana. Over 90 per cent of Ghanaians above 12 years are aware of the disease called AIDS and some of the means by which the HIV virus is transmitted. The problem, however, is that there is very little appreciation of the closeness of the pandemic and for that matter the vulnerability of each individual, regardless of his/her place of domicile to the disease.

Until a few years ago, the average Ghanaian treated HIV/AIDS with nonchalance, due mainly to ignorance and perhaps also the secrecy syndrome surrounding the disease which invariably denied many people the opportunity to see an AIDS patient physically (MOE 2000, Fayorsey, 2002, Kelly M.J., 2001, World Education and USAID 2002, ERNWACA/Ghana 2001). Many people indeed thought and perhaps still think that the HIV/AIDS alarms were/are either a myth or relevant to some other far away places or countries. Risk perception was therefore very low. The closest the average

Ghanaian, in those days, associated the HIV/AIDS pandemic with himself/herself, was in relationship with prostitutes who had returned from Abidjan, Lome or Lagos. In this context, once the individual was convinced that he or no close relation of his/hers would have anything to do with such prostitutes, he/she was confident that the pandemic was nowhere near.

This is particularly true of rural communities where the formal methods through which information on the pandemic is transmitted does not appear to be making any real impact. HIV/AIDS is still perceived in these areas as a problem of some distant and perhaps strange people. Risk perception and required behaviour changes are therefore very low.

It is sometimes argued that a breakdown of social control by parents and teachers over the adolescents is partly responsible for the high adolescent sexual activity in recent times. But the question may be asked if the adolescents need any social control, external to themselves, if they truly understand, appreciate and identify themselves individually with the risks involved in early sexual activity.

Advocacy for abstinence by anti AIDS campaigners appear to have very little effect because the youth are told only one side of the story about sex. The other side (ie. perceived benefits and pleasures), they hear or experience only through peer group influence and pressures.

Worst of all, HIV infection is still perceived in many communities as a taboo and a humiliation to the family. No family ever or easily admits that a deceased member died of AIDS even if the symptoms are so obvious. They are also not ready to disclose that a member of the family is HIV positive. This concealment syndrome which reinforces the general low risk perception in the rural communities need be broken. The problem is how to do this. A possible answer to this question is what this study seeks to explore.

#### RESEARCH NEEDS : WEAKNESS IN COMMUNICATING HIV/AIDS INFORMATION

Admittedly, various education programmes have been introduced by various agencies and

NGOs to bring awareness to Ghanaians of all shades on the HIV/AIDS pandemic and its prevention. One is indeed tempted to state that the HIV/AIDS pandemic has attracted the attention and action of more NGOs than any other individual issue. Unfortunately, the interventions targeting HIV/AIDS have generally been very formal in approach and not sufficiently localized to catch the attention and imagination of the ordinary people in the rural areas.

Additionally, the general lack of involvement of members of the community in the awareness creation reinforces the impression in the local people in the rural communities that the message is a remote one on some remote people which have very little to do with them. Awareness creation is, therefore, not leading to any significant attitudinal or behavioural changes.

Subsequently, there is a growing consciousness of the need to adopt a more multi-sector, multi-disciplinary and multi-varied approach to HIV/AIDS awareness building and prevention. A case in mind, meant to remove this phenomenon of absence of local commitment to the campaigns and adopt a more unorthodox approach may be cited in the Akyem traditional area where the Okyehene himself led the campaign, joined in planned walks and even made a symbolic run when tradition prohibits chiefs from running. Though no systematic evaluation of the impact of the Okyehene's campaign strategy on behavioural change has yet been made, it may be safe to conjecture that the level of publicity the event attracted made a great impact on the psyche of the people, especially people in the area who were aware that the king broke the traditional rule with the expressed aim of emphasizing the seriousness of the danger of the epidemic.

Another communication strategy that has proved effective in touching the very heart of people is communicating through entertainment. The "Soul City" programme uses 'edu-tainment' (i.e. education and entertainment) and mass media to combat HIV/AIDS in Southern Africa and has been found to be quite effective in carrying the campaign beyond awareness creation to attitudinal and behavioural change. Similarly, John Hopkins University Centre for Communication has developed several tools for educating the youth through entertainment – the 'Enter-Educate' approaches. These are reportedly

proving to be effective mainly because of their popular, personal, passionate, persuasive and practical approaches. The “Love Life; Stop AIDS Campaign” and the “Journey of Hope” series are some of their tools available in Ghana.

The use of drama/entertainment as an effective tool for communicating HIV/AIDS information to bring home to the people the realities of the pandemic is catching on very fast in the country. But most of the series of dramatized dissemination of HIV/AIDS information occurs on the national and some regionalized television stations and radio stations which are not accessible to majority of rural dwellers for obvious reasons.

Other means of availing the marginalized rural dwellers the benefit of watching these dramatized messages has therefore to be worked out – preferably one that brings the drama to their very door-steps.

African researchers, rooted in local contexts, have a responsibility to help bring to the forefront not only awareness and data on the impact of AIDS but also information on responses that have impacted effectively on attitudes and behaviour of people and those that have been effective in mitigating its impact on communities.

In this particular study, drama was properly blended with music and dance with the active mass audience involvement of the local people. Significantly, the programme was rural based and targeted poor and vulnerable people in some rural communities.

## RESEARCH OBJECTIVES

### **Main Objectives**

The study sought to lift the HIV/AIDS campaign in the Hohoe-South constituency from an information-based approach to a skill-targeted approach. This

was to be achieved through the experimentation of an indigenous communicating model, using not only drama but also brass band music with active community and audience involvement and participation, which is critical for effecting changes in the behaviour pattern of the people.

### **Specific Objectives**

In order to achieve the main objective, the following specific objectives were pursued:

- 1) Validate a specially developed community-based instrument for assessing HIV/AIDS awareness, prevention and impact mitigation levels of attainment.
- 2) Develop a baseline data on HIV/AIDS risk perception, prevention-oriented attitude and general attitude towards HIV positive people and orphans in the selected communities before the introduction of the intervention.
- 3) Use a drama troupe with developed appropriate sketches, accompanied by brass band music, as a medium for communicating information on HIV/AIDS. Through this, raise the risks perception of the rural communities in the Hohoe - South constituency in the Volta Region and promote HIV prevention-oriented consciousness, attitudes and skills in the people through effective audience participation.
- 4) Evaluate the effectiveness of the intervention in effecting changes on the perception, attitude and behaviour of the people towards HIV risks perception, prevention, care for people living with HIV and orphans resulting from loss of parents through AIDS .

## Chapter 2

# METHODOLOGY

### TYPE OF STUDY

The study was designed to be an experiment of the pre-test post-test model. Baseline data was collected to establish the level/status of community awareness and disposition towards prevention methods as well as attitudes towards or stigmatization levels of HIV positive people and their relations. The intervention (information through drama accompanied by brass band music, punctuated with situational explanations by local Resource Persons) was introduced and thereafter an evaluation conducted, using the same instrument, for a comparative analysis of the levels attained before and after the intervention. The focus of the sketches was determined by the results of the baseline - ie. areas where awareness was found to be weak or attitudes found to be negative.

#### **HIV/AIDS Aspects targeted**

Aspects and Risk Perspectives of the pandemic brought home to the community members included:

- Risk perspectives and perceptions ( modes of transmission and nearness).
- HIV/AIDS prevalence rate and what it means
- Prevention methods, including development of refusal skills.
- The “S” factors ( shame, silence and stigma) and their implications.
- Social and economic consequences of HIV/AIDS on the patients, families, community and the state.
- Advantages of early detection and wisdom in voluntary testing
- Dangers of hiding HIV status of self, family or community members
- Care and support for people living with HIV and AIDS.
- Care and support for orphans resulting from AIDS
- Societal values, norms and traditions that may reduce HIV/AIDS risks.

- Societal and cultural practices that can pose HIV/AIDS risks.

#### **Components of the Study**

- I. Conducted baseline study
- II. Prepared and implemented intervention
- III. Evaluated achievements of intervention

#### **The Sample and Sampling**

The target population for the project is the people residing in the Hohoe district of the Volta Region of Ghana. The district is divided into two political/electoral constituencies: Hohoe-North and Hohoe-South. The focus was on the Hohoe-South constituency. This constituency is made up of eleven traditional areas with forty-nine communities.

Two communities each from four traditional areas (making 8 communities) were selected for the study. Six communities from three traditional areas constituted the experimental group while two communities from a fourth traditional area constituted the control group. Only traditional areas with more than four communities were considered for selection into the experimental group.

Selected communities falling into the experimental group were Leklebi Agbesia, Leklebi Duga, Liati Agbonyra, Liati Wote, Ve Gbodome and Ve Deme.

Logba Alakpeti and Logba Vunta constituted the control group communities.

#### **The Intervention**

The intervention involved the use of dram and music to create a relaxed atmosphere and forum for education of the masses on HIV/AIDS. It was introduced into all six experimental communities. The two control communities were excluded.

Sufficient publicity including the beating of gong-gong and use of posters was made before going to any community for the intervention. The arrival of the troupe was usually announced by procession with brass band music through all the principal streets of the community.

The drama/sketches, depicting various scenarios of the life of a person living with AIDS, were thereafter made. They lasted for about ninety (90) minutes. Half way through the sketch a resource person, picked from the locality, was given the opportunity to address the audience on HIV/AIDS. Adequate time was always allowed for questions to be asked. Such questions were not directed to only the resource person but to the Principal Researcher and his two assistants as well.

An opportunity was always created towards the end of the sketch (in this first phase) for the Principal Researcher also to address the audience. His address was climaxed by a presentation of the 'AYA AIDS Game' to the Headmaster/Headmistress of the local Junior Secondary School for the use of the school with a promise of the Principal Researcher to visit the schools to see how the game was being patronized. At Leklebi Duga where there is a Senior Secondary School, the AYA AIDS Game was donated also to the SSS as well.

Audience participation during the question time in all communities was very good. Reports from the field assistants, recruited from the communities indicate that the discussions on issues raised in the sketches and during the question time continued among the people well after the departure of the drama troupe and sometimes into the next day. The enthusiasm with which the people in the selected towns/villages patronized the intervention was indeed impressive and ran contrary to the experiences of the field assistants during data collection (ie during the administration of the baseline instruments).

The heavy patronage necessitated the programmes being held out-doors rather than in chapels as originally planned. Luckily, the research team had taken the precaution of arranging for a stand-by generator and a mobile out-door electrical wiring system for such eventualities. Generally, the drama was adjudged by participants to be very educative and a worthwhile intervention.

The Research Team accepted suggestions made at the Elmina workshop during the Research teams' presentation for a repeat of the intervention. Accordingly the intervention was administered a second time. This time, however, it was administered in only four of the original six experimental communities. Two communities were left out of the

second phase intervention as an extension of the experimentation. The purpose was to establish possible differences in increased awareness levels and changes in perception, attitudes and behaviours arising from the repeat of the intervention in some and not in others. Communities covered during this phase of intervention were Leklebi Duga, Leklebi Agbesia, Ve Deme and Ve Gbordome. Liati Agbonyra and Liati Wote communities were left out of this phase.

The second intervention was equally successful though the team went with an initial premonition of poor patronage because of the repetition of the drama. The talk session was even more interactive in the second interventions with many more people seeking explanation on one issue or the other. In fact rather than ask our Resource Persons to give speeches again, the talk session was conducted in the form of a discussion.

### **Instrumentation**

A special instrument, "**HIV/AIDS Awareness, Prevention and Impact Mitigation Assessment Tool (HAAPIMAT)**", was developed for use in determining the awareness as well as the attitudinal and mental frame of the respondents towards the epidemic and those who were living with it. HAAPIMAT is a five-point continuum rating scale of relevant indicators of knowledge/awareness of the HIV/AIDS danger, prevalence, prevention and protection as well as methods of mitigating the impact of HIV/AIDS on those infected and affected. Indicators covered by the instrument are:

- a) Awareness of- general features of HIV/AIDS
    - Modes of transmission
    - Status of evolving a cure
    - Effects of HIV infection on families and communities
    - Prevention, protection and control measures
  - b) Information to the youth (and sources) about sexuality.
  - c) Life skills acquisition, including female empowerment.
  - d) Managing and mitigating HIV infection.
  - e) Care for orphans
- Separate questionnaires were developed to gener-

ate baseline and post-test data to facilitate the scaling on HAAPIMAT and also to enhance the comparison of the achievement levels **before** and **after** the intervention.

The Assistant Researchers were guided at a workshop to develop specific questions required to generate data to inform the grading exercise. The specific questions produced by the Assistant Researchers were edited by the Principal Researcher and collated into one long list of a hundred questions. The team also identified respondent categories that were most appropriate to answer each developed question. Respondent categories identified were teachers, students/pupils, parents, key stakeholders including traditional, religious and opinion leaders, the youth and Unit Committee members.

The whole research team, including the four field officers (who were all teachers above the rank of Senior Superintendent) was gathered again in a workshop to categorize the individual items/questions meant for the questionnaire according to the respondent categories. In the process, some items/questions were identified to be relevant to all categories while the rest were stratified on the basis of appropriateness. The resultant specialized questionnaires were translated into the local Ewe language (translation by the field officers and validated by an Ewe language specialist teaching at the Leklebi Senior Secondary School)

The main instrument (HAAPIMAT) went through a three staged validation before its eventual use. It was firstly validated by the proposal evaluators during the proposal review stage. Secondly, it was subjected to further review by the entire research team. The focus of this exercise was to ensure that the various levels of measure of the indicators (ie. awareness, preventive skills and care indicators) make a meaningful continuum. It was also a strategic exercise to get the Assistant Researchers familiar with the main instrument. Lastly the instrument was given to two HIV/AIDS experts for content validity of the indicators and the appropriateness of the five point continuum in establishing clear and logical distinctions between one level and the next.

The questionnaires were trial-tested in one of the non-participating communities in the district (Ve Golokuati) to determine whether the questions upon

which community achievement levels would be estimated, could indeed provide information required to establish such levels for the comparison. The choice of Ve-Golokuati for the pre-test was influenced by the fact that that community had been a centre of a good number of anti-HIV/AIDS NGO intervention activity. The expectation, therefore, was to get a good range of possible responses from the pre-test to change most of the initially open-ended items into close-ended ones.

The pre-test revealed the length of time required to administer each questionnaire as against the limited time the respondents were ready to sacrifice. This necessitated a review of the questionnaires and their further reduction in length. It was agreed then that no questionnaire should contain more than 65 items. Some of the common items were consequently removed from some questionnaires. This should however have no adverse effect on the generated data because HAAPIMAT is community based and not individual respondent based

### **Data Collection**

The pre-test data collection was preceded by the recruitment and training of field officers. Preference was given to retired teachers because they were more likely to be available whenever they were required and also because they were more likely to take ethical considerations more serious and approach data collection in a more mature and responsible way. The recruited teachers were not below the rank of Principal Superintendents at the time of their retirement.

Another key preparatory activity that preceded data collection was preliminary visits to all communities during which meetings were held with representatives of key stakeholders including the chiefs, opinion/religious leaders, Unit committees, youths, teachers and pupils/students. Traditional rites for permission to conduct the interviews were performed to guarantee the cooperation of the community. The traditional leaders undertook to beat the 'gong-gong' to inform community members of the presence of the field officers.

It was also necessary to commission a playwright to write sketches for dramatization. Even before commissioning the writing of the sketches,

**Table 1**  
**Questionnaire Administration (Achieved)**

Community		Students		Teachers		Parents		Leaders		Youth		Total	
		M	F	M	F	M	F	M	F	M	F	M	F
Duga	1st	13	12*	4	2	5	5	6	4	5	5	61	
	2nd	12	12*	3	3	5	5	7	3	5	5	57	
Agbesia	1st	7	8	3	3	6	4	7	3	5	5	51	
	2nd	7	7	2	3	5	5	6	4	5	5	49	
Deme	1st	8	7	4	2	5	5	7	3	5	5	51	
	2nd	7	8	4	1	4	4	6	3	5	5	47	
Gbordome	1st	8	7	2	4	5	5	6	4	5	5	51	
	2nd	7	7	2	4	5	5	7	3	4	4	48	
Agbonyra	1st	7	8	2	4	4	6	7	3	5	5	51	
	2nd	8	7	2	3	4	5	6	6	5	5	49	
Wote	1st	7	8	4	2	5	5	7	3	5	5	51	
	2nd	7	6	4	2	5	5	6	1	5	5	46	
Vunta	1st	7	8	5	1	5	5	5	5	5	5	51	
	2nd	6	6	4	2	5	5	6	4	5	5	48	
Alakpeti	1st	8	7	4	2	5	5	5	5	5	5	51	
	2nd	5	7	3	2	5	5	6	4	4	1	42	
Total	1st	65	65	28	20	40	40	50	28	40	40	416	
	2nd	59	60	24	20	38	39	47	28	38	35	388	

\* This is the only sampled community where there is a senior secondary school.

the research team had drawn up key HIV/AIDS information that should go into the sketch. The sketches were critically rehearsed and revised to ensure that the audience was never misinformed in any way.

**Data collection was in two phases:**

1) Baseline data on levels of HIV/AIDS awareness and prevention and on impact mitigation were collected prior to the intervention using the questionnaires developed for the purpose. Each field officer, under the supervision of an Assistant Researcher, had responsibility to administer questionnaires in two communities. They were programmed to spend four days in each community (i.e. eight days for the first phase data collection) but some of them spent as many as eleven days because of the general reluctance of some respondents to make time for the interviews.

The administered and completed questionnaires in the two phases are as presented in Table 1.

2) At the end of implementation of the intervention, the second phase of data collection using the same questionnaires was carried out. This second phase posed a real problem and proved to be very

tasking and frustrating. Instead of the planned 8 days of data collection, field officers in some communities spent more than three weeks.

The problem arose from some misconceptions of the people about 'all' HIV/AIDS projects. They contended that there was a lot of money being voted for fighting the disease and so they ought to be paid monies to respond to questionnaires. Unfortunately also, the farming season had started and this made potential respondents unwilling to sacrifice time to respond to questionnaires.

**DATA PROCESSING AND ANALYSIS**

a) All administered questionnaires were collected and edited by the Assistant Researchers before they were passed on to the Principal Researcher. He, in consultation with his assistants, developed a coding manual and the responses in the questionnaires were accord

ingly coded for data entry to be effected. The generated qualitative data were also collated.

b) Data analysis was done on community basis to create room for future monitoring of

progress and achievements. This was also to create room for the comparison of progress made in the various communities and relate this to the introduction or absence of the interventions. Analysis was based on the level on the continuum that various categories of respondents of each community reached on each indicator. Thereafter the average level on the continuum of each indicator for all the

c)

Stakeholders together, in the community, were calculated or qualitatively assessed by the team, working together. This was taken to represent community levels. Communities were then rank-ordered according to their levels of achievement.

Presentation of analyzed data is done in simple percentages and graphical illustrations.

## Chater 3

### RESULTS

#### Results of Community Placements

The results of the placement of the communities on the continuum of HAAPIMAT at both the pre-test and post-test stages are presented in Tables 2 to 9.

In the Leklebi Duga community (Table 2), the levels of attainment of the various categories of respondents at the pre-test stage were generally low. Except in the under-listed areas, levels on the continuum fell below level three :

**Table 2**  
**Results from: Leklebi Duga Pre-test /Post-test**

Areas of Assessment	Parents		Teachers		Students		Youths		Key Stakeholders		Whole Community	
	Max = 5 Pr	Po	Max = 5 Pr	Po	Max = 5 Pr	Po	Max = 5 Pr	Po	Max = 5 Pr	Po	Max = 5 Pr	Po
1. Awareness of general features of HIV/AIDS	3	4	4	5	2	4	2	4	3	4	2.8	4.2
2. Awareness of basic information on Ghanaian situation	1	3	3	4	1	4	1	3	2	4	1.6	3.6
3. Risen above common misconceptions about HIV/AIDS	2	4	2	5	1	3	1	4	2	4	1.8	4.0
4. Awareness of Ways/Methods of Transmitting the Virus	3	4	3	4	2	5	2	4	2	4	2.4	4.2
5. Risk Perception	2	3	1	4	1	3	1	3	2	4	1.4	3.4
6. Accepts that there is no cure for AIDS	3	5	2	5	2	4	2	4	3	5	2.4	4.6
7. Acknowledges that there is useful treatment	1	3	1	3	1	1	1	3	1	3	1.0	2.6
8. Willingness & readiness to submit to VCCT to know HIV status	1	4	1	2	4	5	1	4	1	3	1.6	3.6
9. Knows that HIV/AIDS has serious adverse effects on both family and community – could mention some of these effects	2	4	2	5	1	2	1	3	2	4	1.6	3.6
1. Knows the methods of preventing infection	2	4	3	5	1	4	2	4	2	4	2.0	4.2
11. Exhibits or ready to adapt positive attitude towards preventing infection	1	3	1	3	1	1	1	3	1	3	1.0	2.6
12. Unhindered flow of information to youth about sex education	1	4	2	4	1	3	2	3	2	4	1.6	3.6
13. Seriousness of community to take steps to combat the epidemic in community	1	3	1	3	1	1	1	3	1	4	1.0	2.8
14. Level of acquisition of life skills by youth	1	3	1	4	1	3	1	4	1	4	1.0	3.6
15. Positive feeling & attitude towards HIV positive people	1	5	2	5	3	4	1	4	2	5	1.8	4.6
16. Ready to show love and care or already caring for AIDS orphans	1	4	2	4	2	4	2	4	2	5	1.8	4.2
<b>Total for all areas (Max = 75)</b>											<b>27.2</b>	<b>59.4</b>

- Awareness of general features of HIV/AIDS: 3 or higher with parents, teachers and Key stakeholders.
- Awareness of methods of transmission: 3 or higher with parents and teachers.
- Accepts that AIDS has no cure: 3 or higher with parents and key stakeholders.
- Knows methods of preventing infection: Level 3 with teachers.
- Positive attitude towards PLWHA: Only students reached level 3.

The most critical areas before the intervention, according to the community scores on the various areas are:

- Acknowledges that there is useful treatment for AIDS – 1.0 out of maximum score of 5
- Exhibits or ready to adapt positive attitude towards preventing infection – 1.0
- Seriousness of community to take steps to combat the pandemic – 1.0
- Acquisition of life skills – 1.0
- Risk Perception – 1.4

Most of the areas of assessment showed significant whole community improvements, rising above level 3 on the continuum after the interventions. The areas that still remained below level 3 on the continuum were:

- Acknowledges that there is useful treatment for AIDS – 2.6
- Exhibits or ready to adapt positive attitude towards preventing infection – 2.6
- Seriousness of community to take steps to combat the pandemic – 2.8

In almost all the areas of assessment, the placement of almost all categories of respondents at Leklebi Agbesia (Table 3) on the continuum at the pre-intervention stage fell below level 3. The only exception was in the area of students' attitude towards VCCT where pre-intervention score was 3. Even with this score the community's mean score on this area still fell below 3.

The highest pre-intervention mean score of the community (2.2) was recorded on the area of Awareness of general features of HIV/AIDS

The most critical areas according to the community scores on the various areas are:

- Seriousness of community attempts to com-

bat the pandemic – 1.0 out of 5

- Risk Perceptions – 1.4
- Awareness of the Ghanaian situation basic information on HIV/AIDS – 1.4
- Level of acquisition of life skills – 1.4
- Positive attitude towards PLWHA and orphans – 1.4

The post-intervention scores on the various areas have shown remarkable movements up the continuum. Overall, the mean score moved from the pre-intervention level of 25.6 to 57.2. The specific areas with movements to very high levels on the continuum (5 is maximum) are:

- Readiness to show love and care or already showing it to orphans – 4.4 out of the ultimate of 5.
- Acceptance of the no cure status of AIDS – 4.2.
- Awareness of general features of HIV/AIDS – 4.0
- Knowledge of HIV transmission methods – 3.8.
- Risk perception – 3.8.
- Unhindered flow of information on sex (sex education) to the youth – 3.8
- Positive attitude towards PLWHA – 3.8.

At Ve Deme (Table 4) the situation before the intervention was not very different except that awareness of the general feature of HIV/AIDS was much higher among all the respondent categories. The other areas in which the placement of various categories of respondents rose up to 3 on the continuum were:

- Respondents having risen beyond common misconceptions about HIV/AIDS: 3 with teachers and key stakeholders
- Awareness of methods of transmission: 3 with teachers, youth and key stakeholders
- Willingness and readiness to submit to VCCT to know HIV status: only students reached level 3
- Knows methods of preventing HIV infection: Only teachers reached level 3

The most critical pre-intervention areas were:

- Seriousness of community to take steps to combat the pandemic – 1.0 out of a

**Table 3**  
**Results from Leklebi Agbesia Pre-test/Post-test**

Areas of Assessment	Parents		Teachers		Students		Youths		Key Stakeholders		Whole Community	
	Pr	Po	Pr	Po	Pr	Po	Pr	Po	Pr	Po	Pr	Po
	Max = 5		Max = 5		Max = 5		Max = 5		Max = 5		Max = 5	
1. Awareness of general features of HIV/AIDS	2	4	3	4	2	4	2	4	2	4	2.2	4.0
2. Awareness of basic information on Ghanaian situation	1	3	2	4	1	3	1	4	2	4	1.4	3.6
3. Risen above common misconceptions about HIV/AIDS	1	4	2	5	1	2	1	3	2	3	1.4	3.4
4. Awareness of Ways/Methods of Transmitting the Virus	2	4	3	4	1	3	2	4	2	4	2.0	3.8
5. Risk Perception	1	4	2	5	1	2	1	3	1	5	1.2	3.8
6. Accepts that there is no cure for AIDS	2	5	3	4	2	3	1	4	2	5	2.0	4.2
7. Acknowledges that there is useful treatment	2	3	3	4	1	3	2	3	2	3	2.0	3.2
8. Willingness & readiness to submit to VCCT to know HIV status	1	3	1	3	3	4	1	4	1	3	1.4	3.4
9. Knows that HIV/AIDS has serious adverse effects on both family and community – could mention some of these effects	2	3	3	4	1	1	1	3	2	4	1.8	3.0
10. Knows the methods of preventing infection	1	3	2	4	2	3	2	3	2	4	1.8	3.4
11. Exhibits or ready to adapt positive attitude towards preventing infection	2	3	2	5	1	4	1	3	1	3	1.4	3.6
12. Unhindered flow of information to youth about sex education	2	4	2	5	1	3	1	3	2	4	1.6	3.8
13. Seriousness of community to take steps to combat the epidemic in the community	1	3	1	3	1	1	1	3	1	3	1.0	2.6
14. Level of acquisition of life skills by youth	1	3	2	4	1	3	1	3	2	3	1.4	3.2
15. Positive feeling & attitude towards HIV positive people	1	4	1	4	2	3	1	4	2	4	1.4	3.8
16. Ready to show love and care or already caring for AIDS orphans	1	4	2	5	2	4	1	4	2	5	1.6	4.4
<b>Total for all areas (Max = 75)</b>											<b>25.6</b>	<b>57.2</b>

- maximum of 5.
- Acknowledges that there is a useful treatment for AIDS -1.0
- Positive feeling and attitude towards PLWHA – 1.2
- Ready to show love and care for AIDS related orphans – 1.2
- Exhibits or ready to adapt positive attitude towards preventing infection – 1.2
- Risk Perception – 1.4

- Acquisition of life skills – 1.4
- The intervention is believed to have had remarkable impact on the levels of attainment in the various HIV/AIDS areas targeted at the whole community level. Placement in as many as eight areas rose sharply to level 4.0 or higher on the continuum. The areas are:
- Positive feeling and attitude towards PLWHA -4.8.

**Table 4**  
**Results from Ve Deme Pre-test/Post-test**

Areas of Assessment	Parents		Teachers		Students		Youths		Key Stakeholders		Whole Community	
	Max = 5 Pr	Po	Max = 5 Pr	Po	Max = 5 Pr	Po	Max = 5 Pr	Po	Max = 5 Pr	Po	Max = 5 Pr	Po
1. Awareness of general features of HIV/AIDS	3	4	3	5	3	4	3	4	3	5	3.0	4.4
2. Awareness of basic information on Ghanaian situation	1	4	2	4	2	4	2	4	2	4	1.8	4.0
3. Risen above common misconceptions about HIV/AIDS	2	4	3	5	1	4	2	4	3	4	2.2	4.2
4. Awareness of Ways/Methods of Transmitting the Virus	2	4	3	4	2	5	3	4	3	4	2.6	4.2
5. Risk Perception	1	3	2	4	1	3	1	2	2	3	1.4	3.0
6. Accepts that there is no cure for AIDS	2	5	2	4	2	5	3	4	3	5	2.4	4.6
7. Acknowledges that there is useful treatment	1	2	1	4	1	3	1	4	1	3	1.0	3.2
8. Willingness & readiness to submit to VCCT to know HIV status	1	3	1	4	3	4	1	3	1	2	1.4	3.1
9. Knows that HIV/AIDS has serious adverse effects on both family and community – could mention some of these effects	1	3	2	4	1	3	2	3	2	4	1.6	3.2
10. Knows the methods of preventing infection	2	4	3	4	2	4	2	5	2	5	2.2	4.4
11. Exhibits or ready to adapt positive attitude towards preventing infection	1	3	1	3	1	2	1	3	2	4	1.2	3.0
12. Unhindered flow of information to youth about sex education	2	4	2	4	1	2	1	3	1	3	1.4	3.2
13. Seriousness of community to take steps to combat the epidemic in community	1	3	1	2	1	2	1	2	1	3	1.0	2.4
14. Level of acquisition of life skills by youth	1	4	2	3	1	3	1	4	2	3	1.4	3.4
15. Positive feeling & attitude towards HIV positive people	1	5	1	5	2	4	1	5	1	5	1.2	4.8
16. Ready to show love and care or already caring for AIDS orphans	1	4	1	5	2	4	1	4	1	4	1.2	4.2
<b>Total for all areas (Max = 75)</b>											<b>27.0</b>	<b>58.7</b>

- Accepts that there is no cure for AIDS - 4.6
  - Knows the methods of preventing infection - 4.4
  - Awareness of general features of HIV/AIDS – 4.4
  - Risen above common misconceptions about HIV/AIDS - 4.2
  - Ready to show love and care to HIV/AIDS related orphans - 4.2
  - Awareness of methods of transmitting the HIV -4.2
  - Awareness of basic information on Ghanaian situation - 4.0
- Areas in which community placement is still very low are:
- Seriousness of community in taking steps to combat the pandemic - 2.4
  - Exhibits or ready to adapt positive attitude

towards preventing infection – 3.0

- Willingness to submit to VCCT to know status – 3.1

Teachers at Ve Gbodome (Table 5) were also found to be more informed on some aspects of the HIV/AIDS problem. They constituted the sole category of respondents whose placement on the continuum at the pre-test stage rose to level 3 in as many as four areas of assessment. Those areas were:

- Awareness of general features of HIV/AIDS;
- Area of rising above some common miscon-

ceptions about HIV/AIDS;

- Awareness of methods of transmitting HIV and
- Could mention some serious adverse effects of the epidemic on both family and community

The most critical areas with low placement at the community level were:

- Awareness of basic information on the HIV/AIDS situation in Ghana - 1.0
- Acquisition of life skills for protection – 1.2

**Table 5**  
**Results from Ve Gbodome Pre-test/Post-test**

Areas of Assessment	Parents		Teachers		Students		Youths		Key Stakeholders		Whole Community	
	Max = 5 Pr	Po	Max = 5 Pr	Po	Max = 5 Pr	Po	Max = 5 Pr	Po	Max = 5 Pr	Po	Max = 5 Pr	Po
1. Awareness of general features of HIV/AIDS	2	4	3	5	2	4	2	4	2	4	2.2	4.2
2. Awareness of basic information on Ghanaian situation	1	3	1	4	1	4	1	3	1	4	1.0	3.6
3. Risen above common misconceptions about HIV/AIDS	2	4	3	5	1	3	1	4	2	4	1.8	4.0
4. Awareness of Ways/Methods of Transmitting the Virus	2	4	3	5	1	4	2	4	2	4	2.0	4.2
5. Risk Perception	1	4	2	4	1	3	2	4	2	4	1.6	3.8
6. Accepts that there is no cure for AIDS	2	4	2	4	1	4	1	3	2	5	1.6	4.0
7. Acknowledges that there is useful treatment	3	3	2	3	2	3	3	4	1	4	2.2	3.4
8. Willingness & readiness to submit to VCCT to know HIV status	1	4	1	4	3	4	1	3	1	3	1.4	3.6
9. Knows that HIV/AIDS has serious adverse effects on both family and community – could mention some of these effects	2	4	3	4	1	3	2	3	3	4	2.2	3.6
10. Knows the methods of preventing infection	1	3	2	4	1	3	1	4	2	4	1.4	3.6
11. Exhibits or ready to adapt positive attitude towards preventing infection	1	2	2	3	1	2	1	3	2	4	1.4	2.8
12. Unhindered flow of information to youth about sex education	1	3	2	2	1	2	1	3	1	3	1.2	2.6
13. Seriousness of community to take steps to combat the epidemic in community	1	3	2	4	1	2	1	3	2	4	1.4	3.2
14. Level of acquisition of life skills by youth	1	4	2	4	1	4	1	4	1	3	1.2	3.8
15. Positive feeling & attitude towards HIV positive people	2	5	1	5	2	4	1	4	1	5	1.4	4.6
16. Ready to show love and care or already caring for AIDS orphans	2	5	1	5	2	4	1	4	1	5	1.4	4.6
<b>Total for all areas (Max = 75)</b>											<b>25.4</b>	<b>59.6</b>

- Unhindered flow of sex education information to the youth - 1.2
- Knowledge of methods of preventing infection - 1.4
- Exhibits or ready to adapt positive attitude towards preventing infection - 1.4
- Seriousness of community to take steps to combat pandemic - 1.4
- Positive feeling and attitude towards PLWHA

The results of the post intervention assessment indicated a movement to a higher placement along the continuum in every area. The impact of the interventions on two areas of assessment was truly outstanding. These were particularly so in the areas of positive feeling towards PLWHA and care for HIV/AIDS related orphans (4.6 in each area). The other high placement areas were:

- Awareness of general features of HIV/AIDS - 4.2
- Rising above some common misconceptions about HIV/AIDS - 4.0
- Accepts that there is no cure for AIDS - 4.0

Even with the interventions, the placement of two areas was still below acceptable levels. These were:

- Unhindered flow of sex education information to the youth - 2.6
- Exhibits or ready to adapt positive attitude towards preventing infection 2.8

Results of analyses from Liati Agbonyra (Table 6) at the pre-intervention stage are similar to those of the earlier reported upon communities (Table 6). The pre-intervention levels were generally low. Teachers again lead the category of respondents who were relatively more informed. The areas in which some category of respondents place up to level 3 were as follows:

- Awareness of general features of HIV/AIDS: teachers and key stakeholders
- Risen above common misconceptions about HIV/AIDS: teachers only
- Acknowledge that there is useful treatment for AIDS: students, youths and key stakeholders

- Could mention some serious adverse effects of the epidemic on both family and community: teachers
- Knows methods of preventing infection: youths and key stakeholders
- Positive feeling and attitude towards PLWHA: students only

The four most critical areas by the whole community score before the intervention were:

- Seriousness of community to take steps to combat pandemic – 1.0
- Acquisition of life skills for self protection - 1.0
- Risk Perception – 1.2
- Willingness to submit to VCT to know HIV status - 1.2

The results of the post-intervention assessment reveal movement to higher levels on the continuum. In as many as seven areas however, the attainment did not reach level 3 and in no area did it reach level 4. The most significant of such movements were recorded in the following areas:

- Awareness of general features of HIV/AIDS - 3.8
- Acknowledgement that there is no cure for AIDS - 3.4
- Positive feeling and attitude towards PLWHA - 3.4
- Ready to show love and care for AIDS related orphans - 3.4

The still critical areas after the one-shot intervention are:

- Seriousness of the community to take steps to combat the pandemic - 1.4
- Acquisition of life skills for self protection - 1.8
- Exhibits or ready to adapt positive attitudes towards preventing infection - 2.0
- Risk Perception - 2.4

The pre-intervention assessment at Liati Wote (Table 7) also projected teachers as the most informed category of respondents. They scored up to level 3 in five areas while students scored in only one, youth in one, key stakeholders in three and parents in none. In no area, however, did the whole community score reach level three. The highest pre-intervention

**Table 6**  
**Results from Liati Agbonyra Pre-test/Post-test**

Areas of Assessment	Parents		Teachers		Students		Youths		Key Stakeholders		Whole Community	
	Max = 5 Pr	Po	Max = 5 Pr	Po	Max = 5 Pr	Po	Max = 5 Pr	Po	Max = 5 Pr	Po	Max = 5 Pr	Po
1. Awareness of general features of HIV/AIDS	2	4	3	4	2	3	2	4	3	4	2.4	3.8
2. Awareness of basic information on Ghanaian situation	1	2	2	4	1	2	2	3	1	3	1.4	2.8
3. Risen above common misconceptions about HIV/AIDS	1	3	3	3	2	2	1	3	2	3	1.9	2.8
4. Awareness of Ways/Methods of Transmitting the Virus	2	3	3	4	2	2	2	3	3	3	2.4	3.0
5. Risk Perception	1	2	2	3	1	2	1	2	1	3	1.2	2.4
6. Accepts that there is no cure for AIDS	2	3	2	3	2	3	2	3	2	4	2.0	3.2
7. Acknowledges that there is useful treatment	2	2	2	4	3	3	3	4	3	4	2.6	3.4
8. Willingness & readiness to submit to VCCT to know HIV status	1	3	1	3	2	4	1	3	1	3	1.2	3.2
9. Knows that HIV/AIDS has serious adverse effects on both family and community – could mention some of these effects	2	3	3	4	1	2	1	3	2	3	1.8	3.0
10. Knows the methods of preventing infection	1	3	2	3	2	3	3	3	3	3	2.1	3.0
11. Exhibits or ready to adapt positive attitude towards preventing infection	1	2	1	2	1	2	2	2	2	2	1.4	2.0
12. Unhindered flow of information to youth about sex education	2	2	2	3	2	3	1	2	2	4	1.8	2.8
13. Seriousness of community to take steps to combat the epidemic in community	1	2	1	2	1	1	1	1	1	1	1.0	1.4
14. Level of acquisition of life skills by youth	1	2	1	2	1	2	1	1	1	2	1.0	1.8
15. Positive feeling & attitude towards HIV positive people	1	4	2	4	3	3	1	3	2	3	1.8	3.4
16. Ready to show love and care or already caring for AIDS orphans	1	3	2	4	3	4	1	3	2	3	1.8	3.4
<b>Total for all areas (Max = 75)</b>											<b>27.8</b>	<b>45.0</b>

‘whole-community mean score’ was recorded in the area of awareness of general features of HIV/AIDS. The areas in which various categories of respondents placed up to level 3 on the five point continuum are:

- Awareness of general feature of HIV/AIDS: teachers, students and key stakeholders
- Having risen above the common misconceptions about HIV/AIDS: teacher only
- Awareness of Ways of transmitting HIV: teachers and key stakeholders

- Accepts that there is no cure for AIDS: teachers only
  - Acknowledges that there is useful treatment for AIDS: youths and key stakeholders
  - Knows that HIV/AIDS has serious adverse effects on both family and community: teachers only.
- The most critical areas (lowest placed on the continuum) at the pre-intervention stage were:
- Seriousness of community to take steps to combat the pandemic - 1.0

**Table 7**  
**Results from Liati Wote Community Pre-test/Post-test**

Areas of Assessment	Parents		Teachers		Students		Youths		Key Stakeholders		Whole Community	
	Max = 5 Pr	Po	Max = 5 Pr	Po	Max = 5 Pr	Po	Max = 5 Pr	Po	Max = 5 Pr	Po	Max = 5 Pr	Po
1. Awareness of general features of HIV/AIDS	2	3	3	4	3	4	2	4	3	4	2.6	3.8
2. Awareness of basic information on Ghanaian situation	1	2	2	4	1	3	1	2	2	4	1.4	3.0
3. Risen above common misconceptions about HIV/AIDS	2	3	3	5	1	3	2	3	2	4	2.0	3.6
4. Awareness of Ways/Methods of Transmitting the Virus	2	3	3	3	2	3	2	3	3	3	2.4	3.0
5. Risk Perception	1	3	2	3	1	2	1	2	2	3	1.4	2.6
6. Accepts that there is no cure for AIDS	2	2	3	3	1	2	1	4	2	4	1.8	3.0
7. Acknowledges that there is useful treatment	1	3	1	2	2	3	3	3	3	4	2.0	3.0
8. Willingness & readiness to submit to VCCT to know HIV status	1	4	1	3	2	3	1	4	1	3	1.2	3.4
9. Knows that HIV/AIDS has serious adverse effects on both family and community – could mention some of these effects	1	4	3	4	1	1	1	2	2	3	1.6	2.8
10. Knows the methods of preventing infection	2	3	2	3	2	3	2	3	2	3	2.0	3.0
11. Exhibits or ready to adapt positive attitude towards preventing infection	1	3	2	3	1	2	1	1	2	2	1.4	2.4
12. Unhindered flow of information to youth about sex education	1	3	1	3	1	2	1	2	1	2	1.0	2.4
13. Seriousness of community to take steps to combat the epidemic in community	1	2	1	2	1	1	1	2	1	2	1.0	1.8
14. Level of acquisition of life skills by youth	1	2	1	2	1	2	1	2	1	2	1.0	2.0
15. Positive feeling & attitude towards HIV positive people	1	4	2	3	2	3	1	3	2	3	1.6	3.2
16. Ready to show love and care or already caring for AIDS orphans	1	4	2	3	2	3	1	3	2	3	1.6	3.2
<b>Total for all areas (Max = 75)</b>											<b>26.0</b>	<b>46.2</b>

- Unhindered low of sex education information to the youths - 1.0
- Acquisition of life skills to protect self - 1.0
- Willingness to seek to know HIV status - 1.2
- Risk Perception - 1.4

The post-intervention assessment results convey at least slight improvement in every specific are of assessment. The improvements were remarkable (more than 1.5 climb) only in the following areas:

- Awareness of basic information on the Ghanaian situation - from 1.4 to 3.0
- Having risen above common misconceptions about HIV/AIDS – from 2.0 to 3.6
- Willingness to seek to know HIV status - from 1.2 to 3.4
- Positive feeling and attitude towards PLWHA - from 1.6 to 3.2
- Ready to show love and care for AIDS related orphans - from 1.6 to 3.2

Areas considered still critical arising from the post-

intervention assessment are:

- Seriousness of community in taking steps to combat pandemic -1.8
- Exhibits or ready to adapt positive attitude towards preventing infection – 2.4
- Unhindered flow of sex education information to the youths - 2.4
- Risk Perception - 2.6

Logba Vunta (Table 8) is the second control community and consequently had no intervention. Re-

sults from the first assessment categorized the community as quite an informed community, relative to some of the other communities. The teachers, parents and students reached the level 3 point on the continuum in a number of assessment areas while youths and key stakeholders reached that level in one or two areas each.

Except in the area of risk perception where there occurred a slight decrease in the whole community score, minimal increases or no differences were observed in all other areas. The only area in which

**Table 8**  
**Results from Logba Vunta Community Pre-test/Post-test**

Areas of Assessment	Parents		Teachers		Students		Youths		Key Stakeholders		Whole Community	
	Max = 5 Pr	Po	Max = 5 Pr	Po	Max = 5 Pr	Po	Max = 5 Pr	Po	Max = 5 Pr	Po	Max = 5 Pr	Po
1. Awareness of general features of HIV/AIDS	3	3	3	3	2	2	2	2	3	3	2.6	2.6
2. Awareness of basic information on Ghanaian situation	1	2	2	2	1	1	1	1	1	1	1.2	1.4
3. Risen above common misconceptions about HIV/AIDS	2	3	3	2	1	1	1	1	2	2	1.8	1.8
4. Awareness of Ways/Methods of Transmitting the Virus	3	2	3	3	1	2	2	2	2	3	2.2	2.4
5. Risk Perception	2	2	1	1	1	1	1	1	2	1	1.4	1.2
6. Accepts that there is no cure for AIDS	2	2	2	3	1	1	1	1	2	2	1.6	1.8
7. Acknowledges that there is useful treatment	3	4	3	3	3	4	3	3	2	2	2.8	3.2
8. Willingness & readiness to submit to VCCT to know HIV status	1	1	1	1	3	3	1	1	1	1	1.4	1.4
9. Knows that HIV/AIDS has serious adverse effects on both family and community – could mention some of these effects	1	2	2	2	1	1	1	1	3	2	1.6	1.6
10. Knows the methods of preventing infection	2	2	3	3	2	2	2	2	2	3	2.2	2.4
11. Exhibits or ready to adapt positive attitude towards preventing infection	1	1	1	1	1	1	1	1	2	2	1.2	1.2
12. Unhindered flow of information to youth about sex education	1	1	2	2	1	1	2	2	2	2	1.6	1.6
13. Seriousness of community to take steps to combat the epidemic in community	1	1	1	1	1	1	1	1	1	1	1.0	1.0
14. Level of acquisition of life skills by youth	1	1	1	1	1	1	2	2	1	1	1.2	1.2
15. Positive feeling & attitude towards HIV positive people	1	1	2	2	3	3	1	1	2	3	1.8	2.0
16. Ready to show love and care or already caring for AIDS orphans	2	1	2	2	3	3	1	2	2	2	2.0	2.0
<b>Total for all areas (Max = 75)</b>											<b>27.6</b>	<b>28.8</b>

the score of any category of respondents ever got to level was in the area of acknowledgement that there is a useful treatment for AIDS. This was the only area on which whole community score ever reached level 3.

Both the first and second assessments in this community are consistent in portraying the same areas as having scores that can be considered critical scores. The areas falling into this classification are:

- Seriousness of community to take steps to combat the pandemic – 1.0

- Level of acquisition of life skills for protection – 1.2

- Risk Perception - 1.2

- Exhibits or ready to adapt positive attitude towards preventing infection - 1.2

- Awareness of basic information on Ghanaian situation – 1.4

- Willingness to seek to know HIV status – 1.4

- Unhindered flow of sex education information to the youth - 1.6

Logba Alakpeti (Table 9) is one of the two control

**Table 9**  
**Results from Logba Alakpeti Community Pre-test/Post-test**

Areas of Assessment	Parents		Teachers		Students		Youths		Key Stakeholders		Whole Community	
	Pr	Po	Pr	Po	Pr	Po	Pr	Po	Pr	Po	Pr	Po
	Max = 5		Max = 5		Max = 5		Max = 5		Max = 5		Max = 5	
1. Awareness of general features of HIV/AIDS	2	3	3	3	2	2	2	2	3	3	2.4	2.6
2. Awareness of basic information on Ghanaian situation	1	1	2	1	1	1	2	1	2	3	1.6	1.4
3. Risen above common misconceptions about HIV/AIDS	2	2	2	3	1	1	1	1	2	2	1.6	1.8
4. Awareness of Ways/Methods of Transmitting the Virus	2	2	2	3	2	2	2	2	2	2	2.0	2.2
5. Risk Perception	1	1	2	1	1	1	1	1	2	2	1.4	1.2
6. Accepts that there is no cure for AIDS	2	3	2	2	1	1	2	2	2	3	1.8	2.2
7. Acknowledges that there is useful treatment	2	3	2	3	3	3	3	3	2	3	2.4	3.0
8. Willingness & readiness to submit to VCCT to know HIV status	1	1	1	1	3	2	1	1	1	1	1.4	1.2
9. Knows that HIV/AIDS has serious adverse effects on both family and community – could mention some of these effects	1	2	2	2	1	1	1	1	2	2	1.4	1.6
10. Knows the methods of preventing infection	2	2	2	3	2	2	2	2	2	2	2.0	2.2
10. Exhibits or ready to adapt positive attitude towards preventing infection	1	1	2	1	1	1	1	1	2	2	1.4	1.2
12. Unhindered flow of information to youth about sex education	1	1	2	2	1	1	1	1	2	2	1.4	1.4
13. Seriousness of community to take steps to combat the epidemic in community	1	1	1	1	1	1	1	1	1	1	1.0	1.0
14. Level of acquisition of life skills by youth	1	1	1	1	1	1	1	1	1	1	1.0	1.0
15. Positive feeling & attitude towards HIV positive people	1	1	2	2	2	2	2	1	2	2	1.8	1.6
16. Ready to show love and care or already caring for AIDS orphans	1	1	2	2	2	2	1	1	2	2	1.6	1.6
<b>Total for all areas (Max = 80)</b>											<b>26.2</b>	<b>27.2</b>

groups which did not experience any intervention. But a was done in the experimental communities, completely different sets of respondents were selected for the second round assessment. Teach-

ers here were surprisingly not found to be as informed on HIV/AIDS issues during the pre-test stage as was the case in most of the selected communities. However, some categories of respond

**Table 10**  
**Responses to some Specific Questions (Responses with highest frequency only)**

Question	Duga	Agbesia	Deme	Gbodome	Agbonyra	Wote	Vunta	Alakpeti
In your opinion where can people suffering from HIV/AIDS be found?	Abidjan Every where	Big towns Every where	Big towns Every where	Accra Every where	Big towns Mostly E/R	Accra & Kumasi Every hospital	Big towns Accra	Big towns Big towns
Will you agree that HIV and AIDS may be in your town here too?	Doubt it	No	No	No	No	Don't know	Don't know	No
	Yes	Yes	Yes	Yes	Yes	Yes	D.K	D.K
Is there a cure for AIDS?	Yes	Yes	D.K	Yes	DK	Yes	Yes	Yes
	No	No	No	No	No	No	D.K	No
Do you believe that AIDS truly exists?	May be	DK	DK	Perhaps	DK	Difficult to say	DK	DK
	Yes	Yes	Yes	Yes	Yes	Yes	Not Sure	DK
Can somebody be living with HIV without knowing?	No	No	No	Not possible	No	No	No	No
	Yes	Yes	Yes	Yes	Yes	Yes	DK	Possible
Do you agree that HIV and AIDS is a punishment from God for evil deeds?	Yes	Possible	Not Sure	Yes	Yes	Possible	Possible	Yes
	No	No	No	No	Perhaps	DK	Perhaps	Possible
Do you believe that sex is still held as sacred as it used to be?	No	No	No	No	No	No	No	No
	No	No	No	No	No	No	No	No
What is responsible for the changing perception of sexual activity?	WC	WC	Educ.	Neglect of Culture	Educ.	TV	WC	WC
	WC	WC	WC	Educ.	Educ.	TV	WC	TV
Why are you unable to introduce your love partner to your parents? (students only)	It is a secret	They will kill me	I am afraid	I am afraid	I don't have one	I am afraid	I don't have one	I am afraid
	I just can't	It will show disrespect	They will stop me	It will show disrespect	I am afraid	They will stop me	They will beat me	It will show disrespect
Do you know whether your child has a love partner?	No	Can't have	No	Can't have	Can't have	No	Doubt it	No
	No	No	No	No	No	No	No	No
Will you accept the view that the male partner must always have the last say in decisions about sex?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	Not Always	No	No	Not Sure	Not Sure	No	Yes	Yes
Would you keep it a secret if a member of your family were suffering from AIDS?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	Break Silence	Break Silence	Break Silence	Break Silence	Perhaps	Yes	Yes	Yes
How often do you talk about HIV/AIDS in your house?	Never	Never	Never	Never	Never	Never	Never	Never
	About twice	A few times	Occasionally	Once	Once	Once	Never	Never
How do you feel towards people suffering from AIDS?	Keep my distance	Keep my distance	Keep my distance	Fear & scorn	Keep my distance	Fear & abhor them	Keep my distance	Fear & scorn
	Love & care	Reach out to them	Reach out to them	Pity, love& care	Sympathy, love& care	Pity, love& care	Keep my distance	Keep my distance
Do you accept the view that AIDS patients should be offered free medical care by the Govt.?	Why should they?	No	No	Why the special attention	DK	No	No	DK
	Yes	If Govt. can afford it	Yes	Certainly	Shd. be subsidized	Partially	No	No
Should fathers also provide sex education to their daughters?	No	No	Yes	Yes	No	Sometimes	Why not	No
	Yes	I think so	Yes	Yes	Not Sure	Yes In presence of mothers	Not sure	No
Is it appropriate for adults to discuss sexual issues with youth who are not their children?	No	No, it spoils the chn.	No	No	No	No	No	No
	Yes	Yes, if sex educ.	Yes	Yes, if sex educ.	Yes, but in a group	Yes, if sex educ.	No	No
Do you believe that HIV infection can occur by touching or eating with an HIV/AIDS positive person?	Possible	Yes	Likely	Yes	Perhaps	Yes	Possible	Yes
	No	No	No	No	No	No	Possible	Likely

TV = Television, WC = Western Civilization, DK = Don't Know, Govt. = Government, chn. = children

ents placed up to level 3 in some areas of assessment. Such areas were:

- Awareness of general features of HIV/AIDS: teachers and key stakeholders
- Acknowledges that there is useful treatment for AIDS: students youths
- Willingness to seek to know HIV status: students

The most critical areas as portrayed by the results of the first assessment were:

- Seriousness of community to take steps to combat pandemic – 1.0
- Youth acquisition of life skills for protection – 1.0
- Risk Perception - 1.4
- Willingness to seek to know HIV status - 1.4
- Knows that HIV/AIDS has serious adverse effects on both family and community – 1.4
- Exhibits or ready to adapt positive attitude towards preventing infection – 1.4
- Unhindered flow of sex education information to the youth - 1.4

The results from the second assessment did not show any significant variations at both the individual or whole community levels. The whole community scores from the second assessment are either slight increases or decreases of the first scores in spite of the fact that different sets of respondents were used on the two occasions. The areas identified after the first assessment as the most critical areas have emerged again as the most critical areas. The only variation in the trend with the second assessment is the inclusion of “Awareness of basic information on the Ghanaian situation” among those in the critical score group.

### **Results on Key Specific Questions**

The results on some key specific questions are presented in Table 10.

There are two rows of responses to each question. The top rows are the responses during baseline data collection (ie. pre-test) while the second rows represent results from the post-test assessment.

## Chapter 4

# DISCUSSIONS

### **The Validated HAAPIMAT**

The study sought, indeed as a by-product of the process, to validate HAAPIMAT, a specially designed community-based instrument for assessing the community attainment levels of HIV/AIDS awareness, prevention and impact mitigation. It was important to be assured that at both levels of validation, the various levels of measure of the indicators (ie. awareness, preventive skills and care indicators) of the main instrument, HAAPIMAT, were found to make a meaningful continuum. The ability of this instrument to bring out the true attainment levels of the communities, however, depended on the relevance and appropriateness of the specific questions contained in the questionnaires that was administered.

The community-based character of the instrument and for that matter the results was ensured by the selection and use of completely different respondents during the two phases of data collection – the pre-test and post-test data collection phases.

### **Awareness Levels**

The study has confirmed that basic HIV/AIDS information has reached almost 11 parts of the country. It has confirmed the contention by some earlier reports that awareness creation is no longer the real problem with the HIV/AIDS problem in Ghana. In no community did the level of awareness fall below two points. People know what the disease is, what it does or can do, the most common infecting method as well as what cannot be done to the disease – ie no cure. While knowledge about the modes of infection was limited mainly to the sexual channel (UNAIDS, 2003 states that 80 per cent of infections occur through sexual intercourse) that of prevention and protection was also limited mainly to the use of condom. The other protecting and preventing methods were generally either overlooked or forgotten until during the post-test stage levels of attainment showed improvement in the experimental communities. The communities were also generally weak in knowledge about the specific Ghana-

ian situations or highlights with regard to the epidemic.

It was discovered further that the relatively satisfying awareness levels were clouded in a range/myriad of misconceptions among the people in the various communities. For example, some people at the pre-test stage believed that the disease was a punishment from God to prune society of immoral people. They considered that those infected were getting their fair punishment for immorality and therefore needed no sympathy or any assistance. Others believed that the disease could be acquired merely by touching or getting close to an infected person. Consequently, many respondents tended to fear, dread and keep their distance from people living with the disease wherever they are found. In all experimental communities, however, the results of the post-test assessment showed a significant rise above these common misconceptions.

It is possible that the existence of these misconceptions about the HIV/AIDS epidemic was responsible for the very low pre-test risk perceptions in all communities, falling as low as 1.2 points in some communities and never rising beyond 1.6 points in any community. Many were those who considered themselves far from any risk merely because they knew that neither they nor any close relative of theirs was a prostitute or would have anything to do with them.

On the critical issue of whether AIDS truly exists, none of the communities had positively declared its existence but chose to hide behind the indecision excuse. Similarly, in no single community was the idea acceptable at the pre-test stage that somebody could be living with HIV without knowing it himself/herself. However, there occurred appreciable increases in the post-test levels of the four communities that had the benefit of two instances of the interventions while the two Liat towns that had only one instance of the intervention each recorded only slight increases in risk perception. There were no differences in the risk perception of the two control towns.

### **Stigmatisation and the Secrecy Syndrome**

Stigmatisation of PLWHA is a natural sequence from misconception held about the epidemic. For example, the very strong perception that the victims of the disease are all immoral people and for that matter sinner portrays them not only as social outcasts but also spiritual rejects. This is likely the reason for the unwillingness of families, even if the symptoms are very obvious, to admit that a member of the family is either suffering from or died of AIDS. It is not surprising that at the pre-test stage all respondents in all communities opted for the secrecy option should any of their family members be living with HIV or AIDS. The stance changed in the four intensive experiment (two-phase) communities while it remained unchanged in the two control communities. While one of the two communities with only one instance of intervention remained unchanged the other showed an inclination towards a reviewed stance – they will ‘perhaps’ break the silence.

The indications are that this issue of stigmatisation is one of the strong cases against people wanting to know their HIV status. The levels of attainment on the HAAPIMAT with regard to the desire of people to know their status in all eight communities were very low at the pre-test measurement stage. The other factor militating against their willingness and readiness to submit themselves to voluntary counseling and testing is the complete absence of a cure for the disease. People would have felt encouraged to know their status if they saw any hope or benefit in knowing a possible positive status. As it was, most people preferred to remain ignorant of their status and possibly die when the time is due rather than remain in a continuous apprehension of knowing and waiting for an eminent death. This argument is confirmed by the fact that respondents in the experimental communities tended to be more inclined to seek to know their HIV status after the interventions when they got to know that there are anti retroviral drugs that can delay the maturation of the HIV into AIDS if it is detected before the situation degenerates into an AIDS situation.

### **Sex Education Information Gap**

The easy flow of information on sex education and on HIV/AIDS has also come out strongly as a prob-

lem area in the fight against HIV/AIDS. It was truly disturbing to have learnt from the results of the pre-test that not even in one community did a reasonable number of parents give an indication that they had ever talked about HIV/AIDS with their children. In a way, this may also be traced to misconceptions in the minds of not only parents and adults but also the youth. In this context, however, the misconceptions are not only related to HIV/AIDS but also to general moral and ethical behaviour of children.

The idea seems to be deep rooted in the minds of many adults, especially parents that sex issues are sacred and need as much as possible to be kept confidential from children. They contended that the more children or the youth are exposed to information on sexual life or issues the more immoral and socially corrupt they become. The idea of non-parent adults providing sex education to children, especially girls was even more repulsive to most adult respondents at the pre-test stage. That was why many parents, in particular, did not take kindly to the proposal/suggestion of the possible introduction of sex education into the school curriculum.

But there surely was a contradiction in the arguments of respondents against sex education which was strongly brought home to them during the discussions introduced into the second intervention sessions. If respondents claimed that the influence of televisions and Western civilisation was responsible for the changing perception of sexual activity among the youth, then the introduction of sex education into schools could not do any worse. On the contrary, it could serve as a counter check on the negative influence of the identified agents. The post-test measure of this area in the four communities that benefited from the second intervention is clearly indicative of the fact that the message and counter argument made sense to the people.

Equally serious is the implication of students’ responses to the question of whether or not they introduce their love partners to their parents and their reasons for not doing that if the response to the first part was in the negative. About 50 per cent of the students ( with median age of 15 years ) did not deny having lover partners (perhaps signifying they are sexually active) and admitting failure or refusal to introduce them to their parents. The reasons put

forward for their failure is rather worrisome and included the following:

- It is a secret which I must protect
- They (Parents) will kill me
- I am afraid

The deduction that can be made from such explanations of young youths wanting to keep some private and guarded life of their own to themselves is the general hostility of parents to their children's socialising efforts. This may be dangerous and assume a risk factor because by the relationships these children are exposed to risk situation and temptation without the advantage of any parental guidance. This may be happening when parents are under the illusion that their children have no such relationships. Under such circumstances it was no wonder that parents in four communities were so categorical in their assertion that their children could not have love partners while the other four simply said they did not know whether the children had lovers or not.

### **Behaviour and Attitude Changes**

The main concern of the study was to facilitate positive behaviour change and attitudinal development that is likely to stem the spread of HIV/AIDS in the communities covered. This was to be achieved through the experimentation of an indigenous communicating model, using not only drama but also brass band music with active community and audience involvement and participation. What the interventions sought to do was to create a forum for members of the communities, while entertaining themselves, to be exposed to learning experiences that strongly send caution messages against some risk behaviours. The indications from the results are that this objective was achieved to the extent of the time limits permissible by the study.

The results from the data analyses are quite fascinating and indicative of both the validity of the instrument and the efficacy of the belief that the indigenous communicating model used can go beyond awareness creation to facilitating behaviour change and positive attitude development. This was in spite of the fact that behaviours and attitudes are hard to change and require a very long time to manifest. Nevertheless, the analyses of relevant data in all the six experimental communities indicate the

willingness or intentions of respondents to modify their HIV risk behaviours such as attitude towards the use of condoms or their stigmatized perception of PLWHA or their dependants. The emphasis is on intention to change behaviour and not necessarily an assessment of a real behaviour or attitudinal change itself.

The contention of the effectiveness of the approach is confirmed by the differences in the analysed results between the experimental communities and the two control communities and also the light differences in the level of progress made between the experimental communities that benefited from two interventions and those that benefit from only one intervention. Communities that benefited from the two interventions and for that matter participated in the discussions expressed a stronger willingness and desire to change some perceived risk behaviours.

### **Life skills development against Infection**

Life skills in this context refer to skills to protect oneself and others from infection. They include refusal skills by girls and those that empower them to insist on their rights, self control and self discipline and the persistent and correct use of the condom.

Unfortunately, exactly what can be considered the right of girls, and indeed even women, in relationships seem to be in some form of controversy devoid of any common acceptance. The age-long traditional beliefs or norms as they relate to the male and female positions and rights in relationships tend to work heavily in favour of males.

It is argued that the most socio-economically deprived young people are the most vulnerable to sexual exploitation and risk HIV infection. Essah and Aidoo (2001) argued that because males are generally often more favoured in education and employment in Ghana, young girls and women tend to lean heavily on men for solutions to their financial problems and so expose themselves to sexual exploitation. Similarly, Rivers K and Aggleton P, (1999) observed that young women in many developing countries, including Ghana, have little control over how, when and where sex takes place.

The male is the one expected to make the first move in establishing relationships and when it is about to develop into marriage, it is the male that

pays the dowry. Accordingly, the males are endowed with unequal powers and rights over the females. This probably explains why almost all respondents at the pre-test stage, including substantial number of females and girls tended to accept the view that the male partner must always have the last say in decisions about sex .

Their positions however changed in the post-test measures in the experimental communities. This included even more than 50 per cent of the males. The rights of females, including their refusal rights, was eventually accepted in those communities. One hopes that this acceptance would remain with the people and stand the test of time.

### **Care for PLWHA and Orphans**

It has been stated that most respondents confessed their fear and perhaps even hatred for people living with HIV or AIDS. They feared and kept their distance because of the misconception that they could get infected merely through proximity and hated the PLWHA because they were considered a disgrace either to the family or the community.

In such circumstances one could hardly expect any compassion or reaching out to the PLWHA or the dependents they left behind. The level of care and support for the PLWHA and AIDS related orphans was low. It was not expected that this trend would change over the short time of this study.

Nevertheless, there was significant improvement in the expression of the desire and will to show love and care for PLWHA and AIDS related orphans. Significantly, the same intentions were not expressed in the two control communities.

### **Issues from Discussions during Interventions**

A common issue that emerged during all sessions was the perceived refusal of the formal medical sector and sometimes even Government to encourage the herbal medical approach to evolve a cure for the disease. The issue of having to pay for VCT services as a limiting factor for encouraging people to know their status was another frequently raised issue. Related to this was the issue of whether it was ethical for doctors to prescribed HIV tests on their patients without seeking the consent of such

patients. Obviously, this is an issue for the medical profession to examine in the context of the rights of their patients as far as HIV/AIDS issues are concerned.

Another common issue was the fear of the mosquito as an agent of HIV infection. The discussions revealed clearly that many people in the communities carried that misconception. The basis of course being that since the virus can be transmitted through blood and the mosquito is known to suck blood from one individual to another it stood to common sense that the mosquito should be an agent of dispersing the virus. This was one of the grounds for people wanting to keep their distance from PLWHA. In the end some discussants were strongly of the view that an investigation into whatever is contained in the enzymes of the mosquito that neutralizes the power of the HIV in the blood it sucks from PLWHA may provide some kind of a clue to protecting people against infection.

Apart from these, an important caution on a hitherto unrecognised risk behaviour was brought to the fore. Breast milk is perceived in some rural communities as a good remedy for irritating eyes or eyes with sores on it. People with irritating eyes generally sought the assistance of nursing mothers to drop breast milk on the eyes. It is believed that it gives some relief. Since HIV is transmitted through breast milk such practices become risky especially if there is a sore on the eyes to create a door of entrance into the body for the virus.

The issue of misconceptions about the epidemic was another important aspect of the discussions. Some of these misconceptions apparently affected the behaviour patterns of the people. For example, there were some who conceived the idea that HIV is a laboratory manufactured disease either to destroy Africans or to create markets for condom. Others contended that the imported condoms are intentionally contaminated with the virus in the factories. Worst of all, some females claimed to have heard that some women sanitary materials have also been intentionally contaminated at the places of manufacture. With such beliefs, it was had to expect such people to patronize the use of condoms.

Some apparently enlightened members of some communities contended that since the virus is

reported to be transmitted through body fluids, then such other body fluids as sweat, saliva, tears, vomit and urine could equally be risky hence the caution to keep their distance from PLWHA.

### **Community Response to the Epidemic**

Because of the low risk perception in almost all communities studied very little, if anything at all appeared to be done by the communities indicating concern and as their contribution to the national fight against the epidemic. This may be explained in the fact that there was no visible sign of any eminent danger to

the people. Though the communities were aware of the general dangers of the epidemic in some other places, they could not bring themselves to accept that anybody in their community had up till then died of the disease. The scores on community response in all communities at the pre-test stage was unacceptably low and only improved slightly in the four intensive intervention communities. It improved only slightly in the two communities with one intervention each while it showed no improvement at all in the control communities.

## Chapter 5

### SUMMARY AND RECOMMENDATIONS

#### SUMMARY

The main instrument of this study, HAAPIMAT, is useful as a community-based assessment instrument for determining a community's level of attainment or progress on various aspects of HIV/AIDS issues including combating and mitigating the impact of the epidemic on the people.

The study has revealed that the use of music and drama as a medium of conveying HIV/AIDS messages to communities and in particular, using local and well known people in the community as communicating links on the very controversial aspects of HIV/AIDS information has proved to be an effective. This has facilitated a movement beyond mere knowledge acquisition to a higher level of behaviour and attitudinal change. The study has confirmed the prevalence of a number of misconceptions and speculations borne out of ignorance about some aspects of the HIV/AIDS . These misconceptions and speculations tended to be a wedge between the PLWHA and the very people who should show love and care and reach out to them. Once these misconceptions and speculations are convincingly undermined and removed, it becomes much easier for the PLWHA to win the sympathy, goodwill, acceptability and support of the people among who they live.

Some traditional beliefs and norms were found to place females at a disadvantage, apart from their natural physiological disadvantage which makes them more vulnerable to infection. If females should enjoy the same level of protection from infection, then there is the need to revise some of these norms and recognize their rights, especially their rights of choice or at least a say in when, where and how to participate in sex as well as their refusal rights. Men will need to begin to respect females as equal partners in a relationship and not a subordinate or just an agent of sexual satisfaction.

A good number of people believe that given the required support, encouragement and

recognition, the herbal medical approach could make a break-through in evolving a cure for AIDS. Finally, almost all the communities, even after the interventions have been found to be giving too little attention to the fight against the pandemic. Perhaps the communities have not yet begun to see the epidemic as their direct responsibility.

#### RECOMMENDATIONS

1. The instrument HAAPIMAT can be used in other studies to assess community attainments especially in generating baseline information. The validity of the instrument for any particular purpose will however depend on the relevance of the specific questions used to generate the data for assessment.
2. The unorthodox approach to educating communities on HIV/AIDS issues has the potential of going beyond knowledge acquisition to effecting attitudinal and behavioural change. This is particularly so if the approach is combined with active community involvement and participation to fuse amusement, experience sharing, personal self appraisal and an unconscious learning.
3. HIV/AIDS is still shrouded in a number of misconceptions and speculative reasoning. This has been found to influence people's risk perception and affect their relation with people living with HIV or AIDS. As long as these misconceptions remain, people's attitudes and behaviour are unlikely to change for a more proactive approach to protecting self and others and reaching out to those infected and affected by the disease. It is recommended that HIV/AIDS education programmes should specifically target undermining and invalidating these misconceptions.
4. Related to recommendation 3 above, it is important that the beneficiary communities of

HIV/AIDS programmes and messages do not see such programmes or messages as being brought by some people who probably have nothing at stake in the community. Organisations seeking to educate and empower communities, especially rural communities, against the HIV/AIDS epidemic should endeavour to involve some locally known people in the community in such programmes. It is worth starting such programmes by first spending some time to train some local potentials to perform some critical roles in the operation of the organisation in the community.

5. There is an urgent need to minimise the vulnerability of females, especially young girls, to HIV infection. This demands that the rights of females be protected and that the females themselves are assisted not only to know their rights but also feel empowered to protect and defend them. The legal system must be made to be more responsive to this need and more severe punishment meted out to those who violate the rights of girls and women. This could serve as a deterrent.
6. The low level of community concern and protective action should be considered a

serious flaw in the campaign against the epidemic. There is the need to put in place a mechanism to continually remind the various communities not only of the implications of the continuing spread of the disease but also of the community's obligations and responsibility to stem down the spread. In this regard, it is recommended that the concept of the workplace focal person be extended in scope and focus so that communities can also have people to look up to for continual reminder of their responsibilities. It might be useful to institute community focal persons for such a function. These could be agents of NGOs, the District Assemblies or the Ghana AIDS Commission.

7. There is no doubt that herbal medicine is proving its efficacy with a good number of medical problems. There are equally reports that some herbal centres are making tremendous strides in the area of treatment of the opportunistic diseases of AIDS. One is inclined to think that with a little more support from both the orthodox medical practitioners, especially the scientific investigators and also from Government, a lot more could be achieved through herbal medicine.



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# APPENDICES

## APPENDIX 1

### RESOURCE PERSON'S SPEECH DURING INTERVENTION

#### Purpose

Good evening Togbuiwo, Mamawo, Miatorwo, Mianowo and everybody assembled here. We are happy you have found time to meet us. We have come not only to entertain you but also to bring to your attention once again a problem that has become the greatest stumbling block to our development as individuals and as a nation. Our very survival is under serious threat. Unfortunately many of us are still taking this threat as a joke.

I believe you know what I mean. I am referring to the dreadful HIV/AIDS pandemic

#### Spread and Risks

Let no one deceive himself by thinking that HIV/AIDS is an Accra, Kumasi, Lome or Abidjan disease or problem. It is .....(name of specific town) disease as well. AIDS could be in our midst here without us knowing. The disease/virus can take as long as 8–15 years to grow into AIDS - that is longer than it takes a child who enter primary one to finish JSS. During this period of gestation there could be nothing to show as a symptom. The person lives a normal life, looks very health, probably with a lot of weight and may be looking very attractive. He may even have a lot of money to be throwing about and enjoying a lot of life. It is believed that such people are very many these days. They could be men or women. Such people who have the virus but are not yet suffering from AIDS are called carriers and are more dangerous than those who are known to be actually living with AIDS. In most cases the people themselves do not know. People get to know their status only after going through an HIV test.

We are told that all over the world there were about 40 million people living with HIV/AIDS by 2003. They will be much more than that by now.

Of this huge number, more than three in every four are found in African South of the Sahara alone. That is our part of the world. It is also said that 16,000 people get infected everyday and 15,000 of this happens in Africa. By the year 2000, 13 million people are said to have died of AIDS in Africa alone. These figures are known because people in other countries do not see any need to hide their relations suffering from this disease as we do hear in Ghana. Unfortunately in Ghana, we consider it a family disgrace and so we hide it. But there is nothing disgraceful about it because we know it is not everybody who has the virus through irresponsible sex. Some had it by share accident and by no fault of theirs.

In Ghana, the disease started with only 42 cases in 1987 but now over 43,000 full blown AIDS cases have been reported. It is estimated that there are more than 500,000 people who are HIV positive. The HIV prevalence rate in Ghana is between 4.0% and 4.6%. It has spread to all regions with the heaviest concentration in Eastern Region and Ashanti.

About 90% of HIV/AIDS patients across West Africa and for that matter Ghana fall between the ages 15 and 49. This age range is considered the high risk range. This is because the youth are the most mobile and move from place to place. They also like adventure, including sex adventure, and therefore expose themselves to risks.

#### Modes of transmission

The question then is how is the disease contracted? I will talk briefly on that.

According to what has been found out, the main mode of infection is through sexual intercourse with somebody who already has the virus. HIV infection could also be caused by vertical transmission and transmission through blood. The point is that the virus can only survive in fluid, including blood and the fluid that both male and females pass out during intercourse. It is for this

reason that it is possible for pregnant mother with the virus to pass it on to their babies even before they are born. The virus can also be passed from one person to another through the common use of such sharp things as blade, needles and shaving sticks which could inflict a cut and move the virus from one body to the other. It could also be dangerous for two people to use one tooth brush which could inflict cuts on the gum. Even kissing can sometimes be dangerous.

### Prevention

If these are the modes by which the virus is spread, how do you prevent infection?

- First and foremost, love yourself enough not to want to put yourself in any preventable trouble. Married people should equally love their wives and children not to put them in any trouble either.
- Avoid casual sex. You will be helping yourself and pleasing God if you completely abstain from casual sex. God has given everyone the power of self control to be able to do this. If however you are unable to completely abstain, then always protect yourself by using condom and learn to use it properly. I want everybody here to know that girls and women also have a right to tell the males how and even when to have sex and the men have a responsibility to listen to their demands/choices.
- As much as possible avoid the use of needles, blades or shaving sticks that has been used by someone else. Let's stop the habit of always expecting to take injection when we go to the hospital. As a precaution, some people even take their own barbering tools to the barber when they want their hair cut.
- Don't hide the status of any relative who you know has got infected. And let us all stop blaming infected people because it makes them want to hide their status and secretly continue to spread it. Let us also stop seeing such people as social outcast. They are normal human beings like any of us.

### Treatment & Mitigation

So far, no cure has been found for AIDS but it is possible to treat or control the disease to make the patient live longer than could otherwise have been possible. The truth is that AIDS itself does not kill but breaks up the immune system and opens up the body to easy attack by various other diseases which can kill. The disease also makes the patient lose appetite for food and therefore continually loses weight.

There are, however, various drugs that can remedy some of these and delay the development of the virus into AIDS. This is the more reason why it is useful to know one's status early so that one can begin treatment early. We know that some drugs have been developed in the advanced countries to delay the development of the virus into AIDS. But they are quite very expensive. It is said that the dose for one person per year costs about \$1000 (About ₦9 million). The good news however is that Government has plans to subsidize the cost of treatment for those who are known to be HIV positive. So you see, going through the HIV test is now worth it. There is still hope of living normal life even if you test positive.

The greatest assistance and treatment we can offer an AIDS patient however is **love and care**. Most of them die pre-mature out of despair, frustration and tension. They die early because the public, including even their own relations tend to accuse and reject them. We are quick to condemn all of them as prostitutes and sinners. But it is not all infections that occur through sex. Even those which occur through sex, it is not all that are sex in sin as we tend to conclude. Some faithful wives or husbands also get infected because the partner was unfaithful but we tend to blame them all.

I have a very important message for you all tonight. From tonight, stop condemning those who test HIV positive. If we treat them as social outcasts, they will hide their identity and out of frustration knowingly infect others. They need our love, compassion and care and not hatred or re-

minder of their weaknesses or sins. We need to keep their hopes alive. Remember that you could also become like them purely out of accident. And their children also need love, care and support.

There are some life habits that assist HIV to destroy the immune system very fast. These include drinking, smoking and poor feeding habits. My advice to you all is that even if you are not bold enough to go and take the HIV test to know your status, just assume that you could be one and, for that matter, avoid those things that help the virus to develop quickly. Togbuiwo, Mamawo, ladies and gentlemen, AIDS is real and is closer to you than you can imagine. **Let us run away from it. Start this run today.**

Thank you for your attention

## APPENDIX 2

### MAIN ISSUES CONTAINED IN DRAMA

1. HIV/AIDS is an illness that brings about a lot of suffering on those infected.
2. Anybody may be infected, through ones own carelessness or by accident.
3. Both male and female can get infected with HIV.
4. Most infections occur through sexual intercourse. However, there are some other ways of getting infected
5. One does not need to have unprotected sex more than once with an HIV positive person to get infected.
6. The use of condom may protect a person against infection but it is not 100 per cent sure.
7. It is not every HIV positive person who was once a morally bankrupt person.
8. People living with the virus may look very strong and healthy – the gestation period can be very long. It varies from person to person.
9. The sufferings of AIDS patients far out-way whatever benefits they must have derived from unprotected sexual activity.
10. It is very expensive to care for people living with AIDS.
11. Lack of care and disillusionment can hasten the death of people living with AIDS.
12. AIDS itself does not kill but brings about attack by other diseases which kill.
13. AIDS can be treated for relief but no cure has yet been found.
14. It is important that people show love and care to people living with HIV/AIDS.
15. The more people living with HIV/AIDS are scorned the more reluctant they are to reveal their status and protect others.
16. It is not helpful to the community when people continue seeing people living. With AIDS. as criminals or sinners or try to keep the plight of their relations a secret.
17. It is also important to show love and care for orphans resulting from AIDS related deaths
18. The whole community has a responsibility to take steps to combat the spread of the HIV/AIDS epidemic.
19. The problems of HIV/AIDS is not only that of the family but affects the whole community.
20. HIV/AIDS is very dangerous and need to be fought by all. Yes No

### APPENDIX 3

(PLAY WITH TITLE “BEWARE:HIV/AIDS IS NEAR YOU”)

**TITLE: KP NYUIE; DIKANAKU DLELEA TEDE DUWO**

**TADODZINU: FEFE SIA LE NU FIAM TSO M VOVOVO SIWO DZI AMEWO TONA  
XDA DIKANAKU DLELE (HIV/AIDS).**

#### **NUKPKP GBĀT**

*(Le Afet Agbenyo fe Afeme. Afet Agbenyo Do Dze Kple Viawo)*

- Afet Agbenyo: Kuv
- Kuv : Papa, nyee nye si
- Afet Agbenyo : Fu du yi nay nviwòwo ve nam fifi laa. Mele wo dzm.
- Kuv: Yoo! Papa mesee (Efu du do go. Ekp Sika dzo yina daa)
- Kuv: Davi Sika! Davi Sika!
- Sika: Nu Kae dz?
- Kuv: Papa be yele mi kata dim fifi laa!
- Sika: Ebe nya kae dz? Menye fifia koe miegb tso Sleme oa? Enyo mesee.
- Sika: Akos, Nviwòwo de?
- Akos: Woawoe nye ma n anyi de fo Agbedut fe baa.
- Sika: Gbl na wo be papa le miaym (Akos k wo, Wo katã va n anyi)
- Afet Agbenyo: Akos, y dawò nam le dzodofe.
- Akos: Dada! Papa be nava
- Afen Sedzi: Nya kae gadz? Fofowò y ame akpa.  
(Akos kple dada Afen Sedzi va n anyi)
- Afet Agbenyo: Vinyewo mia woe z! Kuv le afi maa?
- Kuv : E! Papa, meli.
- Afet Agbenyo: Kuv, see ne woasee be, menye nya k adeke tae mey mi o. Dze ade ko medi be miado tso dlele vdi si wole meky be “dikanaku” si va b de mia domii hele amewo wum atradii la nti.

- Afeav: Papa d kae woychna be “dikanaku?”.
- Afet Agbenyo: Dikanakud nye dlele vdi ade si ke woxna tsoa ame ade si nti d la le la gb. Ne ame ade x d sia la, d la an efe lāme fe gede eye be amea abl azu xakui hafi ava ku emegbe. Ke le ame adewo gome la, dda an wo nti fe gede hafi dzesia nava dze.
- Afen Sedzi: Akpe na wò!. Vinyewo, mido to ne miase mia fofò fe nya siawo nyuie hee!
- Afet Agbenyo: Medi be mana mianya bena dikanakud sia x anyi n de mia dome gli. Eye hena fifia la, womekp atike adeke na dlele sia dada o. Ne ex dda la, ekema nyae be yeku da di hafi le agbe.
- Akos: Papa, ale ke wo x dlele sia?
- Afet Agbenyo: D sia fe xax konue nye to nychnu kple ntsu fe gb d d yakats me. Mchnu sia kon ye b wu. Le go bubu me la, wote n x dlele sia toa abuidodo me. Xe adewo xi hā la, etoa lānuwo abe bledihē ene si wozā na ame ade si ke n d sia le xoxo la me. M bubu hāe nye ne wodo u si wode le lāme na ame ade is nti dlelea le, eye wodoe na ame si nti mele o la, eya hā axax b b. Ke bubu hāe nye ne nychnu ade f fu hafi dlelea ge de lāme ne alo dlelea le enu xoxo hafi wof fua la, devia hā axax dlelea hafi woadzii.
- Kuv: Papa, mede kuku wogbl mese be ne wozā m d le ntsu kple ny fe gb d me la, womax d sia o.
- Akos: Nyatefee, nychnuwo kple ntsuwo fe m d b fifia lo!
- Afet Agbenyo: Ele eme vavā be m d li gake menye wo katòe nyo o. M d adewo n anyi etefe didi eya ta le wozāzā me la, woate n an, adze alo awò g hā. Ke ne edz alea la, dlelea ate n atso ame si n wòle la ayi na ame evelia.
- Afen Sedzi: Ei! Ekema tsitsiawo, deviwo, sr d, kesin d kple ahetsiwo siaa fe agbe le xaxa me kon.
- Afet Agbenyo: εε! Ele me tututu eya ta m nyuit koe nye be miatsri ahasiw d kple gbolow d alo hoteliw d vivivo.
- Kododo: Ke ne ele alea de miagate n ade sr d?
- Akos: Ao! Tre ko mian atsi vi madzimadzii elabena ne metsi ko la, enyo nam wu be maku.
- Afen Sedzi: Ao! Ame adeke matsi ko o. Ke bon ele be hafi nychnu kple ntsu ade nade wo d la, ele na wo be woayi K dzi woado wofe u kp anya nenyē be dlelea li loo alo meli o hafi woade sr d.

Afet אגבניו: Vinyewo! Ne miele ηku de ame siwo gb כnyits כtso Abidzan, South Afrika kple Ge nutowo me ηu la, miakp כbe wodzra wo dokuiwo do nyuie. Won כga wum na amewo ko. Esia כgbi megadzro mi be yewoadze wo yome loo alo akpl כwo do ayii o. D כlelea כafe le tefe mawo ηut כ.

Afeav כ. Ei! Wogbl כna mi le suku be ame siwo dzea ame siawo yome vevit כnyכnuviawo la, hoteli alo gbolod כwova כna eye ηutsuawo hã va zua agbamekכlawo le amedzrodzefewo kple baawo.

Afet אגבניו: Vinyewo! Edz כdzi nam be miex כnya siwo me miedzro la. Medi be mate gbe de nya sia dzi na mi be, miafe ככככככ le agbe sia mee nye be ne mieku la, miadi ni ke menyе miawo maku miadi o.

Wo Katã: Yoo! Papa miesee. Akpe na wò kekeke!

Afet אגבניו: Miate ηu ayi gb כ. Miagado go emegbe.

Wo Katã: (Wodzo)

### NUKP כ K P כ EVELIA

*(Le Nuwכkp כ fe Dehadzrafe. Dutsu Adewo Do Dze)*

טכgbale Nuwכככ, ηdi na wò

Davi Nuwכככ: ηdi, afemetכwo? Eli nyuie dea? Miawoe gadee le me ets כ.

טכgbale: Nuwכככ, dehaa va doa?

Nuwכככ: Eva do xoxoxo.

טכgbale: Ku tre deka dodem mats כwu ets ככ. [Ex כaha la, henoe] (tufuie). Egbet כha ganyo nam ηut כ.

Afla: Agoo! טכgbale!

טכgbale: Nye טכgbale xoxo ככ kכto, ebe yex כasi wu Klogo. Tכe de ‘me nam kכ (Taa! [Wona asi hel כgbe])

טכgbale: Tכdomefla!

Afla: Nye Tכdomefla. Ebe yenye mi de dzo wכãdãwo fe nu me.

ʘgbale: Nuwkp, ku tre deka nam mafla. (Ekui ne wòno kpaa!)  
 Afla: Ehe! Klogo ʘtɛ nye ma gbna daa .....  
 ʘgbale: Gbee wodo de anyia? Atkpli hãe nye ma ʘlã gbna daa.....  
 Klogo kple Atkpli: (Wova do) (Wolɔ gbe)  
 Afla: Nuwkp, wò ahaa egbet ya gale eme lo!. Ku tre deka, deka na  
 nɔvinyeawo) (Nuwkp ku aha nawo. Wonoe)  
 Afla: Klogo!  
 Klogo: Enye tututue! Devi gbã abɔgo megbãa Klogo o! Mia tɔwo miafe  
 sekendri sukua gbã !. Egbã lo!  
 Afla: (Emu aha. Edo asi de ya me) (Tututu! Egbã nyatefe)  
 ʘgbale: Ale ke sukua w hafi gbã. Nu kae dz!  
 Klogo: Woya mese be wova do sukuviawo kp nyits be woade ʘ le Kpando  
 kɔdzi .....  
 Afla: (Edo xli sesie) (Efiã asi nyɔnuvi ade si va yina la yome) Nyɔnuvi enyi  
 kple ʘtsuvi ade ʘue AIDS dɔlelea le.  
 Atkpli: (Edo asi nu) Mido to mase nu! Busunya kae nye ‘ma gbɔm miele.  
 Klogo: Oo! Nyatefee! Vinye nyɔnuvi Awusi hã le wo dome.  
 Atkpli: Nyatefea? Nyatefee! Ekema mieku de. Ke wogale suku dema?  
 Klogo: Ee! Wole edem! Ɖe nebe wonenya woa? Ne ekp devi mawo hã  
 manya be naneke le dzɔɔɔ de wo dzi o de.  
 Klogo: (Edo asi de dzi) Nye hã medze ahiã deka nyits hafi wògbe lo !  
 Atkpli: Mese nyits be nufiala Bɔglo hã va di dase le Sɔlime be yede Kpando  
 kɔdzi wodo yekp eye dɔlelea le ye ʘu.  
 ʘgbale Ɖe wogblɛ le ʘjuti loo, alo eya ʘtɛ di dasea?  
 Klogo: Eya ʘtɛ va di dase sia le tsɔtsix me.  
 ʘgbale: Ekema miafe sukua gba vavã.  
 Atkpli: (Ele sigareti de asi) Ele be woade nufiala Bɔglo dzoe yi wo de.

- Klogo: Ao! Sukutatwo be womadee o, elabena eya wɔɛ nyuie be wodi dase be amewo nanya be yeke dɔɔ lem. Enyo wu be woabe de eme ama dɔɔlele vɔɔdi sia na ame bubuwo.
- Atɔɔkli: Eɔɔ ne ekpɔɔ nufiala Bɔɔglo sia la, efe lāme nyo eye wogadze deka de dzi wu tsa.
- Ƴɔɔgbale: Yuie! ‘ye ma! Dutsu nyo, dikanaku dɔɔlelawo fe fia! Mese be le ale si wova de gbefā le edokui ηuti ta la, wo fe sɔɔlimetwo dzɔ ga home gāa ade ne be wòatsɔ anɔ atikewo flemii.
- Klogo: Gake mienya! Wobe wodo viawo katā kpɔ ke dɔɔlelea mele woawo ηuti o.
- Atɔɔkli: Ahā! Efia be srā fe dzodzo le gbɔɔ kplɔ de dzɔgbewɔɔ sia me.
- Klogo: Ekema miana amewo nase egɔme be, ele be miakafu ame siwo ɔ faa le gbefā dem be yewole dɔ vɔɔdi sia lem. Wodze na akpedada wɔɔɔ.
- Ƴɔɔgbale: Nenye be ame siwo ɔ dɔɔlelea ηuti alo wo fe fometwo de wòal ase egɔme eye woade gbefā le dɔɔ ηuti la, dɔɔ sia fe kakaaka abɔɔ le miafe nutoa me.
- Afla: (Emu aha vlevlevle hele afa dom) AIDS wu mi vɔ loo!.....
- Wo katā: (Mina miakplɔ Aflla ayi afe mee) (wodzo)

### NUKPɔKPɔ ETɔɔLIA

*(Le dodo le sɔɔlime megbe. Dutsu kple nyɔnu adewo do dze)*

- Daa Lanyo: Mia tɔwo mitɔ mabia mi se.
- Wo katā: (Wotɔ) Nya kae dzɔ? Nya kae le asi wò!
- Daa Lanyo: Miese be Fo Agɔkpa gbɔɔ?
- Dɔɔmenyo: Agɔkpa ka?
- Daa Lanyo: Esi ɔ South Afrika si va afe le Teduzā me nyitsɔ laa va wɔ sho na amewo
- Mɔkpɔkpɔ: Wo be edze dɔ sese ade hegɔ va afea? Ede va kpɔɔea?
- Dɔɔmenyo: Miese o de? Davi Dosu hā dze dɔ vevie wotsɔ tso Abidzan gbɔɔ egbe nye ηkeke etɔ. Wo be .....

Tɔbu: (Edo xli) Dosu ka? Dosu dekaa? Ekema mieku de. Miafe ame vevi siawoa? Ao! Ao!  
(Ekpla asi ta eye adatsi lolo de ŋku dzi nɛ)

Afetɔ Agbetɔ: Mide va kpɔ wo da kpɔa? Nyea mede va kpɔ fo Agɔkpa. Wo be anyrãe wowɔ le eɲu le efe dɔ me.

Mɔkpɔkpɔ: Tututu! Wo be Davi Dosu hã exɔɔ va dzrae na dzotɔ ade wodui kple dadi dzo.

Afetɔ Agbetɔ: Nyea le nye susu nu la, ewɔ nam abe dɔ vɔdi siae. “AIDS” si va bɔ fifia le wo.

Tɔbu: ‘Leke miewɔ nya?

Afetɔ Agbetɔ: Ale si mede va kpɔ la, e .... e.... ewɔ nam .....

Tɔbu: Ohoo! Suklidi hã naa amewo blɔna nenema lo!

Afetɔ Agbetɔ: Ne ekpɔ fo Agɔkpa la, magakpɔ dzesi o. Efe nu me katã wɔ abi. Gbe hã vɔ le enu eye mete ŋu le nu hã dum o, gawu la, wo be afɔdzi kple adudɔ deko wole gbɔgbɔ le eɲu.

Daa Lanyo: Agbetɔ! Wò nya me kɔ nam. Ne edo Davi Dosu hã gbɔ la, vovototo adeke mele nu si negblɔ tso fo Agɔkpa ŋu kple etɔ dome o.

Mɔkpɔkpɔ: Ehiã be miakpe de wo ŋu lo! Elabena woawo hã wowɔ wotɔ sinua le dua fe ŋɔyiyi wɔwo me.

Afetɔ Agbetɔ: Miawoe le nu fom. Nyea nyemegale wo gbɔ de ge ava xɔ busu adeke va fu afe me o.

Dɔmenyo: Mese ame adewo be wofe dɔlele sia la trɔe wonye woyɔ de wo.

Afetɔ Agbetɔ: Alakpae! Menye trɔ nya adeke o. Dikanakudɔ le wo lem. De mienɔ nufiala Bɔglo kple sukuvi gbogbo mawo fe nyawo blea?

Tɔbu: Ekema nenemae woawo hã woava zua?

Afetɔ Agbetɔ: Dikeke adeke mele eme o.

Mɔkpɔkpɔ: Megale egblɔ be ehiã be miana kpekpedeɲu ame siawo lo!

Afetɔ Agbetɔ: Esi wò nele esia gblɔ de enya be wofe fomɔwo ka le wo ŋua? Ame bubuwoe le wo dzram do!

Mɔkpɔkpɔ: Gake dzixɔse le asinye be ne miena kpekpedeɲu wo la, dɔ sia male mi o.

- Daa Lanyo: Eya ta mina miayi wofe fometwo gb, ade nya me na wo be tete de dikanaku dlelelɛ ɲua, mana be ame naxɔ do sia o. Ehiã be woana kpekpedeɲu wo boɲ to nududu nyui nana wo me, atikewo fefle, wofe nuwo nyanya na wo kple wo xaxɔ de miafe hawo me, ado dzidzɔ na wo eye woade dzi fo na wo. Menyo be woanyɛ ɲu le wo ɲu o.
- Dɔmenyo: Ekema ne ele nenema la, mina miado ɲkeke ayi wo gbɔ.
- Wo katã: (Wodzo)

**NUKPƆKPƆ ENELIA**  
(Le Fo AgƆkpa fe afe me)

- Wo katã: (Wodze mɔ yina. Lanyo fɔ nake, Dɔmenyo hã tɔ atikutsetsewo, MƆkpƆkpƆ ku tsi de ahatukpa me eye Agbetɔ kple Tɔbu kplɔ wo do)  
(Wo do Fo AgƆkpa fe agbo nu)
- Afetɔ Agbetɔ: Agoo! Agoo!
- Nɔvinyo: Amee (Eɔu agboa) Miawoe zɔ. (wona zikpuiwo, wonɔ anyi). Mia gbɔ fa, miafe amanie de?
- Afetɔ Agbetɔ: Tɔbu see ne woasee be mietsɔ nya ɔ adeke vɛ o. Dɛko mieva be, miakpɔ mia fo da.
- Nɔvinyo: Yoo! Miawoe zɔ! Mina miage de dzi le hɔlua me.
- Wo katã: Wodze Nɔvinyo yome hetɔ de xaxɔ mɔ nu.
- Nɔvinyo: Efo agoo! Ame adewo va be yewoakpɔ wò da.
- Fo AgƆkpa: Migede eme. (Woge de xaxɔ me)
- Fo AgƆkpa: Agbetɔ miawoe zɔ.  
(Wo katã wona asi wonɔewo henɔ anyi ɔ gbe)
- Fo AgƆkpa: Nɔvinyo see ne wòado mia nɔviawo gbɔ be miagbɔ fa. Ale ke wogava fo de mia dzi alea mahã?
- Nɔvinyo: Tɔbu miese gbea?
- Afetɔ Agbetɔ: Tɔbu see ne wòado gbɔ, be, deko miedi tsa va be miakpɔ efe fɔ me da, an ɔ egbɔ vie.
- Fo AgƆkpa: Yoo! Miawoe zɔ kekeke. Miawoe bu ame ɲu.

Daa Lanyo: Fo Agkpa ale ke nye wò lãa me/

Fo Agkpa: Fifia ya la enyo wu gbã .....

Nvinyo: Oo nyatefee akpe miada na Mawu.

Dmenyo: Nyatefee esi wogb teti eye meva kpa da la mev.

Fo Agkpa: Esi megb teti ya la, nyemega bu agbe na dokuinye o, eye mekp be ame gedewo be yewoate de nyunye g hã.

Mkpka: Efo! Afi ka koñue wònye le ve wom?

Fo Agkpa: AIDS d lem mele.

Wo Katã: Ao! Baba na wò!

Tbu: Efo! Ale ke new nya be d ma lem ye le?

Fo Agkpa! Hm! De wodo nye u kp le Dkazi le Cape Town afi mae wogb nya sia nam le. Wona menya be atike adeke meli si ada dlele sia nam o. Afe ku nyo wu gbe ku, eya tae megb va afe do. Ke mida akpe na Nvinyo nam. Ne menye eyae o la, anye ne meku xoxoxo.

Wo Katã: Nvinyo wòele d dzi kakaka!. Woele ame ta kp. Mawu neyra wò.

Nvinyo: Efo, wò hã nade akpe na wo. Lanyo f nake, Mkpka du tsi, Dmenyo hã ts atikutsetse gbogbo adewo, akdu si nelna vevie la hã le eme eye Fo Agbet kple Tbu ha ts cidid akpe bla (¢50,000.00) nam be mats adze kokoe na wò.

Fo Agkpa: Nu gbogbo siawoe miets ve namua? Yoo! Mex wo kple dzidz. Mawu nado etefe na mi.

Afet Agbet: Nvinyo miele m biam be miagatr ayi afe me.

Nvinyo kple  
Fo Agkpa: Yoo! M li miawoe w d kekeke.  
(Wo katã wodo hedzo. Nvinyo de af m me na wo vie hetr)

Nvinyo: Mase mi de afii. Miade afe me nyuie.

Wo Katã: Yoo! Miagado go.

## NUKPᵀKPᵀ ATᵀ LIA

*(Le Afetᵀ Agbetᵀ fe afe me. Daa Lanyo, Dᵀmenyo, Mᵀkpᵀkpᵀ kple Tᵀbu wova do go kple wofe nunana vovovoawo hena Davi Dosu gbᵀ yiye le efe afe me.)*

- Afetᵀ Agbetᵀ: Nᵀvinyewo miva do xoxoa?
- Wo Katā: Eeē! Miesusui be mietsi megbe gbᵀ hā de?
- Dᵀmenyo: Ahā! Tᵀbu hā va do! Ke miesᵀ gbe de?
- Afetᵀ Agbetᵀ: Enyo ekema miadze mᵀ zi deka.  
(Daa Lanyo tsᵀ bli, Dᵀmenyo tsᵀ miniki go ene, milo go deka kple sukli, Mᵀkpᵀkpᵀ tsᵀ adzalē fomeviwo Afetᵀ Agbetᵀ tsᵀ te adewo, Tᵀbu tsᵀ Mᵀli gbogbo ade wodze mᵀ do ta Davi Dosu gbᵀ)
- Mᵀkpᵀkpᵀ:Nᵀvinyewo! Esi me Davi Dosu gbᵀ tso Abidzan kple devi gbogbo mawo la, srᵀa meva kpᵀ o.
- Daa Lanyo: Koo! Woya menya oa? Wobe srᵀa ku xoxoxo eya tae wògbᵀ kple deviawo do.
- Tᵀbu: Aā! Eya tae deviawo dzi kpᵀkpᵀ va zu agba na eya kple efe fometᵀwo.
- Afetᵀ Agbetᵀ: Gake fometᵀwo mele kpekpedeju gobi adeke namii o.
- Dᵀmenyo: Ahā! Eya tae deviawo gbugᵀ suku do.  
(Wodo Davi Dosu fe afe me mᵀ nu)
- Wo Katā: Agoo!
- Dzidefo: Amee! Miawoe zᵀ loo!  
Yayra mifᵀ zikpuiwo ve na ameawo. (Ameawo nᵀ anyi) (Wolᵀ gbe)
- Davi Dosu: (Ese ameawo fe ᵀka. Eyᵀ via Dzidefo da be wòava ye gbᵀ le xᵀa me)
- Dzidefo: Mami!
- Davi Dosu: Dzidefo ame kawoe?
- Dzidefo: Dada megᵀna. (Ebᵀ nᵀ ameawo gbᵀ.
- Wo Katā: Dzidefo miefᵀ sesiea? Mianᵀ de?
- Dzidefo: Ele xᵀa me.
- Afetᵀ Agbetᵀ: Miedi be miakpᵀe ado gbe ne

Dzidefo: (Efu du yi dada gb). Dada Agoo!

Davi Dosu: Amee. Ame kawoe va?

Dzidefo: Dada ame adewoe va le diwom.  
(Davi Dosu te dndndna ameawo gb)

Davi Dosu: Mina zikpui ameawoa?

Dzidefo: Eê! Won anyi xoxo.

Davi Dosu: (En anyi) Miawoe z

Wo Katã: Yoo! Ddi na wò.

Davi Dosu: ndi mia 'femetwo de, miawoe z. Gbnye fa.

Afet Agbet: Oo, miagbã hã fafae. Ke mieva be miakp wò da ado dze kpli wò.

Davi Dosu: Miawo ya miele vnm nam oa?

Dmenyo: Ao! Nu ka ta miav na wò?

Davi Dosu: Mezu bibii na fonyemetwo ya, de AIDS d si lem mele la ta, esia w be mebia nya sia mi do.

Daa Lanyo: Kpao! Miate ñu adu nu, ano nu, ale tsi kple wò gake esia mana be miav d sia o de.

Mkpkp: Miate ñu amlaba deka dzi kpli wò, anya wòfe nuwo kej g hã.

Davi Dosu: Yoo! Akpe na mi. Nyemenya be mi ame adewo ya miese nu gme alea o de.

Tbu: Ke ale kee nye wò alãa me?

Davi Dosu: Nenema ko wole. Mewuam hã o eye mele kakam de eme hã o.

Daa Lanyo: Deviwò de, wogale sukua dem fifia?

Davi Dosu: Ale ke woaw ade suuu? Dzikpla meli o. Wo fofò ku xoxoxo eye nye ñutu hãe nye si tsi aba dzi.

Afet Agbet: Ke ne ame ade adi be deviwò domet ade neva n ye gb de ala?

Davi Dosu: Makp nu nyui agbea? Akpe ko made de!

- Daa Lanyo: Yoo! Davi Dosu miесе wò nyawo katã Mawu ñut awе sia. Dzidefo nu siawoe miets ve na mi miva fwo dzra do. (Dzidefo kple nviawo f nuawo yi dzadzrado ge).
- Davi Dosu: Nyee miel nu gbogbo siawo ve naa? Akpe! Akpe! Na mi. Mawu ñut nedo etefe na mi.
- Daa Lanyo: Edziyi, nyñnu bibliahabнkwо hã be miats sidi akpe blaet sia na wò.
- Afet Agbet: E. P. Hamea hã be newoats sidi akpe blaet sia na wò.
- Tbu: Hekpe de esiawo ñuti la, miafe gbedoxme hadziha hã be newoats sidi akpe blaevе sia na wò. Wo be mana nanya be Ksidagbe le dodo le Slime megbe la, yewoava n gb wò vie ado dzidz na wò kple hadzidzi wo.
- Davi Dosu: Yoo! Ne mieyi la, miats nye akpedada yina Hame bliboa kple nunamelawo katã.....
- Mkpkp: Miatwo hafi miadzo la, mia ts afe blibo la katã ade asi na Mawu. (Wodo gbea da).
- Afet Agbet: Davi Dosu az miegale m biam.
- Davi Dosu: Yoo! M li. Miawoe w d egbe. Miade afe me nyuie (Wodzo)

### NUKPKP ADELIA

(Dunenyo dukа di anyi de Abl me le ñdi kanyaa ade)

- Tgbui Zukpe II: Tsiami le afi ma?
- Tsiami: (Ele tsitre nu) Tgbui meli! Agoo! Dodoe nezi.
- Tgbui Zukpe II: ñdi na mi; mia femetwo, miawoe z.
- Tgbui Zukpe II: Tsiami see ne woado duk la gb be nu si ta meyi wo ñdi siae nye be dlele le si nye AIDS vax n de miafe Dunenyo duk sia me ale gbegbe, eye ne mietr asi le enuti o la, dua atsr kenken azu afedo me. Nye kple nye ametsitsiwo mieva kpe be ehiã vevie be miagagbugb ale miafe dekn si nye 'gbtow' na detugbiwo me de asi sesie. Miedze sii be nyñnuwo kple ñutusuwo fe matrewo vivivoe va w be dzi de le dzila gedewo fo hena knu sia kw na wo vi nyñnuviwo. Ke miele edom de duk gb be, tso fifia heyina la, nyñnuvi siwo katã ato knu sia fe dodokpwo katã me nkw la, duk adz ga akp nenem devi siawo dzi woade suku ado. Nenyе d ameawo be yewoasr hã la, duk dewo d me, ade wo hã le d me, afle dknwu ha na wo. Esia yome la miado bubudede x anyi na nenemeawo fe dzilawo. Tsiami see ne woade duk gb. Gbenye dze anyi.

- Tsiami: Anyin *ifea* miесе *ṭgbui fe nufoa?*  
Ṭgbui Adoglo *Kasi fe asi le dzi.*
- Ṭgbui: *Nefo nu!*
- Adoglo *Kasi:* (Etsi *tre*) Tsiami le *afi ma?* Se ne woado duk *meviwo gb* ne Ṭgbuiwo nasee be meda akpe na Ṭgbui de *e fe nya viviawo ta.* Le gonye me la, meda asi de Ṭgbui *fe nyawo dzi.* Esia ana be *miafe ny* *nunuviwo fe gbegblē vivo nu atsi.*
- Tsiami: Ṭgbui Davi Sewaa *fe asi le dzi.*
- Ṭgbui: *Nefo nu!*
- Davi Serwa: Tsiami see ne woado duk la *gb* ne *ṭgbuiwo* na see be, meda akpe de Ṭgbui *fe nyawo ta.* Hafi woawo *gbṭo* na wò la, ele be *nax fe wuiat* and *ṭṭo* *tsim ey* *ṭ* manya *ṭ* *utsu o.* Eya ta nyea mekp *be ne mi dzilawo mial* *ale* *ṭ* *nu sia* *ṭ* *me de asi la,* ekema mia vi *ny* *nunuviwo fe gbegblē* de *ṭ* *utsunya me vivo sia dzi ade kṭ.* Esia agahe bubu *ve* na *miavi ny* *nunuviwo hã.*
- Tsiami: Ṭgbui Dada *Kwla fe asi le dzi.*
- Ṭgbui: *Nefo nu!*
- Dada *Kwla:* Tsiami le *afi maa?* Ṭgbui *fe nya siwo wogbl* *la nyo ṭ.* Medo *velia na e fe susua.* Ke *nya si le nye hã sie nye be neny* *be wogbugb* *gb* *ṭ* *ow* *ṭ* *nu sia ve la,* *ṭ* *utsuwo fe ny* *nunuviwo nu beble kple ga dzi ade kṭ.*
- Tsiami: Ṭgbui Masta *Zikṭwo fe asi le dzi.*
- Ṭgbui: *Nefo nu!*
- Master *Zikṭwo:* Tsiami *lea?* Deko *nye hã medi be mada akpe gã* *ade na Ṭgbui kple e fe ametsitsiwo* *de wo fe susua ta.* Hafi Ṭgbuiwo *fe tadodzinua nade blibo* *la,* *medi be max* *ṭ* *nu ame sia me be woats* *ṭ* *nu faa ava* *ṭ* *dodokṭ na HIV/AIDS fe* *ṭ* *ume* *ṭ* *me.* Megakpe *ṭ* *na amea deke be woade gbefã* *le d* *ṭ* *ne amewo na se o* *Ke madoe de Ṭgbuiwo gb* *be ne ame ade atenu ade gbefã* *d* *siale edokui ṭ* *uti la,* *woana nunana* *ṭ* *xe ame ma hã* *abe Gbṭow* *ṭ* *lawo ke ene.*  
(Esi *wogbl* *nya sia* *ṭ* *la,* *zit* *ṭ* *gã* *ade dze fufofea)*
- Tsiami: Agoo! Agoo! *Ḍodoe nezi! Oṭfo Zṭblewu fe asi le dzi.*
- Ṭgbui: *ṭ* *fo nefo nu!*

Ծոճֆօ Շճblewu:      Tsiami le afi ma, see ko dukճa nasee. Ծոճbuiwo hã nasee be nye hã mekpճ dzidճ ղոճ le nya siwo katã woda de anyi egbea la ta. Nenybe be miewճ de wodzi la, ado dukճa de ղոճ, ade mi tso AIDS fe կոկոտի te. Ke azճ la, mele edom de Ծոճbuiwo kple աճse ha siwo katã le Dunenyo dua me la, ղոճ be ele be dukճa nado dugbadza dzigbe ղեկեդուդու anyi be miadzճ ga. Ga si miakճ la, miatsճe ado աճ ame siwo AIDS ճեկե sia աճ wozu tsեևիւո, ahowo kpe ahosiwo la, fe agbenճe de ղոճ elabena gedeawo le fu kpem ղոճ. Tsiami gbe nye dze anyi.

Tsiami:                    Anyinճfeա miese gbea.

Ծոճbui:                    Nya siwo katã woda de anyi egbea eye miedzro wo me de, mieda asi de wo dzia?

Dukճmeviwo:            Mieda asi de wodzi! Wonyo ղոճ! Miexճwo hã!

Ծոճbui:                    Tsiami lea? Fifia mekpճe be ղոճ ke eye ame gedewo le asi, agble kple tefe vovovowo yi ge eya ta meda akpe manyagբեկե ade na mi. Miana dukճa anyա akameti siwo akբոճ nya siawo ղոճ emegbe. Akpe na mi.

Tsiami:                    Ago! Ծոճbui be midzra do, Ծոճbui be yeke zi loo!

Dukճmeviwo:            Haaa!  
 (Ծոճbui kple efe ametsitsiwo dzo eye ame ha la hã kaka zitճեկե gã ade me)

