Impact of Socio-Cultural Factors Contributing to the Spread of HIV/AIDS:

A Case Study of Dar el Salaam Displaced Camp, Omdurman Area, Khartoum State, Sudan (2010)

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July, 2012
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July, 2012
Dedication

I dedicate My Humble Research to My Parents, My Dearest Husband and My Beloved Sister, (Mariam)
Acknowledgement

First, thanks to Allah for watching and keeping me save until I finished my research.

I would like to express my deepest thanks, gratitude, and appreciation to my supervisor, Professor Ahmed Hamad Alnory, for supporting me in all research’s stages. My thanks also go to my co-supervisor Dr. Mohamed Salih Mahfouz, for his important advice, and assistance during questionnaire designing, literature review and all research’s stages. My thanks are extended to Ustaz Ehab, Ustaz Aiman, Tayseer and Rana of population studies centre for their help at all times.

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<td>ACORD</td>
<td>Agency for Cooperation Research in Development</td>
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<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
</tr>
<tr>
<td>ARC</td>
<td>AIDS - Related Complex</td>
</tr>
<tr>
<td>ART</td>
<td>Anti-retroviral Treatment</td>
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<tr>
<td>CAFA</td>
<td>Community Animators Friends Association</td>
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<tr>
<td>CARE</td>
<td>Cooperative for Assistance and Relief Everywhere</td>
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<tr>
<td>CDC</td>
<td>Centers for Disease Control and prevention</td>
</tr>
<tr>
<td>COSSMHO</td>
<td>Coalition of Spanish Speaking Mental Health Organizations</td>
</tr>
<tr>
<td>DPI</td>
<td>Department of Public Information</td>
</tr>
<tr>
<td>EMRO</td>
<td>Eastern Mediterranean Region</td>
</tr>
<tr>
<td>ETR</td>
<td>Education, Training, and Research Associates</td>
</tr>
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<td>FMoH</td>
<td>Federal Ministry of Health</td>
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<tr>
<td>FP</td>
<td>Family Planning</td>
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<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>IEC</td>
<td>Information, Education and Communication</td>
</tr>
<tr>
<td>KAP</td>
<td>knowledge, Attitudes and Practices</td>
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<tr>
<td>MICS</td>
<td>Multiple Indicator Cluster Survey</td>
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<td>NCHS</td>
<td>National Center for Health Statistics</td>
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<td>NGOs</td>
<td>Non-Governmental Organizations</td>
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<td>NHASP</td>
<td>National HIV/AIDS Support Project</td>
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<tr>
<td>Abbreviation</td>
<td>Full Form</td>
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<td>PLoS Med</td>
<td>Public Library of Science – Medicine</td>
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<tr>
<td>PLWHA</td>
<td>People living with HIV/AIDS</td>
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<tr>
<td>PMTCT</td>
<td>Preventive Mother to Child Transmission</td>
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<td>PNG</td>
<td>Papua New Guinea</td>
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<tr>
<td>SIECUS</td>
<td>Sexuality Information and Education Council of the United States</td>
</tr>
<tr>
<td>SMS</td>
<td>Statistical Modeling Society</td>
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<td>SNAP</td>
<td>Sudan National AIDS Program</td>
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<td>STDs</td>
<td>Sexually Transmitted Disease(s) IX</td>
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<td>STIs</td>
<td>Sexually Transmitted Infection(s)</td>
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<td>SPSS</td>
<td>Statistical Package for Social Sciences</td>
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<tr>
<td>Trep. Doct.</td>
<td>Tropical Medicine Doctors</td>
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<td>UN</td>
<td>United Nations</td>
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<td>UNAIDS</td>
<td>United Nations Program on HIV/AIDS</td>
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<td>UNDP</td>
<td>United Nations Development Program</td>
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<td>UNFPA</td>
<td>United Nations Fund for Population Activities</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<td>UNESCO</td>
<td>United Nations Educational, Scientific and Cultural Organization</td>
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<td>WHO</td>
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ملخص البحث

لقد أصبح مرض الايدز من الأمراض الجيوبوليتيكية التي تهدد الشعوب. وأصبح البحث العلمي مشغولا بهذا الأمر. تهدف هذه الدراسة بعض العوامل الثقافية - الاجتماعية التي قد تساعده على انتشار فيروس نقص المناعة البشرية المسبب لمرض الايدز فيما بين النازحين وتركز موضوع البحث على معسكر دار السلام غرب مدينة امدرمان. كانت العينة عبارة عن معينة عشوائية. شملت جميع القبائل والمجموعات العرقية والاثنية الموجودة في المعسكر أثناء فترة البحث. حددت الفترة الزمنية بين 18 - 65 عاما لعدد من المبحوثين بلغ 450 مبحوثا. تم جمع البيانات بالتعاون مع جمعية كافا بجامعة الاحفاد. تم تحليل البيانات باستخدام الحزمة الاحصائية للعلوم الاجتماعية (SPSS).

اظهرت الدراسة أن نسبة 79.3 في المائة من المبحوثين سمعوا بمرض الايدز وان نسبة لا تتعدى 13.8 في المائة يعرفون طرق انتقال العدوى. غير ان نسبة كبيرة تبلغ 67.7 في المائة لا يعرفون مكان اجراء الفحص. ولم يخضع للفحص سوي نسبة ضئيلة بلغت 6 في المائة. وافاد العديد من المبحوثين بضعف او عدم احتمال تعرضهم للإصابة لكونهم لا يمارسون الجنس ويمتنعون عن فعل كل ما يعرضهم للعدوى أو ان الله يحفظهم استجابة للدعاء. ومن اجاب باحتمال فرصة الإصابة عزاء للمشاركة في استعمال الاذات الحادة غير المعقم او نقل الدم الملوث. و في مجال السلوك الخاص بالوصم والتمييز تجاوز المصابين بالفيروس , كانت نسبة 69.6 في المائة لا تمانع من رعايتهم اذا كانوا من افراد الأسرة. 56.7 في المائة من المبحوثين لا يرون في استمرار الطلبة المصابين في الدراسة، ونسبة 50.4 في المائة لا يرون في استمرار الاصحاب في التدريس. ونسبة 47.1 في المائة لا يرون في استمرار زميل العمل المصاب في العمل معهم. أما فيما يتعلق بصاحب المتجر المصاب فقد كانت نسبة من يوافقون على شراء بضاعته أو التعامل معه لا تتعدى 32 في المائة. وضفت نسبة 50 في المائة من العينة ان يبقى امر الإصابة سرا خوفا من العار والفضيحة. وأوضحت الدراسة أن هناك تساويا واضحا بين بعض الممارسات الثقافية - الاجتماعية التي يحتل تؤدي الى زيادة انتشار الإصابة بالفيروس, منها تعدد الزوجات وتكرار الافراح وتعرض الافراد من الازواج بزوج اخر وتبادل الاخوان او الاخوات في صفقات الزواج؛ وظهور الولادة في مجتمعات. وممارسة الحجامة و الفصادة وغيرها من الممارسات المتبعه داخل المعسكر. أوصت الدراسة بالتنسيق وتضافر الجهود واتساق كل المؤسسات العاملة في برامج التوعية والمكافحة المحلية منها والعالمية.
مع مراعاة اختلاف اللهجات والثقافات المحلية في وضع وبث الرسائل التوعوية. زيادة مراكز الفحص ودمجها مع وحدات الرعاية الصحية الأولية والمستشفيات العامة ومراكز الصحة الإنجابية لأذب الخوف من الوصمة والعار. زيادة عدد وحدات الارشاد النفسي والعاملين بها.
Abstract

AIDS has become geopolitical diseases that threaten people, and became preoccupied with scientific research in this matter. The study aims at exploring socio-cultural factors that may impact the spread of HIV/AIDS among the displaced in Dar a salaam camp in Omdurman – Sudan. The study was conducted among a randomly selected sample of 450 respondents (aged between 18 - 65 years) resident at the camp, who include various tribes, religious and ethnic groups and gender. A quantitative approach technique is used to collect data through structured questionnaire and available data from reports, publication and documents. Data entry and analysis were performed using Statistical package for the Social Sciences (SPSS). The study shows that 79.3 percent of respondents heard about the disease (AIDS), but only 13.8 percent are aware of the modes of transmission. However there is a large degree of misconception about the modes of transmission. 67.6 percent do not know where to have test for HIV/AIDS, with only 6 percent who actually had the test for various reasons. But a large percentage of 60.7 percent of respondents are willing to have the test. About half of them want to know whether they are infected or not. The others are either afraid to know their status or think it is not necessary to know. 69.6 percent do not mind taking care of infected family members. Most of them are willing to allow an infected co-students or teachers or co-workers to be with them at school and place of work or eat with them. Only 32 percent are willing to buy goods from an infected shopkeeper. However 50 percent prefer to keep the infection of relative secret for fear of stigma and discrimination. The study indicated that there is clear adherence to socio-cultural practices that may contribute to the spread of HIV/AIDS including polygamy, piercing, widow inheritance, cross marriage, circumcision in groups, Fissadah, Hijamah, etc. Consequently, the study makes recommendations in the areas of policies, and behavior change, coordination and concerted efforts and the involvement of all institutions “both local and global” working in outreach.
programs and control, taking into account different dialects and cultures in the development of local broadcast messages. Increase testing centers and integrated with reproductive health centers and primary health care units, because of the fear of stigma. Increase the number of units and psychological counseling staff.
Chapter One

1.1 Introduction:

This chapter contains the country profile and background, importance of the study, objectives, methodology, sample design and data collection, as well as the organization of the study.

1.2 Country background:

Until June 2011, Sudan was the largest country in Africa, with a surface area of 2,492,360 square kilometers or about 967,500 square miles. Total population was (in thousands) 39 154 according to the population census (2008) report, with an annual growth rate 2.827% (1999-2008). Sudan had 597 tribes that speak over 400 different languages and dialects split into two major Ethnic groups: Arabs of the largely Muslim Northern Sudan versus the largely Christian and animist Nilote Southern Sudan of the south. These two groups consist of hundreds of smaller ethnic and tribal divisions, and in the latter case, language groups.

However, Sudan split into two countries in July 2011- the Republic of South Sudan and the Republic of Sudan-after the south voted for independence in a referendum stipulated by a peace agreement reached between the two parts of the country years earlier. Now, the Sudan is the second largest country in Africa, with an area of 1,882,000 Square Kilometers, and a population of 33,419,625 People as estimated in early 2011. It now shares land borders-totaling 6,780 km- with seven other states, including more than 2000 km. of borders with the newly born
Republic of South Sudan. The people of the post-referendum-Sudan descend from a mixture of many ethnicities and groups; most notable are (Arabs/African Hamites), and 96.7% of the population is Muslim, according to statistics released immediately after the independence of South Sudan. Age structure is 0-14 years 43.2%; 15-65 years 53.4%; 65 years and over 3.4 %. Median age is 59 years, (58 years for men and 61 for women). Population growth rate is 2.8% per year. Rate of urbanization: 32.9%. Population in urban areas represents 49% of total population.

Environment and the richness of resources such as oil, gold, silver, cobalt, and other minerals, it remains one of the poorest countries in the world. Droughts, famine, civil strife in the southern part of the country and Darfur, have caused large numbers of its population to be displaced inside and over the common borders with its neighbors.

Continued conflict between the central government and opposition forces in the Sudan regions of Darfur, Blue Nile, South Kordufan and Eastern Sudan have oftentimes reflected grave socio-political divide across the country and forced the allocation of considerable portion of the national budget to security purposes, depriving socio-cultural development of the vital investment it needs. This state of affairs exacerbated the struggle over natural resources and perpetuated the socio-economic disenfranchisement of the local communities.

In 2010, Sudan was considered the 17th fastest growing economy in the world, given the rapid development of the country-largely from oil profits. Due to the
secession of South Sudan, the economic forecast for the country in 2011 and beyond remains uncertain as more than 80% of Sudan’s oil fields exist in the southern part of the country. (World Bank report, 2011).

The significant disparities between urban and rural areas have contributed to an increasingly urban informal sector which accounts for more than 60% of the Sudan gross domestic product. This fact encouraged rural-urban migration, which coupled with the influx of refugees and displaced persons as result of instability, contributed to the increased population movement.

1.2.1 Demographic characteristics

According to the population census 2008, population under 5 years of age amounts to 14.39% and aged (5-24) represents 47.38%. Population under 15 years old is 42.61%. Population 60 years and above is 5.15%. Dependency ratio is 91.42%, total fertility rate is 5.9 per woman (1999), Infant mortality rate amounts to 81.0 (per 1000 live births) (2006). Under 5 years old mortality rate is 34.0 (per 1000 live births) (2006). Maternal mortality rate equals 1107.0 (per 100000 Birth) (2006). And only 49.9% of people 15 years and above being literate, male 50.6% and female 49.2% (2000) and literacy rate of population aged (15-24) is 54.8% (2000), male 57.2%, female 53.0%. School age population enrolled in basic education amounts to 48.3% (2000), male 49.7% and female 46.9%. Poverty headcount rate (percentage below the national poverty line) is 46.5, (2009), Average household size (1999) amounts to 6.4 persons. Female headed households: 28.0% (out of total household), percentage of insecure households
(poor food consumption) 17.0, (2009). Infertility (1999) 3.0%, knowledge of any family planning methods (percentage of female age 15-49 years old) 61.0% (1999). Place of delivery (1999): home 86.0%, private hospital 1.0%. Birth attendants (1999), trained professional 57.0%, trained or untrained Traditional Birth Attendants 31.0%, untrained relatives or none 14.0%. Females (age 15-49) who have ever heard of HIV/AIDS (1999) represent 43.0%. Total life expectancy at birth stands at 60.8 years (2010, world development indicators). (Source: Sudan central bureau of statistics, MICS 2000/ SMS).

The population distribution is mostly rural, with 70.49%, urban 29.51% and 7.3% nomad population. GDP per capita in USD 1,920 (2008), total expenditure on health 3.6% (2008), general government expenditure on health 36.6% of total health expenditure (2008). Out-of-pocket expenditure 63.4% of total health expenditure (2008), general government expenditure on health 3% of total government expenditure. Ministry of health budget 6.3% of government budget (2006). A cost sharing policy that has been in force since the early nineties means that patients have to pay for most services and medications even in the government health facilities.

1.3 Statement of the problem

The factors driving HIV/AIDS epidemic in Sudan have been identified as war and the resulting population movements that include internally displaced persons, refugees, and military personnel. Sudan's long borders with nine African countries some of which have high HIV prevalence rates; the economic crisis in the
country; and urbanization with remarkable rural-urban migration. All these conditions interact to provide an enabling environment for high risk sexual behaviours and rapid spread of HIV infection.

Statistics from different sources revealed very high awareness rates, as well as its spread mechanisms. The number has risen continually, from only two infections in 1986 to 17,079 in September 2011, according to the Federal Ministry of Health/Sudan repot, (2011).

And according to the primary results of health survey, conducted by the Federal ministry of health with UNAIDS 2009, there are about 90,000 newly infected persons, and 320,000 persons are currently living with HIV/AIDS, but only 17,079 AIDS cases have been officially registered since the start of the epidemic in Sudan 1986, indicating under detection, under-reporting, and surveillance difficulties among groups at high risk.

Heterosexual was the major mode of HIV transmission, which accounts for about 97% of all reported HIV/AIDS cases, and about 90% of them were adult in reproductive age, and HIV prevalence was 1.4%, (UNAIDS & PR report, 2009). However, according to the latest data released by the National AIDS Control Programme in February 2012, HIV infections reached 45,000, amounting to 0.67%. Prevalence among commercial sex workers and prostitutes amounted to 4.4%, among homosexuals 6.3%, among youth 2.3% and among vendors and tea sellers 1%. Only 10% of the infected are receiving medical treatment.
1.4 Research importance

The AIDS epidemic in Sudan, according to recent Middle East and North Africa (MENA) synthesis report, is concentrated in the Southern part of the country. Years of civil war and limited epidemiological data in Sudan makes it rather difficult for a proper assessment of the nature and dynamics of the epidemic.

And according to the epidemiological and behavioural review on the HIV situation in Sudan (August, 2009), the overall HIV prevalence is estimated at 1.1% (0.67% in the North) while it is expected to gradually increase up to 2.2% in 2015 (1.2% for North). Data from the estimation and projection for this reporting period for the North Sudan showed that in 2009, total number of adults and children living with HIV is about 122,216; AIDS orphans (ages 0-17) currently living with HIV/AIDS (27,888); total deaths, 6,301 (4,771 adults and 1,530 children). Number of new HIV infections 23,766 (21,416 adults; 2,351 children).

Need for anti-retroviral treatment (ART) - adult aged (15+) 18,423, children 2,981, while mothers needing PMTCT is estimated at 6,715.

1.5 Research Questions

1. Why are HIV/AIDS cases still high in Sudan while awareness is also high compared with other African countries in the region?

2. What are the socio-cultural behaviors and practices that may increase the spread of HIV infection?
1.6 Research Objectives

1.6.1 General Objectives

1. In general, the main objectives of this study are to add a new valuable data set to the field of HIV/AIDS in Sudan and to enhance methodology on the research on HIV/AIDS socio-cultural and factors.

2. To evaluate the displaced sample knowledge and attitudes towards HIV/AIDS and to improve vulnerable population attitudes and practices towards HIV/AIDS.

1.6.2 Specific Objectives

Specifically the research intends to:-

- Estimate the level of knowledge of HIV/AIDS among the studied population.
- Find out why HIV/AIDS cases are still high in Sudan compared to some African countries in the region.
- Identify the different socio-cultural factors that may contribute to the spread of HIV/AIDS in Sudan, including religious traditions, values, beliefs, practices, risky sexual behaviors and personal experiences.
- Propose some recommendations that may help in filling the information gap and develops the IEC/advocacy strategies in the area of HIV/AIDS.
1.7 Research Hypothesis

- Nonsexual cultural practices that do not fit the age distribution pattern of AIDS, and may expose individuals to HIV include practices resulting in exposure to infected blood.
- Information and awareness messages are confused, with unclear language or phrasing and no respect to the local cultures.
- Low level of education leads to low level of awareness.
- There is further reason to believe that religious traditions and perceptions may be linked to stigma.

1.8 Methodology

This survey took place between May and July 2010.

1.8.1 Study Design

Observational study design, using cross sectional data.

1.8.2 Characteristics of the Survey Population

Dar Al Salaam Jabarounah camp is located in western Omdurman, housing a displaced population (as a result of civil war, drought, and economic situation), of about 40,235 persons resident in this camp. The majority were nomads from different tribes (mainly from South and West of Sudan) Fallata, Bargo, Hawsa, Fur, Nuba, Dinka, Shuluk, Rawashdah, Jawamaah, Hassaniyah, Silahab, Rezegat, and Baggara. They are Muslims, Christians or followers of other beliefs.
The camp was divided into a number of areas and small villages. Respondents groups were randomly selected from the following blocks: Group one selected from 41, 42, 43, 44 blocks, Group two from 48, 49, and 50. Group three from 39 A, 40, 45, 46, Group four from 39 B and 47 blocks.

1.8.3 Sample design and size

Provisionally the sample was selected on the basis of the following simple random sampling equation:

\[ n^* = \frac{t^2 pq}{d^2} \]

Where,

- \( P \) is the anticipated population proportion
- \( q \) is the complement of \( p = (1-p) \).
- \( t \) is student statistics corresponding here to 5% level of significance.
- \( d \) is the absolute precision on either side of the population proportion taken here as 5%.

The value of \( p \) is usually an educated guess and is normally needed. It represents the anticipated percentage of the proportion that has AIDS. In general, it is taken as 50% because it gives the maximum possible sample size. However, in an actual field survey simple random sampling is not the method of choice. Here we resorted to cluster sampling design where we divided the study area into four
clusters as explained below. For this reason, we multiplied the $n^*$ by a design effect of two to give the final sample $n$.

$$n^* = \frac{2^2 \times 50 \times 50}{100} = 100$$

Thus multiplying by the design effect of 4 (4 is the number of clusters), we have

$$n=100\times4= 400$$

Now $n$ has to be adjusted by the population correction factor:

$$n = \frac{n^*}{1 - \frac{n^*}{N} \sqrt{\frac{N-n}{N-1}}}$$

And substituting the above equation gives $n$ a little over 400 which we increased to 450, because the larger the sample size, the more the statistical precision.

1.8.4 Data collection

A quantitative approach technique is used to collect information through structured questionnaire and the review and analysis of available data from reports, publication and documents. Field survey was conducted by designing questionnaire to collect data and information, interviewing individuals and groups and gleaning life history from simple randomly selected sample 450 participants, male and female, age range from (18 to 65 years), from Dar Al Salaam Camp in Omdurman.
1.8.5 Training of data interviewers and field work

One - day workshop for the data collectors and the moderators was conducted at the premises of Reproductive Health Centre of Ahfad University for women, Omdurman.

First: explaining the objectives of the study, the target population, and the plan of work (what to do step by step) and the time frame.

Second: providing information and background about the campus, how risky the area will be, explaining the questionnaire coding and grouping and how to handle every part of it. Then indicating the preferred time to visit and to start filling the questionnaire and Pre-testing the questionnaire among the trainees group.

Third: handling all legal and official authorization documents including the police station inside the camps, (providing list of data collectors to police office in the camp.

1.8.6 Questionnaire

A pre-tested questionnaire contains about 30 questions and 39 variables were used for data collection. 30 questionnaires were filled by selected group for pre-testing, and after two weeks they were refilled by the same group and by different interviewer, reviewed, evaluated and then the questions were re-written to avoid mistaken and misunderstandable phrases or words.

The questionnaire consists of four groups of questions; group one included; age, sex, occupation and education. Group two involved identifying the socio-cultural practices, knowledge of HIV/AIDS transmission, and knowledge of HIV/AIDS
prevention. And the third group of questions concerned evaluation of transmission and prevention of HIV/AIDS. The fourth group of questions dealt with stigma, discrimination and health care. (Appendix No.1)

1.8.7 Pilot Study

The main objective of the pre-testing is to test the adequacy and the content of the questionnaire, sample design and the plan of the field work. Length of interview, identification of the respondents, perception of the respondents towards the contents of the questionnaire, sequences of topics and adequacy of field staff will be tested through pre-testing operation.

1.8.8 Results of the Pre-Test of the Questionnaire

The questionnaire was tested in a pilot survey to check consistency of questions and expected reliability of responses. 30 respondents were selected purposively for this purpose. They were addressed in two sessions. The first session was canvassed by one interviewer, and after two weeks a different interviewer canvassed the same 30 respondents. The 60 cases were entered into Statistical Package for the Social Sciences (SPSS) reliability analysis module. The result is shown in the table attached. (See appendix No.2). The table indicates a very high consistency judged by the very high value of Crobach Alpha which is amounting to more than 96%. The corrected item total correlation also reflects high reliability since R is within the range (-0.25-1-00) which is used as a yardstick for reliability.
1.8.9 Plan for Data Analysis and Interpretation

To ensure data collection quality, the field work supervisor reviewed the submitted questionnaire daily and reviewed any errors or inconsistency. The data entry stage started immediately after data collection was finished. The data entry took place at the Population Studies Centre of Gezira University. The data entry and analysis were performed using (SPSS). To ensure the quality of the process of data entry, double data entry is performed, with 99% accuracy.

Data analysis involves descriptive statistics as well as inferential statistics. Simple tabulation, frequencies and Chi-square test were used to test the differences between different variables.

All statistical tests were two-sided; and a level of \( P<0.05 \) was used to indicate statistical significance.

Statistical analyses were performed using the SPSS (Version 18.0) software.

1.8.10 Ethical Considerations

The principles of voluntary participation, informed consent, and confidentiality were strictly observed to protect the rights of research participants.

- The required approval or permissions were obtained for field work from official authorities and departments to avoid violations.
- Respondents’ willingness to answer the questions was ensured.
- Use of insensitive words or phrases during interviews was avoided.
- Personal biases and opinions avoided (being fair).
• Findings kept anonymous (respondents were told that research results will be anonymous).
• Accurate presentation into the appropriate context of what was observed and told.

1.9 Organization of the Study

Chapter one contains country background, demographic characteristics, statement of the problem, research importance, research questions, research general and specific objectives, research hypothesis, methodology, sample design and size, data collection, questionnaire pilot study and results of the pretest. Chapter two consists of the literature review including world situation, Sudan situation and the role of local and international organizations. Chapter three contains the study results. Chapter four dealt with conclusions, recommendations and references.

1.10 Definitions of Culture

A according to Mexico Declaration (1982), include: modes of life, traditions and beliefs, sexual norms and practices, power and gender relations, representations of health and disease, perceptions of life and death, family structures, languages and means of communication, as well as arts and creativity.
Most people understand that culture has something to do with the customs and beliefs of a group of people.

Culture is a concept which has been defined in many ways and forms depending on the individual, social background, level of education, ideology, etc. (Daryl and et al 2003).

In 1872, Darwin defined attitude as a motor concept, or the physical expression of an emotion.
Chapter Two

Literature Review

2.1 Introduction

This chapter presents the review of recent and available data from different sources, national and international reports, publications, and surveys.

The spread of HIV/AIDS depends on, and exposes, every weakness in society. It spreads when there is poverty, illiteracy, lack of public health, absence of reproductive rights, high and widespread of alcohol and narcotics use, and if corruption becomes part of daily life. And more widely, where sexual networks are extensive, e.g., where a person is traveling or mobile and having sex with multiple partners in multiple locations creating a mode of transfer from one sexual network to another, when social distances between at least one pair of partners are significant. It is for these reasons that HIV/AIDS is not simply a medical disease but also a social one. (Gorbach P; et al., 2005).

African societies share some traditional social and cultural practices and beliefs, especially in rural areas where child bearing and rearing, were highly valued for their contribution to farm production and livestock breeding. Large families were considered essential to ensure that enough children survived to continue the family line and fulfill important religious, social and cultural obligations. and sexual behavior, (UNESCO, 1999).

However, HIV surveillance remains weak in the Middle East and North Africa regions. More comprehensive available evidence reveals trends of increasing HIV infections (especially in younger age groups) in such countries as Algeria, Libya, Morocco and Somalia. (WHO/EMRO, 2005). Knowledge of AIDS is generally poor, and preventive practices are rare, even among populations most at high risk of becoming infected. Substantive efforts are clearly needed to
introduce more effective HIV prevention strategies in the Middle East and North Africa, *(UNAIDS report, 2010)*.

Women in less developed countries are 30 times more likely to die from reproductive health-related causes than women in industrialized countries. And, teenage women are twice as likely to die from pregnancy-related health complications as are women in their twenties. *(Carol J; 1994)*.

In 24 Sub-Saharan countries, two thirds or more of young women (aged 15-24 years) lacked comprehensive knowledge about HIV modes of transmission. Data from 35 out of the 48 countries in sub-Saharan Africa show that, on the average, young men were 20% more likely to have correct knowledge of HIV than young women. Education levels make a huge difference, too, *(UNICEF, 2004)*.

According to the *(UNAIDS, 2010)* Annual Report, over the past several years, nearly 3 million women and children had been infected in the sub-continent, and the prevalence of HIV/AIDS remained “astonishingly high” in countries such as Sudan, Botswana, Lesotho, Swaziland and Zimbabwe. In some, such as South Africa, the figure was close to 20 per cent of the population.

Factors thought to influence this sexual transmission in Africa include; promiscuity, with a high prevalence of sexually transmitted disease; sexual practices that have been associated with increased risk of transmission of AIDS virus (homosexuality and anal intercourse); and cultural practices that are possibly connected with increased virus transmission (female "circumcision" and infibulations). *(UNESCO, 1999)*.

Other nonsexual cultural practices that may expose individuals to HIV include practices resulting in exposure to blood (medicinal bloodletting, rituals establishing "blood brotherhood," and possibly ritual and medicinal enemas); practices involving the use of shared instruments (injection of medicines, ritual scarification, group circumcision, genital tattooing, and shaving of body hair); and
contact with nonhuman primates. At the current time promiscuity seems to be the most important cultural factor contributing to the transmission of HIV in Africa, (*UNESCO; Country assessment, 2002*).

In several countries in Africa, a combination of inadequate surveillance data and strong socio-cultural taboos against homosexuality could be hiding sex between men as a factor in HIV transmission. Little is known about HIV transmission in prisons, although available data point to elevated risk in those settings. HIV prevalence of 18% has been reported in prisons in Tripoli, Libya, 2% in Sudan in 2002 and almost 1% in Morocco in 2003, (*Sammud, 2005*).

In 2004-2005, researchers at Education, Training, Research Associates, working through Family International/ Youth Net, conducted a review of 83 evaluations of programs in developing and developed countries. The review analyzed the impact the programs had on sexual risk behavior among young people. In general, the findings for all the studies were similar in both developing and developed countries. They were effective with both low and middle income youth, in both rural and urban areas, with girls and boys, with different age groups, and in school, clinic, and community settings.

At the earlier stages of many epidemics, wealthier men acquire HIV more often than poorer men. However, as epidemics mature, the pool of infections tends to accumulate among poorer classes. This occurs because poorer and more marginalized people have less access than others to information, services, and social power to protect themselves. In many countries, women in general fall into this category. HIV spreads more easily where populations have high levels of other STDs. In all-male situations, such as prisons, mines, or construction camps, the risk of HIV transmission is high, (*O’Farrell, 1992*).

In most cases when one member of the couple has the disease they inform friends, families and neighbours of their conditions. When the husband is ill, men’s groups hide the infection from their in-laws and the majority of their neighbours. Only the family and friends of the wife will know of the infection
when the husband is tested positive. In other cases, mothers of deceased positive patients have revealed to their friends and neighbours the condition of their sons, and receive the solidarity and support of many of them, in spite of the general poverty. Women attend the ill and do the housework, while men help to move them from one place to another and contribute money, (Felicia, 1998).

Those who work in funeral homes prepare corpses using uniforms, gloves and masks. They do not think that preparing the corpse of a person who has died of AIDS is different from their normal routine. However the magic beliefs surrounding the infection seem to prevail among them, as they reject carrying the coffins and insist on the fact that these have to be specially covered. This issue has not been well researched and documented up to now. This may lead external prevention and care agents to consider that women are frequently ignorant of their physiological functions (Uganda, Dominican Republic and Thailand), (UNESCO, 1999).

Earlier ethnographic studies on Papua New Guinea (PNG) analyze sexual aspects of culture in terms of symbolic, ritual, and kinship or exchange systems. These rituals included physical and psychological practices that often involved pain, such as penile bleeding or other scarification and purging, dietary prohibitions, and a variety of ways to make the initiates “feel” the lessons they were learning and turn them into hardened warriors, (Carol, and et al 2005).

Courting parties are explicit sexual events. Boys are called out from their villages to have sex with the girls from other village; host and guest roles were reversed on the next occasion. In other societies, courting parties had little to do with eventual marriages, as these were arranged by parents, (Pranee, 2007).

In some areas, men gathered together to dance from dusk to dawn, while the women watched. And then any woman could take her pick of men during the night, and the couple then would disappear into the nearby bushes. She might not have known the man of her choice before that evening. In the morning, each couple then went to the man’s house, and word was sent to her parents to
come and discuss a bride-dowry. The sexual network was quite localized; married men also could participate in such events, as they might gain a second or third wife, (Kyakas, 1992). Today sexual networks are far wider and contribute significantly to the spread of HIV.

In a few societies, sisters were exchanged, if you marry over there, you still have a brother; that space you left must be filled. So another woman is brought in. Nobody even knows if she is caring any transmitted diseases or not, (Agot and et al. 2004).

Older men and women from several parts of PNG reported customs that placed a high value on virginity. However, the greater shame appears to come from a girl getting pregnant before marriage. Young women used numerous devices, practices, and plant medicines, to avoid pregnancy or induce abortion. In several areas, babies conceived out of marriage were absorbed easily by families, and the girls continued to have good options for marriage. Once parents arranged a marriage, sex between the engaged couple was overlooked. Early betrothals were common in the past, even arranged before birth. However, if the arrangement held until puberty, the girl usually would live with the boy’s family for a few years before the marriage ceremony, (Carol, 2005).

South Africa is considered to be one of the countries worst affected by HIV/AIDS in the world. Certain socio-cultural factors have been identified as responsible for the rapid spread of the disease. These factors include gender inequality and male dominance. Women’s inferior status affords them little or no power, particularly when negotiating sexual encounters, nor does it protect themselves by insisting on condom use or refusing sex. Many women also lack economic power and feel they cannot risk losing their source of financial support. These practices increase women’s vulnerability to HIV infection and accelerate the epidemic, (Global report and UNESCO, 1999).

Before the 1900s, few inland people traveled far from home for fear of being killed or even eaten by their more distant neighbors. The most common
marriage pattern in PNG requires mates to be found outside of a stipulated kinship distance, usually from other clans or sub clans. These groups stayed relatively close to each other for purposes of defense and support. Rural marriage patterns usually show that at least 80% of spouses come from the same or contiguous villages. In cities, however, wider mixing is far more common, (Dundon, 2005).

The mode of transmission of human immunodeficiency virus (HIV) in Africa is different from that in the United States and other Western countries, because the male-to-female ratio of affected individuals is 1:1 in Africa vs. 19:1 in the United States and Europe, (Akinade, 2002).

Most traditional societies appear to have utilized public shaming as a social control mechanism. The communities appear to be trying to come to some understanding as to why the virus has come to them. This is the ultimate question, and because the question is essentially spiritual, moral, and social, unfortunately, the most common response by traditional medico-religious and some churches are to suggest that AIDS is God’s payback to sinful people, (Lindstrom and et al, 1993).

Efforts to diminish stigma through the mass media have not been successful (NHASP, PNG, 2006). Stories continue to circulate of shunning, deserting, and even killing people who have HIV. Many babies are abandoned and bodies left unclaimed at hospitals.

Even though the common discourse involves the innocent wife getting HIV from her husband, the wife in many couples is infected and the husband is not—a finding that is common worldwide, (Mola, 2005).

A growing number of countries had taken steps to criminalize HIV transmission. In theory, that had been done to prevent the spread of infection. In practice, it had done the opposite – reducing the effectiveness of HIV prevention efforts by reinforcing stigma. Such measures sent the message that people living with HIV were a danger to society. “We must, instead, encourage tolerance,
compassion and inclusion,” said the President of the General assembly; He called on Governments to review their legal frameworks to ensure compliance with human rights principles, on which a sound AIDS response was based. It was not a medical or scientific challenge only, but also a moral challenge, (UN declaration, 2006).

A study, carried out by Dundon, (2005) showed a fascinating example of spirituality turned against itself as women possessed by the Holy Spirit attempt to expunge sexual transgressors from their community, but become sexually promiscuous as a result of repeated tracing.

In the Fiji Islands, research by Holly, 2007, has shown that men who attend church have more sexual partners than others, as they have greater access to women when attending church socials and other gatherings. Recourse to religion alone is not likely to stem the spread of the virus. And dogmatic barriers set up by religious leaders, such as refusing to permit condom use, or demanding abstinence and faithful marriage as the only acceptable ways to avoid HIV, can contribute to its transmission.

Heterosexual relations have predominantly supported the spread of HIV/AIDS, and specific factors that are at play in these relationships are not widely alluded to. They are divided into two broad categories of mental-facts (those related to the mind) and socio-facts (those related to the wide social setup). (Jabulani, 2002). Control of the epidemic will require a focus on men as individuals responsible for their health and health of women, (Joyce, 2002).

Heterosexual intercourse accounts for 80% of HIV transmission in sub-Saharan Africa. Factors facilitating cross-infection may include sexual practices such as the vaginal use of herbs/substances to dry, contract and heat the vagina for enhancement of sexual pleasure, (Runganga, 1995).

Significant barriers to protective behaviors among lesbian, gay, bisexual, and trans - gender youth, as well as among young men who have sex
with men, include homophobia and violence that damage their self-esteem, lack of access to health care, homelessness, and substance use, (Kevin, 1992).

The reliability of the available HIV/AIDS incidence, prevalence and mortality data for Muslims is low because, either they do not report their statistics or are under-reporting. Global epidemiological indicators, including data from the World Health Organization's Global Health Atlas, do indicate evidence of the burgeoning threat of an HIV/AIDS crisis in Muslim countries and provide HIV/AIDS prevalence and AIDS-related mortality data in countries with 50 percent or greater Muslim population, for the period 2001 to 2003, (Global report, 2008).

The under-reporting of HIV and AIDS cases in Muslim countries has serious bearings on disease surveillance and monitoring. In the Eastern Mediterranean Region, an estimated 700,000 people are currently living with HIV/AIDS but only 14,198 AIDS cases have been officially registered since the start of the epidemic, indicating under detection, under-reporting, and surveillance difficulties, (UN report, 2009).

The continent of Africa, particularly the southern region, continues to have the highest HIV/AIDS incidence and prevalence rates globally. The number of HIV-positive adults range from 6–10% in Nigeria, and 10–18% in Ethiopia; both countries have a majority of residents who are Muslims. By the year 2010, 40% of the African population, where the disease burden is highest, will be followers of the Muslim faith, (UN report, 2009).

The difficulty in establishing effective HIV/AIDS programs comes from a lack of openness, in many societies, regarding sexuality, male-female relationships, illness and death, taboo subjects deeply rooted in the cultures, (Felicia and D. Oyekanmi 1995).

East and Southeast Asia, which include countries like China and India containing some of the world's largest populations, show indicators of soon
surpassing Africa in terms of their absolute number of cases, if HIV/AIDS rates continue to escalate at their current rate. These projections hold particular relevance for HIV/AIDS in Muslim populations; India and China, though not identified as Muslim countries, have a significant number of Muslims (approximately 138 million Muslims in India, and 40 million in China), *(UN Report, 2009)*.

A brief review of the historical and cultural context of polygamy in sub-Saharan Africa and examines the socio-demographic factors that influence polygamous union formation. Data were obtained from the Demographic and Health Surveys in Ghana (1988), Senegal (1986), Kenya (1989), and Zimbabwe (1988-89). The sample was restricted to currently married or cohabitating women. The proportion of women in a polygamous union was 48% in Senegal, 31% in Ghana, 23% in Kenya, and 16% in Zimbabwe, *(Hayase, 1997)*.

Fathering many children is also seen as a sign of virile masculinity, (males are biologically programmed to need sex with more than one woman). The polygamy had contributed to marital stability and protection from diseases since the man maintained sexual relations with the same women, alternating according to an established ‘schedule’ or according to menstruation or breast-feeding cycles. However, seeing the mobility of the population and the prevalence of extra-marital sex, polygamy can be described as further exposing the population to the risk of transmission of HIV/AIDS. And since marriage means reproduction, condoms are seen as a contraceptive rather than as a form of STD and HIV/AIDS prevention, *(South Africa, history on line 2006)* and *(Rwenge, 1996)*.

Some women within a polygamy relation also could be tempted to have extra-marital relations, above all when there is an age gap between the couple. According to *Caldwell (1993)*, these women could consider their husband unable to satisfy them sexually or they could feel attracted to younger men.

The polyandry system, in which a woman can have more than one husband, is a common practice in some groups, but limited to the female leaders.
These have the right to choose their husbands. If the chosen man is married, he must leave his home, even when he is polygamous, to devote himself completely to the woman who offered him this honor. This woman has the right to choose occasional lovers, (Altuna, 1993).

The new forms of polygamy in Angola, particularly in urban areas, in which the couple does not share the same house and where wives are economically independent, could also contribute to female extra-marital relations. Polygamy could also influence the sexual behaviour of young people for they might be inclined to imitate their parents’ attitudes and habits, (UNESCO, 1999, Angola experience,).

Lack of sexual fulfillment and need for money were mentioned as major reasons for extramarital affairs. Moreover, the presence of military camps and construction sites in the area provide a ready source of partners to meet the sexual needs of the wives whose husbands are away for a long time. (Hayase, 1997) and (Jochelson and et al 1991).

The importance of fertility in African communities may hinder the practice of safer sex. Young women under pressure to prove their fertility prior to marriage may try to fall pregnant, and therefore do not use condoms or abstain from sex, (Belsey, 1976). Traditional marriages are still common practice in African countries and even within Latin American, (Mexico, Dominican Republic, and Cuba) a regular couple must have children. Sterility is seen as a great misfortune, and motherhood is the most significant aspect of women’s life, (UNESCO, 1999).

In Jamaica, traditional beliefs on fertility and sexuality still exist, they belief that the body must be strong and clean. It is held that coitus is essential to the physical and mental health of men. For women, coitus is important to avoid the danger of sapping natural vitality. Condoms are regarded as invasive objects that could slip off and disappear, causing sickness, sterility and even death by blocking off the tubes. Many of the rituals and characteristics demonstrating a
man’s masculinity are in fact female characteristics that reflect negatively on the welfare of women. Young men must prove their masculinity by impregnating women. Women must have children or must “have out their quota” in order to rationalize their existence and to release natural vitality, (Civic and Willson, 1982) and (UNESCO, Jamaican experience, 1999).

Also substitution for the widower can spread the risk of infection of the new bride (often a young girl who has not yet been engaged in sexual relations), if the couple is HIV positive. The risk is even higher if the man further engages in polygamous marriages, besides the one/two wives. These practices are also common among Muslim groups, (Okeyo and Allen, 1994).

The Mossi society in Burkina Faso exposes people to HIV or facilitates its transmission. The cultural tradition of a widow marrying her husband's younger brother appears to be a risk for HIV transmission. This custom is forced on the widow “woman with no husband is nothing”. If a man dies of AIDS and has infected some or all of his wives, the younger brother(s) will in turn become infected. On the other hand, a younger brother may be HIV infected and, upon marrying his deceased brother's wife or wives, he infects her or them. Also polygamy is common, (Quedraogo, and et al., 1994).

A sexual ritual is performed usually when the members of the deceased believe that the cause of death of their family member was due to unnatural causes (e.g. witchcraft,). After treatment of the widow/widower by herbalist (traditional healer), which ensures that she/he does not pass on the disease, a sexual ritual is performed by the widow/widower with a relative of the deceased husband or wife (twice per day for three days), (Luke, 1989).

In other communities cultural leaders reported that the practice of widow cleansing and inheritance was still widespread. The deeply rooted tradition of widow inheritance is a determinant of sex among some groups in Uganda, Tanzania, Zaire, and Sudan. It aims at safeguarding the property left by the deceased and to protect his children, the successor brother takes responsibility of
his nephews. In fact they believe that it is an advantage to the psychological development of the children or they will grow up with their father’s relatives and in this sense, the impact of the death could be reduced. If the widow rejects the succession, she runs the risk of going back to her original family without her children. This fact often compels women to accept such practice in order not to be separate from their children and to continue benefiting from the dead person’s family economy. However this practice of sexual networking whereby men who inherit widows have multiple sex partners, high frequency of exchange between widows, and low levels of condom use, encourages the spread of HIV, (Okeyo and Allen, 1994).

According to Pison and et al, 1996, marital instability and mobility are factors that enhance exposure to STDs, particularly HIV/AIDS. Man and woman could go through extra-marital experiences during conflictive periods.

Sexual intercourse outside of marriage, homosexuality, and the use of intoxicants, is prohibits by Islam. Men who engage in risky behaviors have the potential of transmitting the disease to their unsuspecting wives. The stigma attached to the PLWHA, thus prevents those at risk from coming forward for appropriate counseling, testing and treatment. Inequalities help to fuel further spread of the epidemic. For those who are not educated, cultural expectations are very difficult to disregard, (UNESCO, 1999).

Uncircumcised males and females are stigmatized and marginalized in some society. Non-sterilized instruments are used on several persons to perform circumcision. Traditional vaccinations by cutaneous scarification and treatment of sores and cutaneous lesions are other possible ways of HIV transmission. Preparing the cadaver is done without gloves and, in cases of AIDS, exposes the preparers to open lesions, (Quedraogo and et al, 1994) and (Santé, 1997).

Botswana is one of the countries that are experiencing an increase in the numbers of HIV positive people. Little attention has been paid to cultural factors that contribute to the spread of HIV among children and young people
which include; the early marriage of the girl child; the girl child’s role as care-
giver; and the socialization process, *(Caldwell, 1993)* and *(Tapologo, 2002)*.

The presence of refugees, migrant workers in general is a critical factor
in the dissemination of the virus and a material difficulty in taking care of – or
numbering - possibly infected populations, more so when they have no contact
with health services, or are unaware of being infected and, if informed, unwilling
to disclose their situation, especially as regards men. The cultural impact of
migration will also affect those communities, families, wives and children, left
behind in the villages, *(Lagrade, 2003)*.

Some of the husbands not only go away for a long time, but they leave
their families without money. Thus wives are almost destitute and forced into
extra-marital sexual favors in return for money or fish. Sex for fish barter has
been reported in the fishing camps as well as in the beer halls at low-growth
points. Interventions to alleviate the impact of poverty and unemployment could
very well reduce the incidence of HIV infection and curb its spread, with more
enduring effects than mere prevention and care. And in Uganda, migration is an
important risk factor, *(UNESCO report, 2002)*.

People separated for long periods tend to seek sex outside their stable
relationships, which, in the single-sex hostels accommodating migrant labourers,
result in unsafe male-to-male sex. Men frequently become HIV-infected at their
place of work, and then carry the infection back home and pass it on to their
wives and unborn children. Another form of migration occurred when the former
revolutionary cadres returned and were incorporated into the national defense
force. Their return, from areas of high HIV prevalence, contributed to the rapid
growth of the epidemic, *(Winsbury, 1992)* and *(South Africa experience in 1994)*.

Some studies show that women widowed by AIDS, migrate to urban
areas to avoid stigma or to seek economic survival. Cross-border trade is another
factor leading to HIV/STD infections, when businessmen and women travel
between countries and within countries, selling or buying merchandise. By so
doing, they indulge in sexual relations, thereby creating major risk group. Traders and lorry drivers in the area had a history of multiple sexual contacts. Both men and women in trading centres along the major highways are particularly at risk for HIV/STD infections, (Mulder, 1995).

A study carried out by Akinade, 1994, tried to investigate types of practices, personal experiences, risky sexual, marital and cultural behavior and use of bloodletting implements on the body that contribute to the spread of HIV/AIDS. Results showed that cultural practices such as a widow being asked to remarry a younger brother or brother in law, of her deceased husband [who might have died of AIDS], using the same sharp instruments [which may be infected] for circumcision, body scarification, tattooing, and hair scrapping. Other factors mentioned were rape prepubescent girls and body piercing for earrings.

Besides the societal/cultural stigmatization linked to prostitution, especially men-to-men commercial sex, professional sex workers cannot refuse unsafe sexual practices and very frequently, cannot identify their customers if they get infected. Also endangered are young girls forced into early sexual practices, since older men or “connoisseurs” are keen on having intercourse with virgins. Some young prostitutes may even have been forced into sex within the family group or raped by infected men for reasons of sexual “cleansing” (Meel, 2003). In addition, among the poorest populations, women can recur to occasional prostitution as a form of informal payment for food or transportation, (Rankin and et al, 2005) and (Link and et al, 2001)

Among the different churches as well as those contacted in the Muslim community, religious leaders stated that, young people had lost their moral values and fidelity in particular, because parents responsible had lost their control or influence over young people. They believed that the outcome of this failure was the loss of traditional social values that promoted healthy sexual practices and their replacement by new social values such as drug use and alcoholism, which contributed to HIV/AIDS infection and spread. (UNESCO report, 2002).
The churches emphasized abstinence and only having sex when married as the means to stem the epidemic. On the issue of condom use as a preventive measure against HIV/AIDS transmissions, the Catholic Church only states that the use of artificial contraceptives was against the policy of the Church. The Protestant and Moslem respondents claimed they did not prohibit the use of condoms by members of their congregation. Both a Catholic and a Muslim leader further reported that care activities were in place for sick people in general, including people living with HIV/AIDS (PLWHA). (Country assessment, 2002).

Bloodletting for medicinal purposes is common in sub-Saharan Africa. The practice involves a practitioner's (Traditional rural healers and midwives), e.g., pulling the baby from the uterus by force. In some tribes of Zaire, a woman is assisted by other women, one of who inserts her fingers into the vagina periodically to monitor the baby's position. After birth, the umbilical cord is cut with a hunting arrow, (Bailey, 1985).

In eastern Zaire the cuts are made over the affected organ--e.g., the forehead for headache, the abdomen for stomach pains, and the joints for arthritis. The practitioner then takes a mixture of ashes from leaves and rubs it into the wound, exposing himself to the patient's blood. (Zaire experience, 1999).

Scarification is carried out during multiple procedures at different ages throughout childhood. It is found among many groups in West, Central East and North Africa, for the purposes beautification as well as ritual purposes. Typically, cuts are made in different parts of the body (face, neck, abdominal, hands, legs, and even in a genital area. Genital tattooing ‘in female’ involves repetitive insertion of an unsterilized needle with pigment directly into the labia and vaginal wall, circumcision or sub-incision, and a small razor blade or knife is frequently used by more than one individual for a number of functions, such as shaving facial or body hair. thus a relatively large number of individuals of varying ages will be operated on at one time. (Country assessment, 2002).

Female genital mutilation has been postulated to increase the likelihood
of HIV transmission via increased exposure to blood in the vaginal canal. And the abnormal anatomy of a mutilated vagina would predispose to numerous small (or large) tears in the mucosa during intercourse. These tears would tend to make the squamous vaginal epithelium similar in permeability to the columnar mucosa of the rectum, with increased absorption of secretions (and virus).

A less likely explanation involves sexual intercourse shortly at or shortly after the time of female circumcision, when open wounds are present. An increased risk for bleeding during intercourse may increase the risk for HIV transmission. The increased prevalence of herpes in women subjected to female genital mutilation may also increase the risk for HIV infection, as genital herpes is a risk factor in transmission of HIV, (WHO, report 2008) and (Brady, 1999).

Homosexuality is not a part of traditional societies in Sub-Saharan Africa. The few instances of homosexuality noted are related to societal institutions where an older man has authority over younger males. In the Bwamba of Central Africa, a male teacher of some young boys was reported to have exposed his penis and then asked the boys to "blow it like a whistle". It should be noticed, however that gay movements and lobbies are developing, mostly among the White community, especially in the Cape Town area, and are struggling to make the Government take more important measures against HIV/AIDS. As noted among Brazilian gay men, there was a much larger cohort of bisexual men than at first predicted, (UNESCO, 1999) and (Global report, 2008).

There is less information available on anal intercourse than on homosexuality. The only significant reports of significant rates of anal intercourse are claims made by students of genital mutilation, who state that anal intercourse is used of necessity in cases of infibulations. However this practice is mostly limited to Arabic-influenced areas rather than Central Africa. It must be mentioned that societal disapproval of the practices of homosexuality and anal intercourse also exists as a result of the prevalence of Christianity in Central and East Africa. (Country assessment, 2002)
The violence often suffered by young homosexuals as a result of social stigma may cause them to hide their sexuality and not access information that could help protect them against HIV infection. Catholicism, which is one of the strongest forces opposing homosexuality, is common in Central Africa, encompassing over 50% of the population in Rwanda and eastern Zaire. Any study of the practice of anal intercourse would be limited by all of the factors mentioned above. (Rankin and et al, 2005).

Homophobia in the Caribbean is a central organizing principle of the cultural definition of masculinity. Homophobia is more than the irrational fear of gay men, more than the fear that a man might be perceived gay. It is the fear that another man will unmask him, emasculate him, and reveal to him and the world that he doesn’t measure up, that he is not “a real man”. In the end, the “fear of being seen as a sissy” dominates the cultural definitions of manhood, (Michael, 1994).

The connection between masculinity and violence, which is linked to sexuality and sexual relations, has been further investigated. A 1996 World Bank study found that it was encouraged by the environment of the urban gangs and garrisoned communities. UNFPA - sponsored qualitative studies of adolescents found that aggression was another emphasis among young men in their views of sex, whereas young women reflected fear, (Heather, 1999).

Sexual violence against women apparently is so common in many African and Asian communities, (Borrey, 2000). A woman has about a one in three chance of being raped in her lifetime, has among the highest sexual violence statistics in the world. The genital injuries that result from forced sex increase the likelihood of HIV infection; when virgins and children are raped, the trauma is more severe, and risk of infection even higher, (Roderick, 2006).

Women with a history of being sexually abused are more likely to risk unsafe sex, have multiple partners, and trade sex for money. Men who are violent to their partners are also more likely to have sexually transmitted infections.
(STIs). These factors combine to put women who suffer sexual violence at very high risk of contracting HIV/AIDS, \((\text{Carol, 1994})\).

In cases of gang rape, exposure to multiple assailants further increases risk of transmission. Increasing numbers of rapes of female children may represent men’s attempts to seek sexual relations with young girls to avoid HIV infection or because of the belief that sex with a virgin will cure AIDS. \((\text{Meel, 2003})\).

Misconceptions and myths about HIV/AIDS include believing that that infected people can be recognized by their symptoms, the virus can be contracted by sharing food, and sex with a virgin can cure the disease. Beliefs such as this give people a false sense of their level of risk, and contribute to confusion about how HIV is transmitted.

People who do possess some knowledge about HIV often do not protect themselves because they lack the skills, support or incentives to adopt safe behaviours, \((\text{Saewyc, 1999})\). High levels of awareness among the youth, a population group particularly vulnerable and significant as regards the spread of HIV/AIDS, have not led, in many cases, to sufficient behavioural change. Young people may lack the skills to negotiate abstinence or condom use, or be fearful or embarrassed to talk with their partner about sex. Open discussion and guidance about sexuality are often lacking in the home, and many young people pick up misinformation from their peers instead.

In Ghana, Current age was the most important explanatory factor, followed by religion. In Kenya, women’s and men's education, ethnicity, urbanization, and age were significant factors. Ethnicity was the most important factor. In Zimbabwe, every factor was significant. Women's education was the most important factor. Findings reveal different prevalence of polygamy and different effects of socio-demographic factors, \((\text{Hayase, \&and et al, 1997})\).

Men in southern Africa regularly do not want to use condoms, because
of beliefs such that “flesh to flesh” sex is equated with masculinity and is necessary for male health. Condoms also have strong associations of unfaithfulness, lack of trust and love, and disease. Certain sexual practices—such as dry sex (where the vagina is expected to be small and dry), and unprotected anal sex—carry a high risk of HIV because they cause abrasions to the lining of the vagina or anus. In cultures where virginity is a condition for marriage, girls may protect their virginity by engaging in unprotected anal sex, (Olivia, 2006).

Young women are often persuaded to have sex with “sugar daddies” (older, wealthier men) in exchange for money or gifts. Young women infected with HIV by sugar daddies then infect younger men, who in turn infect other young women and in time become HIV-positive older men themselves. Older men also infect older women, usually their wives. Both younger and older women give birth to children, some of whom will be HIV-positive, (Annual Report, 2004/2005).

In Nigeria, poverty is a major factor driving the epidemic, being both a cause and an effect of the HIV/AIDS outbreak. The poor are less knowledgeable of HIV/AIDS’ transmission modes; less aware of methods to protect themselves and have limited access to healthcare which could increase protection from contracting HIV such as effective treatment for Sexually Transmitted Diseases, (Gillies, and et al, 1996).

Gender imbalances within existing sexual relations dictate that men initiated sex in a relationship, implying that stereotypical roles of men (as having ‘the say’) and women is reproduced in sexual relationships. The position of women is dictated by traditional cultural values regarding the role of men (to provide income and sustenance), and women (to bear children). These roles also reflect existing socio-economic differences (age, class, religion, education, and income) between women and men in most African societies, (Felicia, and et al, 1995)
The pilot study conducted by Oyekanmi, 1994, showed unwillingness of the men to use the condoms. Moreover, married women felt that even if their husbands contract any sexual transmitted disease God would not allow the wives to catch it from them. The cultural practice of marrying girls at very tender ages (<12), to older men, means girls would contract three marriages between ages 13 and menopause. And even after menopause, she is likely to contract one additional marriage if only for economic survival.

A study carried out by Orubuloye (1993) has found that adult sons sometimes sleep with the young wives of their elderly fathers. Others know about this but keep quiet for fear of their father anger.

A number of Socio-cultural factors have been identified from the reports as being related to the spread of the HIV/AIDS epidemic. Initiation ceremonies mark the end of childhood/adolescent stage and the beginning of adulthood such as tattoos on face, hips, back and sometimes extending the labia minora and clitoris circumcision for girls, (Akinade, 2002; Carol, 2005; and Botswana, 2002).

Traditional teachings by older women encourage girls to have sexual intercourse only after marriage; boys are encouraged to have sex upon returning to the village in order to practice with adult women. If these women are infected these boys will transmit this virus to their wives in the future and vice verse, (Lagarde, 2003).

The influence of religion (Islam and Christianity) is quite strong among some ethnic groups where initiation rites are practiced. A man should have sex only with his wife/wives, in addition to the traditional practice of engaging in sexual intercourse as soon as they leave the initiation camps. For the Muslim groups more than one wife, is a normal practices and it is culturally and socially practiced, and also for different reasons, (divorce, or if his wife or he is unsatisfied). Divorce can be a risky factor, as remarriage increases the risk of additional people being infected with HIV/AIDS or any other STIs disease,
Cultural leaders (traditional doctors, chiefs and parents) revealed a prevailing belief about HIV/AIDS transmission and spread. HIV/AIDS mode of transmission and the illness (disease) itself was equated to M’pepo, which a man gets when he engages in sex with a menstruating woman or with a woman who has aborted and not cleansed herself by using traditional medicine and sexual rituals. Transmission from a woman to man is also believed to take place through dust or salt, from the unclean or menstruating woman or other members of the family when she adds salt to the family relish pot, or if she sweeps the house while others are in the house, (UNAIDS/UNESCO, 1999).

The implications of this belief are that women and especially young girls are blamed for HIV/AIDS transmission and spread. This group of people therefore believe that HIV/AIDS prevention or control is the responsibility of the mother, aunt and daughter who should abstain from having sex whilst menstruating and until cleansing of the abortion has taken place, (Machel, 2006).

Cleansing takes place in many African societies, using traditional medicine and through a sexual ritual. If the woman is unmarried her parents would perform the sexual ritual on her behalf. It was strongly stated that women should not having sex with men when they are menstruating. Also women and girls, should “confess” in time (i.e. at an early stage) if they have engaged in a sexual act under unclean conditions. If they confess then M’pepo, which manifests itself through symptoms regarded as similar to those of HIV/AIDS, can be reversed or treated using traditional medicine and sexual rituals, bringing the disease to a halt, (Malungo, and et al 2001)

To assess the prevalence of traditional vaginal agent use, an exploratory study was conducted in Malawi between October 1989-October 1990, to determine whether a correlation exists between human immunodeficiency virus (HIV) and traditional practices involving the intravaginal application of substances such as herbs and pulverized stone. The median age of study
participants was 24 years. Although only 11% reported having had a sexually transmitted disease (STD) in the three years preceding the interview, laboratory analysis revealed the presence of such an infection in 46%. HIV infection was found in (23%). 45% of these pregnant women reported use of vaginal agents or vaginal incision, either for the treatment of discharge or itching or for the enhancement of sexual pleasure through vaginal tightening, (Dallabetta and et.al. 1995), (Baleta, 1998) and (Beksinska and et. al., 1999).

The behavioural-analytic study investigated the use of different types of herbs/substances used by 75 HIV positive and 76 negative sexually active females and the perceived effects of these agents. 99% of all subjects admitted using herbs/substances, dry (58%) and heat the vagina (28%). 80% of positive subjects and 69% of HIV negative had used a mean of 4 difference types of herbs and/or substances during the last 5 years. 39% negative and 25% positive subjects had experienced intra-vaginal pain and lower abdominal pains during and after sexual intercourse, laceration of the vagina and excessive vaginal secretions after using herbs, (Runganga, and Kasule J. 1995).

Vaginal examinations revealed that several of the substances cause inflammatory lesions of the vagina and cervix. Furthermore, some products cause extreme dryness that could foster epithelial trauma during coitus, both for the woman and for her partner. Breaks in the epithelium may promote the passage of organisms that cause AIDS and other sexually-transmitted diseases. Thus the sexual practices of drying and tightening the vagina may be increasing the risk of infection, (Brown, & et al, 1993) and (La Ruche, 1999).

Structured interviews were conducted with 63 Zimbabwean women, 33 were attendees at an urban health clinic, and 30 were nurses. Eighty-seven percent of the sample reported using herbs and other agents regularly as a preparation for sexual intercourse. The health and social consequences of such practices are examined; the problems of cervical cancer and HIV and their relation to these practices is discussed, (Runganga, and et. al. 1992).
A study conducted by WHO in 1989 shows that sexual education at school could change the youth sexual behaviours, delay the age of starting sexual relations and increase the use of condoms.

Socio-cultural factors of sexuality are not an isolated phenomenon. They cover norms and cultural values of each community, e. g., marriage practices, family and fecundity (Rwenge, 1996). Among these factors, are analyzing sexual education, the loss of traditional values regarding sexuality, post-birth sexual taboos, family structure within the household, types of marriage and the status of woman, as well as religious norms and values.

The results of the study carried out by (Maria and et.al. 1999) among teenagers between 14-20 years old show that most of the teenagers do not talk about sex with their parents. Parents avoid talking about these issues for it is considered a motivation to the early practice of early sexual experiences. Generally, this subject is tackled among friends, school acquaintances or girlfriend/boyfriend.

Traditional societies have suffered several changes as part of the “modernization” process. Urbanization and formal education moved the individuals away from their groups. The decisions regarding sex became an individual issue rather than a family or community subject. Elders have lost their control over youth, as well as men over women. Some cases of family deterioration have forced children to leave their homes and live in streets where they have to set up their own survival strategies. Prostitution, the drug market, delinquency and other high risk practices and behaviours are prone to facilitate the spread of HIV/AIDS, (UNAIDS / WHO report 2006).

Traditionally, almost all ethno-linguistic groups in Angola have some taboos concerning breast-feeding, post-birth abstinence and other specific rites and circumstances. According to Redinha (1974) and Altuna (1993) abstinence is commonly practiced during hunting, harvest, etc. These taboos, despite the interruption of births, contribute to extra-marital sexual relations and even in
polygamous families when the abstinence periods are relatively long. Woman status is also associated with the roles, that is to say, individual contributions to productivity, regarding gender. Productivity is understood here as procreation as well as economic activity.

Blood brotherhood was formerly a widespread practice in much of East and Central Africa, Kenya, Tanzania and Zaire. This practice has been decreasing in recent years but it still there. The custom involves exchanging a small amount of venous blood between males via the binding of excisions. One report identifies a case of AIDS possibly acquired from blood brotherhood, but other risk factors may have been present, (Morfeld and et.al., 1984).

In other communities, two people exchange and drink each other’s blood as a symbol of mutual faithfulness. In other communities, young people change their blood during the rite of circumcision. “After soaking a piece of manioc in the blood of their foreskins, they eat ‘the bread of the Brotherhood’” (Altuna, 1993). The circumcision (individual or group): when it occurs as part of rites of initiation involves a young population. If the blade is infected, everybody runs the risk of infection.

For many girls the first sexual contact is with their fathers; it is a practice observed in few groups, but which could facilitate the transmission of AIDS. Today virginity does not have a particular social meaning. However it is still valued in some families, above all in the religious ones, there is a tradition that on the wedding night the couple sleeps on a white sheet in order to show the blood stains. The aunts, godmothers or grandmothers are then responsible for taking the sheet and showing it to the neighborhood. If the girl proves to be a virgin, the neighbours bring gifts to her. If not, her family must pay a fine to the husband’s family. In extreme cases, the marriage can be dissolved, (Wendy and et.al., 1997).
The fact that girls are forbidden to have sex before marriage was associated to the social value of virginity. Presently, this has been lost though, and the practice of sex before marriage or a formal union is no longer an immorality. The male participants affirmed that having sex is crucial since girls do not accept to marry men without some sexual experience. Girls gave the same justification: “It is an honor for a man to marry a virgin woman, but it is not the same for women.” Women do not accept to marry a virgin man because they want experienced men. This behaviour compels boys to have sex to better carry out their mission as a husband, (Bearman, 2000).

Some consider that the majority of families do not talk about sexuality either because, sex is a taboo or because parents think that “they would motivate their children to have sex”. However, they acknowledge that mothers could be more “open” than fathers. Teenagers between 14-20 years old expressed the same opinion during the study on risky behaviours among adolescents carried out in Luanda by (Maria, & et al, 1999). Despite this openness, the topics discussed are very limited to menstruation and pregnancy in the case of girls. Thus, the young have to look for information outside of home, running the risk of getting distorted information. Add to that, the school does not carry out its educational role either.

According to a study conducted by Altuna and et.al., in 1993 “Condoms reduce sexual pleasure and are painful”, “When emotion hits there is no room to condoms” “or “due to the fear that the condom could remain in the vagina”, and surgery would be necessary to take it out”. Others say “the prices of the condoms are too high”. Besides that, there is no information regarding the places where the condoms are sold. They believed that the promotion of the use of condoms among the youth would indirectly motivate the “irresponsible” practice of sex once the condom is also used as a contraceptive. The study clearly shows that there is a gap between being informed and daily practices, as well as the cultural pressure on individual behaviours.

Two such studies, by (Emmanuel; and et.al., 1999), show that cultural
and social practices are emerging amongst the youths in schools which are observed to be heavily influenced by foreign religion i.e. Christianity and Islam and less by traditional African religions. The socio-cultural differences that still exist amongst different ethnic groups, particularly amongst the older generations and out of school youths, have great influence on how different ethnic groups may respond to various AIDS interventions.

Many communities believe that HIV/AIDS can result from magic. Some communities distinguish AIDS from two traditional diseases, “tsempho” and “kanyera” which have similar symptoms to AIDS, (weight loss, diarrhea, thin hair). “Tsempho” - violation of sexual restriction; having extra-marital sex; promiscuity’- having sex with a woman who had a miscarriage. “Kanyera” - having sex with a menstruating woman; having sex with a woman who gave birth recently; having sex with a woman who has had a miscarriage; having sexual intercourse with a person with “Kanyera.” As a result, if members of the community are convinced that someone suffering from an AIDS related illness is actually suffering from “Tsempho” or “Kanyera”, they take them directly to a traditional healer for treatment. This is because they believe the latter to be curable with herbal medicines. Meanwhile the sufferer will be exposing others (e.g. spouses) to a high risk of infection, (Kornfield, and et.al., 1997).

In most Malawian families the role of nursing the sick, is left primarily to women as they socialize in support roles associated with production and serving the family. Women are more at risk, if the person being nursed is an AIDS patient. Upon the death of a husband, his relatives usually grab property from the widow. Some of the property might happen to be the one through which the family was generating income. The woman is thus left to fend for herself sometimes through ‘commercial sex, (Dallabetta, and et.al., 1995).

Early marriage for girls, sexual promiscuity and violence, early and frequent pregnancies for married women, men’s extra-marital sexual relations during young mothers’ postpartum period, polygamy, frequently linked with
agrarian societal systems and traditional principles among Muslim populations. Educate a boy better than a educate girl, because the girl go to her husband and his parents. Such attitudes put girls at a higher risk of HIV/AIDS than their male counterparts due to the fact that they may not grasp issues as well as those who have been through school. (Rankin, 2005).

From another point of view, the possible inequities towards women in polygamous systems are often substituted in modern life conditions by highly inequitable and sexually dangerous “informal polygamy” or a multi-partner sexual life on the part of men (including bisexuality in the Dominican Republic, Jamaica, Thailand), for example in Uganda, South Africa, Botswana, Zimbabwe and, to a far more limited extent, on the part of women (for instance in Angola). (Country assessment, 2002).

Given the geo-cultural diversity of the countries reviewed, religious beliefs have been examined in all their diversity. Spiritual beliefs in general can interact closely with the HIV/AIDS issue. Evidence of this was provided by several country assessments (South Africa, Uganda, Thailand, and Dominican Republic). But their impact and influence is very different, depending on the intensity of beliefs and religious practice, the plurality in religious references and its consequence in building ethics and behavioural rules. (Country assessments, 2002).

Animist or magic beliefs are closely connected with fear of death and the risk of discontenting gods or ancestors. In African religions or the voodoo tradition in the Caribbean, it is feared that dead people transmit curses to their descendants (possibly through disease), unless they are properly invoked and celebrated in cult ceremonies. This could be used to illustrate the responsibility of parents in infecting their children and descendants. (UNESCO, 1999).

Sexual acts are sometimes required as part of the rituals pertaining to death and widow inheritance. Among the Sebei, the legal heir has to have sex with the widow to clean out the ashes, three days after the death.. However, it
appears that the acceptability of abstinence is greater in certain Muslim African countries (Senegal, the Sahelian region) or among certain Hindu or Buddhist communities, whether they are monks or spiritual devotees, (UNESCO, 1999)

While the widower is mildly treated and only for a brief period, he is neither isolated, nor restricted nor neglected. In fact, he can return to work immediately after the burial of the wife and even remarry soon after. It is unjustifiable to have a lenient practice for the man and a rigid one for the woman in similar circumstances.

In the culture of the people of the Western Highlands of Cameroon, a husband is almost everything in the family, and has the final say in family matters. He is the protector and defender of the family. In fact, the importance of any wife is measured by the husband’s position or achievements in the community. In most cultures of the area, woman is considered the man’s property and cannot be allowed to inherit the husband’s property. Rather, she as property has to be inherited at this stage by the next of kin or any male relative of the deceased husband, (Luke, 1989).

The feeling of guilt and shame related to the infection and possible death will be dependent on the group’s reaction; for instance the reason for somebody’s unexplained death will be hidden by the family or closest friends and AIDS will be given another name (Malawi, Angola). Besides men will insist on not being tested by female nurses (South Africa, Malawi, and Dominican Republic), (Country assessments, 2002).

War is the one of the factors that fuels the HIV/AIDS crisis. It breaks up families and communities, creating millions of refugees and placing women and children in great peril of sexual attack or systematic rape used to terrorize opposing forces. It destroys the health services that might have been able to identify the diseases associated with HIV/AIDS or screen the blood transfusions that might transmit it. It also destroys the education systems that might have been able to teach prevention and slow the spread of the disease. AIDS contributes to
political instability by leaving millions of children orphaned and by killing teachers, health workers, and other public servants, \((Santos, 2001)\).

Another factor accelerating the spread of HIV infection during conflict is involvement with military forces. In conflict situations, the main perpetrators of sexual abuse and exploitation are armed forces or armed groups. In addition, soldiers are typically young, sexually active men who are likely to seek commercial sex. Even during peacetime, they have sexually transmitted infection (STI) rates two to five times greater than those of civilian populations. During armed conflict their rate of infection can be up to 50 times higher, \((Machel, 2006)\).

In 2000, the UN Security Council focused international attention on the links between conflict and the disease during an unprecedented debate on the threat of HIV/AIDS to Africa. “The simple fact that the Security Council regards AIDS as a significant problem sends a powerful message,” it said. “The Council now regards support for the global fight against AIDS as among its core business.”

Isolation of HIV-like viruses from African green monkeys and macaques has raised the possibility that AIDS has somehow been passed to humans from non-human primates. It is also possible, though less likely, that such transmission occurs relatively frequently and some amount of AIDS in Africa is the result of recurrent transmission from monkeys. To date, African green monkeys \((Cercopithecus aethiops, or vervets) are the only species reported to have an AIDS-type virus in the wild. Hence vervets are the principal suspect in the transmission of disease, \((Kanki, 1985)\).

Although a possible source of exposure of humans to monkey virus is bites from monkeys kept as pets, the commonest type of exposure to monkeys, including vervets, is the hunting of monkeys for meat. In all rural areas and in many cities (e.g., Kigali, the capital of Rwanda), smoked monkeys are a common food item for sale in markets. The monkeys are trapped or shot, eviscerated, and
prepared for eating by singeing of the hair and then smoking of the carcass over a fire, (*Kanki, 1985*).

During the evisceration process, humans are exposed to blood and internal secretions that presumably contain virus. Although smoked monkeys are sold throughout sub-Saharan Africa, monkey hunting is mainly limited to forested areas. (Central Africa). As has been mentioned, it is far more likely that any transmission of HIV-like viruses from monkeys to humans has occurred as a rare event rather than as a recurring transmission pattern, (*Andelman S.1987*).

The study carried out by *Wendy and et al (1997)* indicated that girls and boys actually engaged in sex or thought about engaging in sex at quite an early age (16 years old). The majority of girls said they discussed their intentions with their close friends, many of whom seem equally uninformed and uneducated about sex, and therefore may not give appropriate advice to their friends about condom use, and fidelity, for example. Boys obtained advice from older boys, most of whom advised experimentation with as many girls as possible, and usually did not advise using condoms.

Such views have serious implications for HIV infection because a healthy-looking person can also be carrying the virus. Similarly a person with a lot of money may also be carrying HIV. It is also likely that because of his or her financial position, he or she will be in a more advantaged position to make decisions in the relationship. It is therefore of great importance to deal with what the young people’s ideal of a sexual partner, as some of these may expose them to higher risk of infection.

Interfamily marriages (relatives or cousin) can still be found in more traditional communities, and often lead to severe, hereditary blood diseases among children, like thalassemia and hemophilia. As these children are in constant need of blood transfusions, they face a heightened risk for contracting HIV, (*Azerbaijan, UNESCO 1999*).
According to the President of the UN General Assembly. The fight against AIDS required an attack on “diseases of the human spirit” – prejudice, discrimination and stigma. The latest estimates showed that about one third of the United Nations Member States still had no laws in place to prohibit HIV-related discrimination. In many countries where such laws existed, they were inadequately enforced. Legal frameworks institutionalized discrimination against groups most at risk and against vulnerable populations, (UN, report 2006).

World leaders reaffirmed that the full realization of all human rights and fundamental freedoms for all is an essential element in the global response to the HIV/AIDS pandemic, including in the areas of prevention, treatment, care and support, and recognized that addressing stigma and discrimination is also a critical element in combating the global HIV/AIDS pandemic, (Commitment on HIV/AIDS, 2006).

2.2 World Situation

The latest United Nation’s information and analysis tell that 29 million people needing HIV treatment worldwide still lacked medication. Roughly two out of three HIV-positive pregnant women did not receive services to prevent mother-to-child transmission. The pace of new HIV infections was increasing at a faster rate than that at which access to treatment was being expanded. Africa, where 22 million people lived with HIV, was the scene of three out of four of the world’s AIDS deaths in 2007, (DPI. UN, June 2009).
According to UNAIDS global report 2010, Sub-Saharan Africa comes first in adults and children living with HIV, newly infected with HIV, adults prevalence (15-49 years), and AIDS-related deaths among adults and children.

Table (2.1) shows adults and children living with HIV in 2009 compared to the cases in 2001

<table>
<thead>
<tr>
<th>Region</th>
<th>2001</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sub-Saharan Africa</td>
<td>20.3 m</td>
<td>22.5 m</td>
</tr>
<tr>
<td>South and South east Asia</td>
<td>3.1 m</td>
<td>4.1 m</td>
</tr>
<tr>
<td>North America</td>
<td>1.2 m</td>
<td>1.5 m</td>
</tr>
<tr>
<td>Eastern Europe and Central Asia</td>
<td>760 000</td>
<td>1.4 m</td>
</tr>
<tr>
<td>West and central Europe</td>
<td>630 000</td>
<td>820 000</td>
</tr>
<tr>
<td>East Asia</td>
<td>350 000</td>
<td>770 000</td>
</tr>
<tr>
<td>Middle East and North Africa</td>
<td>180 000</td>
<td>460 000</td>
</tr>
<tr>
<td>Caribbean</td>
<td>240 000</td>
<td>240 000</td>
</tr>
<tr>
<td>Ocean</td>
<td>29 000</td>
<td>57 000</td>
</tr>
</tbody>
</table>

Adapted from UNAIDS global report 2010

m = million
### Table (2.2) Adults and children newly infected with HIV in 2009 compared to the cases in 2001

<table>
<thead>
<tr>
<th>Region</th>
<th>2001</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sub-Saharan Africa</td>
<td>2.2 m</td>
<td>1.8 m</td>
</tr>
<tr>
<td>South and South East Asia</td>
<td>380 000</td>
<td>270 000</td>
</tr>
<tr>
<td>Eastern and Central Asia</td>
<td>240 000</td>
<td>130 000</td>
</tr>
<tr>
<td>Central and South America</td>
<td>99 000</td>
<td>92 000</td>
</tr>
<tr>
<td>East Asia</td>
<td>64 000</td>
<td>82 000</td>
</tr>
<tr>
<td>Middle East and North Africa</td>
<td>36 000</td>
<td>75 000</td>
</tr>
<tr>
<td>North America</td>
<td>66 000</td>
<td>70 000</td>
</tr>
<tr>
<td>Western and Central Europe</td>
<td>31 000</td>
<td>31 000</td>
</tr>
<tr>
<td>Caribbean</td>
<td>20 000</td>
<td>17 000</td>
</tr>
<tr>
<td>Ocean</td>
<td>4700</td>
<td>4500</td>
</tr>
</tbody>
</table>

*Adapted from UNAIDS global report 2010*
In the case of AIDS related deaths among adults and children in sub-Saharan Africa, there were 1.3 million deaths in 2009 comprising 72% of the global total of 1.8 million deaths, and 1.4 million in 2001. In South and South East Asia there were 260 000 deaths in 2009, and 230 000 in 2001. In Eastern Europe and Central Asia there were 76 000 in 2009, 18 000 in 2001, Central and South America 58 000 in 2009, 53 000 in 2001, East Asia 36000 in 2009, 15000 in 2001. In the Middle East and North Africa there were 24000 deaths in 2009, compared to 8300 in 2001. Reliable data on the epidemics in the Middle East and North Africa remain in short supply, making it difficult to track recent trends with confidence, *(UNAIDS 2010 report).*

UNAIDS estimates that there were 33.3 million people living with HIV at the end of 2009 compared to 28.6 million in 2001, sub-Saharan Africa 22.5 million in 2009, compared to 20.3 million in 2001, 68% of the global total. Sub-Saharan Africa has more women than men living with HIV. The total number of people living with HIV continues to rise, but the annual number of new HIV infections declined since the late 1990s. Estimated numbers in 2009 were 2.6 million, compared to 3.1 million in 2001. The decline is attributed to significant scale up of antiretroviral therapy in the past few years.

The largest epidemics in sub-Saharan Africa, Ethiopia, Nigeria, South Africa, Zambia, and Zimbabwe, have either stabilized or are showing signs of decline.

There is increasing HIV prevalence, new infections and AIDS related deaths in Middle East and North Africa. It is estimated that 460 000 people were living with HIV at the end of 2009, up from 180 000 in 2001. There were 75 000 newly infected in 2009-more than twice the number 36 000 in 2001. AIDS related deaths have nearly tripled from 8 300 in 2001 to 23 000 by the end of 2009, *(UNAIDS*
2.3 Sudan Situation

According to UNAIDS report 2010, prevalence among adults aged 15–49 was 1.1% (0.9% - 1.4%) in North Sudan in 2010 with some variations between states, and number of people living with HIV/AIDS was estimated at 260,000. Adult aged 15 and up living with HIV/AIDS were 250,000. Women aged 15 and up living with HIV/AIDS were 140,000. Children aged 0 to 14 years living with HIV/AIDS were 15,000. And deaths due to AIDS stood at 12,000.

The Sudan Household Health Survey (SHHS) (<i>Ministry of Health Sudan, 2006</i>) shows that the rate of awareness about AIDS among women is 70.4%, knowledge about HIV prevention is 4% and the knowledge of mode of mother-to-child transmission of HIV is 54%.

According to the Federal Ministry of Health report, September 2011, people living with HIV/AIDS in Sudan were 17,079. Infected Women are about 83.5% of the total number of those infected with STDs. And about 3490 patients are now treated with antiretroviral, (<i>UNAIDS, Time for focus; 2010</i>)

There are fears that HIV transmission could accelerate and broaden in the aftermath of more than two decades of war, as the lives of former refugees and displaced persons gradually return to normal. For example, HIV prevalence as high as 4.4% has been found among some formerly displaced adults in Yei in the south, along the Ugandan border (<i>Kaiser et al., 2006</i>). More prevention efforts are being mounted in the south, including voluntary counseling and testing initiatives (in Juba, for example), and a handful of antiretroviral treatment sites are now operating.

The post-conflict environment that exists in Eastern and western Sudan also creates a conductive environment for spread of HIV as the displaced, poor
population return to their homes and teams from outside the community join to support the re-construction process. The economic growth that makes the Sudan third among African countries creates an environment where the rural population gets attracted to the urban centres looking for better life. The mobility of population within and outside the country increases the risk of HIV/AIDS infections. The war in Darfur has led to displacement of over 2 million people according to the Annual Health Statistical Report 2006.

One of the big challenges in AIDS education in Sudan is to disseminate information and to clarify some misconceptions about HIV/AIDS, (like, HIV is transmitted by shaking hands or touching, sharing toilets and bathrooms, or through mosquito bites or kissing. Another misconception, shared by some of the people, is that the only people susceptible to HIV/AIDS are homosexuals or sex workers, (UNAIDS Fact sheet, 2009).

According to (SNAP, 2004) behavioral study, only three quarters of pregnant women have ever heard of AIDS and one fifth of the surveyed women believed they could acquire HIV by sharing a meal with an HIV-positive person. Only 5% knew that condom use could prevent HIV infection, and more than two thirds of the women had never seen or heard of a condom. Even among people at special risk of infection (such as sex workers), HIV knowledge is poor and preventive behavior is rare. When surveyed, more than half (55%) of sex workers said they had never seen or heard of a condom and fewer than (17%) knew condoms could prevent HIV transmission. HIV prevalence among the women was 4.4%. Similar gaps in HIV knowledge and behavior have been found among internally displaced people.

And according to UNAIDS report, May 2006, the worst-affected country in the region is Sudan, where the highest infection levels are found in the south. There are recent signs that HIV may be acquiring a stronger presence in the North. Among the minority of women agreeing to be tested for HIV in Khartoum as part of a pilot project to prevent the transmission of the virus from mother to
child, just under 1% (0.8%) tested positive. Among women attending sexually transmitted infection clinics in the capital, over 2% tested positive in 2004, while HIV prevalence of 1% has been found also among university students and internally displaced persons in states in both the North and South of the country.

The Sudan National AIDS Programme (SNAP) estimates that, on basis of a total estimated population of 32,669,996 in North Sudan and prevalence rate among the general population of 1.6%, the total number of people living with HIV in the country is about 522,720. The HIV prevalence among adults of reproductive age 15-49 years is about 2.6%. Approximately 52,272 (10%) of the people living with HIV are currently in need of antiretroviral treatment, out of whom about 1,759 from North Sudan were reported to be accessing treatment. The magnitude of HIV and AIDS among the identified most-at-risk populations in the Northern Sudan has not been objectively reviewed since the national sero-behavioural survey that was conducted in 2002, (El Sadig, 2008)

The most-at-risk groups include prisoners, tea-sellers, long-distance truck drivers and female sex workers. A survey that was conducted among long distance truck drivers reported a lower HIV prevalence of only two HIV positive samples out of 374 that were tested (0.5%), compared to 1% among this sub-population from the national survey of 2002.

In 2002, a behavioral and epidemiological survey was carried out by Sudan national AIDS program covering 11 out of 16 states in North and 3 out of 10 in the South. According to the survey results, the prevalence among general population is 1.6%. A total of 7385 blood samples were tested in 2002 and out of those 118 were positive. Prevalence was 1.0% among women attending antenatal clinics and 4.0% among refugees, while prevalence of the other risk groups tested was 4.4% among female sex workers, 1.6% among TB patients, and 2.5% among tea sellers.

Among displaced pregnant women seeking antenatal care in Khartoum in
2004, HIV prevalence was 1.6%, compared to under 0.3% for other pregnant women, (*MoH Sudan, 2005*).

One of the main operational researches was carried out by *SNAP/UNICEF* in 2005; on knowledge, Attitudes, and Practices on sexual behaviors and HIV/AIDS prevention among young people, in the age range 12 to 24 years from both gender groups, at urban and rural areas in six selected states in the North. This KAP study came out with the key findings from seven main questions. On knowledge on HIV/AIDS, 94.1% said that they have heard of HIV/AIDS, while 37.9% knew that healthy individuals can transmit HIV and no one among the respondents mentioned abstinence and faithfulness to a regular/single sexual partner as means for prevention of HIV/AIDS. On knowledge on Condoms 31.6% heard of condom, 19.9% heard about it and saw it, 4% know it as a preventive method, and 28.8% know where to get it. 10% Know how to use it.

Most of the respondents expressed more than one stigmatizing/discriminative attitude towards people living with HIV/AIDS (PLWHA), like: eat from one dish, buy food from them, forbidding students from attending school and forbidding teachers from teaching. The most highly rated misconception is “mosquito bite can transmit HIV” 40.15% of men and 34.6% of women had the same belief. All respondents answered questions about STIs cited the symptoms which they suffered and no one could clearly say the name of the diseases.

The Sudan Household Health Survey (SHHS) was conducted in 2006 to provide estimates of indicators related to the situation of children and women at the national level, (in all the 25 states of North and Southern Sudan). The diverse issues that influence maternal and child health and included HIV/AIDS were explored in the questionnaire. While 70.4% of all the respondents in Sudan had heard about AIDS 51% of respondents identified sexual intercourse as the main mode of transmission while 39.7% respondents identified blood transfusion as a
mode of transmission, 38.8% mentioned HIV transmission through injection by needles used by others. Only 7.5% felt that HIV can be transmitted by not using condoms.

On ways to prevent HIV transmission (abstinence, faithfulness and condom use), only 4% knew all the three. 54% of all the respondents knew that HIV could be transmitted from infected pregnant mother to her baby. When asked about timing of transmission, only 26.4% knew all the three (pregnancy, delivery, breast milk).

A descriptive study was conducted by Omayma and et.al. in 2006, during April- May 2005 - in Khartoum State to determine (tea sellers’ women) risk behaviour and factor towards HIV/AIDS. The study highlighted that, while tea selling was considered a negative phenomenon by the authorities, the media and public at large, for most of the women interviewed it was their only source of family income. There was no evidence that the tea sellers were involved in sexual activities with their customers but rather the highly competitive business environment made it inevitable for any woman tea-seller to take care of her appearance and to flatter her customers in order to keep them or to attract new ones. While the level of awareness about HIV/AIDS was relatively high among the women tea sellers, this was nullified by misconceptions and stigma against those who are infected.

A qualitative study on female sex workers in Khartoum State aimed at generating relevant information on their socio-cultural and economic conditions as well as their perceptions and understanding about HIV. The study recognized that while sex work is an old phenomenon in Sudan, it is also illegal and therefore, clandestine. This made it difficult to determine the true extent of the sex work industry, which is acknowledged to be of substantial impact on the HIV prevalence in the country, (ACORD and et. al., 2006).

And a study conducted in 2005 among police officers in Khartoum State found that 1% was HIV-infected. Knowledge of HIV was extremely poor.
and only 2% of the respondent men knew that condoms can prevent HIV transmission. In addition, unsafe sex between men appears to be a contributing factor in the epidemic in Khartoum State. Almost all the men participating in the study claimed to have more than one sexual partner, and two thirds said that they had practiced sex for money. Just over half the men were unaware of the risk of HIV infection during unprotected anal sex and only 3% of them said that they used condoms consistently, (Abdelwahab, 2006).

A study of the Sudan government and UNFPA co-operation in the area of population IEC/advocacy in the area of reproductive health included family planning and HIV/AIDS. The study comes out with key recommendations; the need for nationwide socio-cultural behavioral, media and audience researches to guide advocacy activities and develop the national policies and advocacy strategies, (Samia Taha, MSc.1999 Unpublished thesis).

2.4 The Role of Local & International Organizations

A range of national and international NGOs are involved in HIV/AIDS work in Sudan. Most of these agencies work has to do with awareness-raising, and six of them have been identified as sub recipients of global Fund resources for activities targeting various vulnerable groups. The national NGOs coordinate their activities under the umbrella of Sudan AIDS Network (SAN).

The Sudan National AIDS Control Programme (SNAP) was established in 1987 as part of the national response to HIV/AIDS. With support from the WHO in 2001 a Task Force was constituted to conduct a national epidemiological, behavioural and response analysis survey that would form the basis for the development of a comprehensive multi-sectoral strategic plan.
The Sudanese Association of People Living with HIV (PLWH) was formed in 2004. Key concerns raised by the PLWH included low socio-economic status; stigma, education, rights, medical care and psychological wellbeing. The Government has demonstrated strong commitment to support the rights of people living with HIV and to reduce stigma and discrimination, (A/wahab & et.al 2006).

The behaviour change communication component of the national HIV/AIDS response was introduced in 2005, partly due to limited expertise in the area within the country. This document was developed with support from UNICEF in December 2006. There are deliberate activities that are designed to target mass media personnel as part of the strategy to promote accurate reporting on HIV by the media. HIV education has been in the school curricula and the content was reviewed and updated in 2007, to improve the quality and make it relevant to the national response, (SNAP, 2006).

According to Sudan government strategies and UNFPA, the communication strategy, involving mass media, religious group meetings, peer education, school, universities and health education programs-have raised the levels of awareness about the nature and mode of transmission of HIV/AIDS among Sudanese to over 90 per cent, (SNAP/UNICEF, KAP study 2005).

This high awareness level has not been successful in bringing about behavioral change in the society. This is partly attributed to the fact that the information dissemination has been paralyzing, confusing and not empowering at all. And according to the UNAIDS/WHO 2004, the numbers of mortality, morbidity and disability related to reproductive health, HIV/AIDS and STIs are still high.

UN agencies in Sudan have agreed to address HIV and AIDS systematically and on a sector-wide basis. Interventions of distinctively medical nature will be part of the health sector, all other interventions will be grouped in the 'cross cutting' sector, which supports mainstreaming of HIV/AIDS, gender,
capacity building and environment into all sector plans.

There are many programmes in Sudan that have been carried out to increase the awareness of people and provide preventive education concerning HIV/AIDS. One of those programmes is the teachers' programme, to sensitize them about the dangers of HIV/AIDS and return to their communities and share the information with their students. These programmes were sponsored by the Norwegian Refugee Council, with support from UNICEF, and were implemented in Western Sudan, (El Sadig, 2008).

Ockenden International, with support from the UK government's Department for International Development, has designed an innovative response to HIV/AIDS education in eastern Sudan, an area with a largely Muslim population and a wide variety of ethnicities and cultural practices due to presence of displaced Sudanese, mainly from the west and the south, as well as refugees from Ethiopia and Eritrea. Ockenden and its local partners began a large multi-sectoral project to increase awareness and knowledge of HIV/AIDS and to fight HIV/AIDS in the eastern part of Sudan in early 2004, (A/Wahab, 2006).
Chapter Three

Analysis of Field Survey Results

3.1 Introduction

The main objective of this chapter is to present the data concerning the background characteristics of the study population. These characteristics include age group, gender, education, and level of schooling, occupational characteristics and the level of knowledge of the respondents. And to provide the main findings of the study.

3.2 Background Characteristics of the Study population

3.2.1 Age distribution of the respondents according to gender

Table (3.2.1) below shows the age distribution of the sample according to their gender. The result showed that most of respondents are in their middle age with means age of (29.38) years, as the majority (85.8%) is within the age group 18 to 39, (43.3% were males and 42.5% were females), followed by the age group 40 and older, representing only 14.2% of the sample (5.8% males and 8.4% females).

Table (3.2.1) Age distribution of the respondents according to gender

<table>
<thead>
<tr>
<th>Age Group:</th>
<th>Male%</th>
<th>Female%</th>
<th>Total%</th>
<th>P.Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-28</td>
<td>28.9</td>
<td>28.7</td>
<td>57.6</td>
<td></td>
</tr>
<tr>
<td>29-39</td>
<td>14.4</td>
<td>13.8</td>
<td>28.2</td>
<td>0.099</td>
</tr>
<tr>
<td>40-50</td>
<td>4.0</td>
<td>7.1</td>
<td>11.1</td>
<td></td>
</tr>
<tr>
<td>51+</td>
<td>1.8</td>
<td>1.3</td>
<td>3.1</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>

Source: Own construction from survey data (2010)
3.2.2 Educational level of the respondents according to gender

Table (3-2-2) below represents the distribution of the educational level of the respondents according to gender. The result shows that most of the respondents are literate, where 86.7% attended school, (45.3% are males and 41.4% are females), and 13.3% are illiterate (3.7% males and 9.6% females). It is clear that the majority of the study population have completed some level of education. Since chi-square is 11.959, df. = 1 and the p.value is 0.001 that means the relationship between the respondent’s education and gender is highly significant.
Table (3-2-2): Distribution of respondents Education level according to gender

<table>
<thead>
<tr>
<th>Educational level:</th>
<th>Male %</th>
<th>Female %</th>
<th>Total %</th>
<th>P.Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>45.3</td>
<td>41.4</td>
<td>86.7</td>
<td>0.001</td>
</tr>
<tr>
<td>No</td>
<td>3.7</td>
<td>9.6</td>
<td>13.3</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>49.0</td>
<td>51.0</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>

Source: Own construction from survey data (2010)

Figure (3-2-2) distribution of Educational level of the respondents according to gender

Source: Own construction from survey data (2010)

3.2.3 The Level of Schooling of the study respondents according to gender

The result below shows that high percentage 37.4% completed primary school, (females 19.8%, and male 17.6%), while the percentage of those who completed secondary school was 2.9%; (males 2.2% and females only 0.7%). This is the stage at which girls start work. High secondary school graduates are 18.2%, (about 17.8% males while females were 0.4%), which indicates that a number of
students dropped out of school. 9.6% finished some level of khalwah education; (2.2% were male and 7.4% were females). 8.7% are of higher education, (5.6% males while 3.1% were females). 47.6% of the respondents spent between one to eight years of education in khalwah and/or primary school, and 39.8% of the respondents spent between 9 to 16 years of education attending high secondary school and/or university or institute. Since chi-square is 39.481, df is 5 and p.value is .000 that means the relationship between the respondent’s level of schooling and gender is highly significant.

Table 3-2-3 Distribution of the respondents Level of Schooling according to gender

<table>
<thead>
<tr>
<th>Level of schooling</th>
<th>Male%</th>
<th>Female%</th>
<th>Total%</th>
<th>P.Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>khalwah</td>
<td>2.2</td>
<td>7.4</td>
<td>9.6</td>
<td>0.000</td>
</tr>
<tr>
<td>primary</td>
<td>17.6</td>
<td>19.8</td>
<td>37.4</td>
<td></td>
</tr>
<tr>
<td>secondary</td>
<td>2.2</td>
<td>0.7</td>
<td>2.9</td>
<td></td>
</tr>
<tr>
<td>high secondary</td>
<td>17.8</td>
<td>0.4</td>
<td>18.2</td>
<td></td>
</tr>
<tr>
<td>university</td>
<td>5.6</td>
<td>3.1</td>
<td>8.7</td>
<td></td>
</tr>
<tr>
<td>not applicable</td>
<td>3.7</td>
<td>9.6</td>
<td>13.3</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>49.2</strong></td>
<td><strong>41.0</strong></td>
<td><strong>100</strong></td>
<td></td>
</tr>
</tbody>
</table>

Source: Own construction from survey data (2010)
Figure (3-2-3) Distribution of respondents Level of Schooling according to gender

*Source: Own construction from survey data (2010)*

### 3.2.4 Occupational distribution of study respondents according to gender

Table 3-2-4 below shows the occupational categories of respondents. It should be noted that the house wife is the predominant occupation within the sampled group, with 38.7% females while 0.3% are unemployed males; followed by those involved in some kind of private business representing 17.3% of whom 14.9% are males while females are only 2.4%; followed by students at 14.7%, with 9.8% males and 4.9% females; then informal business with 10.7%, with males representing 8.7% while females are only 2.0%; followed by labour representing 5.6%, with 4.7% males while females were 0.9%; followed by employees at 4.0%, with 2.4% males and 1.6% females; professionals amount to 3.4%, with 2.7% males and 0.7% females; followed by workers in the uniformed forces,
technicians and farmers amounting to 3.1%, 1.8% and 0.9% respectively. All of later were males. Since chi-square is 280.107, df is 9 and p. is .000 that means the relationship between respondents’ occupation and their gender is highly significant.

Table (3.2.4) Occupational distribution according to gender

<table>
<thead>
<tr>
<th>Occupational:</th>
<th>Male%</th>
<th>Female%</th>
<th>Total%</th>
<th>P.Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housewife</td>
<td>0.3</td>
<td>38.4</td>
<td>38.7</td>
<td></td>
</tr>
<tr>
<td>Student</td>
<td>9.8</td>
<td>4.9</td>
<td>14.7</td>
<td>0.000</td>
</tr>
<tr>
<td>Private Business</td>
<td>14.9</td>
<td>2.4</td>
<td>17.3</td>
<td></td>
</tr>
<tr>
<td>Informal business</td>
<td>8.7</td>
<td>2.0</td>
<td>10.7</td>
<td></td>
</tr>
<tr>
<td>Worker</td>
<td>4.7</td>
<td>0.9</td>
<td>5.6</td>
<td></td>
</tr>
<tr>
<td>Employee</td>
<td>2.4</td>
<td>1.6</td>
<td>4.0</td>
<td></td>
</tr>
<tr>
<td>Professional</td>
<td>2.7</td>
<td>0.7</td>
<td>3.3</td>
<td></td>
</tr>
<tr>
<td>Uniformed forces</td>
<td>3.1</td>
<td>0.0</td>
<td>3.1</td>
<td></td>
</tr>
<tr>
<td>Technician</td>
<td>1.8</td>
<td>0.0</td>
<td>1.8</td>
<td></td>
</tr>
<tr>
<td>farmer</td>
<td>0.9</td>
<td>0.0</td>
<td>0.9</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td><strong>100</strong></td>
<td></td>
</tr>
</tbody>
</table>

Source: Own construction from survey data (2010)

A cross tabulation between respondents’ main work and chance of getting HIV/AIDS was undertaken. Those who said they have no risk at all are housewives (26%), private business (12.7%), students (8%), informal business (6.4%), workers (3.6%), employees (2%), uniformed forces (1.8%), professionals (1.6%), and (0.9%) for each of the farmers and technicians. Respondents who said they are at a high risk of getting HIV/AIDS are as follows: housewife (2.2%), private business (1.6%), students (1.3%), professionals (0.7%), workers (0.4%), and employee (0.2%). Since chi-square is 24.765, df. = 18, and p.value is 0.132
that means the relationship between respondent’s work and knowledge about HIV/AIDS transmission is not significant.

Figure (3-2-4) Distribution of the study respondents works according to gender

Source: Own construction from survey data (2010)

3.2.5 Socio-cultural or traditional practices prevalent in the camp

Table 3.2.5 below shows that Polygamy is at top of the socio-cultural practices prevalent in the camp among different tribes amounting to 97.6%; followed by Piercing at 95.6%; Widow inheritance at 92.7%; Cross marriage at 88%; Male circumcision at 86.4% and is conducted in groups unless family has money to go to a private doctor; Hijamah amounts to 72.9%, while Fisadah stands at 35.6%. Female Genital Mutilation is practiced among 21.8% mainly within the Muslims’ tribes, and Tattoo came at the bottom of the risky socio-cultural practices with 10.7%. According to these results and high percentages of risky societal and
cultural practices, these people still believed that the virus could not be transmitted through these traditional practices.

**Table (3-2-5) Socio-cultural practices that may contribute to the spread of HIV/AIDS**

<table>
<thead>
<tr>
<th>practice</th>
<th>Yes%</th>
<th>No%</th>
<th>Total%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fissadah</td>
<td>35.6</td>
<td>64.4</td>
<td>100</td>
</tr>
<tr>
<td>Hijamah</td>
<td>27.9</td>
<td>27.1</td>
<td>100</td>
</tr>
<tr>
<td>Tattoo</td>
<td>10.7</td>
<td>89.3</td>
<td>100</td>
</tr>
<tr>
<td>Male circumcision</td>
<td>86.4</td>
<td>13.6</td>
<td>100</td>
</tr>
<tr>
<td>Female circumcision</td>
<td>21.8</td>
<td>78.2</td>
<td>100</td>
</tr>
<tr>
<td>piercing</td>
<td>95.6</td>
<td>4.4</td>
<td>100</td>
</tr>
<tr>
<td>polygamy</td>
<td>97.6</td>
<td>2.4</td>
<td>100</td>
</tr>
<tr>
<td>Cross marriage</td>
<td>88</td>
<td>12</td>
<td>100</td>
</tr>
<tr>
<td>Widow inheritance</td>
<td>92.7</td>
<td>7.3</td>
<td>100</td>
</tr>
</tbody>
</table>

*Source: Own construction from survey data (2010)*

**Figure (3-2-5) Socio-cultural practices that may contribute to the spread of HIV/AIDS**

*Source: Own construction from survey data (2010)*
3.3 Knowledge of respondents about HIV/AIDS

This part presents information about awareness of HIV, knowledge of how it is spread and how it can be prevented, and misconceptions about the modes of transmission and prevention, in addition to the respondent’s assessment of their personal risk of contracting HIV.

3.3.1 Heard of HIV/AIDS

Table 3.3.1 below shows a very high level of knowledge. 97.3% of the respondents have heard of HIV/AIDS, while only 2.7% know nothing about it. Ahfad University for women, CAFA, CARE, Doctors without borders, and other local and international organizations have been launching awareness programs about different issues including HIV/AIDS. All these efforts produced such a high level of knowledge. But hearing of HIV/AIDS does not mean effective knowledge, as will be apparent from the next table.

Table (3-3-1) Distribution of the study respondents who heard of HIV/AIDS

<table>
<thead>
<tr>
<th>Response</th>
<th>Male%</th>
<th>Female%</th>
<th>Total%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>48.2</td>
<td>49.1</td>
<td>97.3</td>
</tr>
<tr>
<td>No</td>
<td>0.9</td>
<td>1.8</td>
<td>2.7</td>
</tr>
<tr>
<td>Total</td>
<td>49.1</td>
<td>50.9</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: Own construction from survey data (2010)
3.3.2 Respondent’s Knowledge about the modes of HIV/AIDS Transmission

The results shows that only 13.8% of the respondents are aware of the four modes of HIV/AIDS transmission- 1) sexual intercourse, 2) blood transfusion, 3) from mother- to- child, 4) and through sharp objects (needles, razor blade, knives, others), while 6.9% do not know anything about the mode of transmission. 3.3% of the respondents knew the four modes of transmission plus one of the following wrong modes- through bugs and mosquito’s bites, or toilet or witchcraft, or hugs. 19.6% knew the four modes of transmission plus two wrong modes from the above. 3.8% knew the four modes of transmission plus three wrong modes of transmission. 0.4% knew the four modes plus four wrong modes of transmission. 1.1% knew only three of the four modes of transmission. 9.0% knew three modes of transmission plus one wrong mode, 4.1% knew three of the four modes plus two wrong modes; 1.3% knew three modes of transmission but added more three
wrong ones. 6.1% knew three modes plus four wrong modes. 4.2% knew only two modes of transmission, 1.1% knew two modes plus one wrong ones; 0.9% knew only one mode (sexual intercourse) and 0.4% of respondents knew one mode of transmission plus one wrong mode. This result clearly shows the misunderstanding of the modes of transmission, which means that the level of misconception about transmission of HIV through mosquitoes and bugs bites, sharing toilet, kisses, hugs, and witchcraft is still high among displaced people in Sudan.

According to a cross tabulation tables, results indicated that awareness was generally high among those who attended some level of education. It is 6.5% among khalwah level, 25.8% among primary level, 4.8% among secondary level, while high secondary school level is about 35.5% and among universities and institutes is 19.4%. Since chi-square is 539.384, and df. = 465, p.value is 0.010, that means the relationship between the level of education and knowledge of how a person can get HIV/AIDS is highly significant.
Table (3.3.2) Respondent’s Knowledge about the modes of HIV/AIDS

Transmission (how a person can get HIV/AIDS)

<table>
<thead>
<tr>
<th>Knowledge about the ways of transmission</th>
<th>percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knew the four modes of transmission</td>
<td>13.8</td>
</tr>
<tr>
<td>Knew the four modes plus one wrong</td>
<td>3.3</td>
</tr>
<tr>
<td>Knew the four modes plus two wrong</td>
<td>19.6</td>
</tr>
<tr>
<td>Knew the four modes plus three wrong</td>
<td>3.8</td>
</tr>
<tr>
<td>Knew the four modes plus four wrong</td>
<td>0.4</td>
</tr>
<tr>
<td>Knew three modes only</td>
<td>1.1</td>
</tr>
<tr>
<td>Knew three modes plus one wrong</td>
<td>9.0</td>
</tr>
<tr>
<td>Knew three modes plus two wrong</td>
<td>4.1</td>
</tr>
<tr>
<td>Knew three modes plus three wrong</td>
<td>1.3</td>
</tr>
<tr>
<td>Knew three modes plus four wrong</td>
<td>6.1</td>
</tr>
<tr>
<td>Knew two modes only</td>
<td>4.2</td>
</tr>
<tr>
<td>Knew two modes plus one wrong</td>
<td>1.1</td>
</tr>
<tr>
<td>Knew only one mode of transmission (sexual intercourse)</td>
<td>0.9</td>
</tr>
<tr>
<td>Knew one mode of transmission plus one wrong way</td>
<td>0.4</td>
</tr>
<tr>
<td>Knew one mode from all above</td>
<td>21.3</td>
</tr>
<tr>
<td>Do not know the modes of transmission</td>
<td>6.9</td>
</tr>
<tr>
<td>Not applicable (didn’t hear about HIV/AIDS)</td>
<td>2.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

*Source: Own construction from survey data (2010)*
3.3.3 This section below represents the distribution of respondents who knew that a person can avoid getting the virus that cause AIDS.

The results shows that only 2.2% of the respondents knew that a person can avoid HIV/AIDS transmission by staying with one faithful uninfected partner, use of condoms, abstaining from sex, delay sex practices, reduce sex partners, avoid sex with those who have more than one partner, avoid sharing sharp objects, and undergo HIV testing. But in addition to those means, they hold the misconception that the transmission can be avoided by praying to god with Duaa and traditional healers treatments.

5.8% of respondents knew the above eight protective methods plus one unprotected method- praying to god or traditional healer’s treatments. 13.1% knew seven methods of protection plus, two unprotected methods- praying to god and seeking treatment from traditional healers. 6.7% knew seven methods of protection plus one unprotected mode- praying to God or treatment by traditional healers. 1.6% knew seven methods of protection, 0.9% knew six protective methods plus two unprotected ones- praying to God and seeking treatment from traditional healers. 1.4% knew six methods of protection plus one unprotected way- praying, or traditional healer’s treatments. 0.7% knew six methods of protection. 17.2% knew five methods of protections plus one unproductive method- praying or traditional healer’s treatment. 0.9% knew five methods of protections. 1.8% knew four methods of protections plus two unprotected methods- traditional healers’ treatments and praying to God with Duaa. 1.1% knew four methods plus one of the unprotected methods- traditional healers or
praying to God. 0.9% knew three methods of protection plus praying and 0.7% knew only two protective methods plus seeking treatment from traditional healers and praying to God with *Duaa*.

In all, it is clear that there is a misconceptions among respondents, 32% of the respondents believe that by praying to God they will be immune and protected from getting the HIV virus and kept safe. 17.8% believes in both traditional healer’s treatments and praying to God for protection.

3.3.4 Knowledge about practices posing a high risk of getting infected with HIV.

Table 3-3-4 below represents knowledge about practices posing a high risk of getting infected with HIV.

**Table (3-3-4) Distribution of respondents who believe they have a high risk of getting HIV**

<table>
<thead>
<tr>
<th>Reasons</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>- sharing sharp objects,(needles, raisers, etc..)</td>
<td>1.1</td>
</tr>
<tr>
<td>- practice sex with out condoms,</td>
<td></td>
</tr>
<tr>
<td>- husband/ wife has other partners,</td>
<td></td>
</tr>
<tr>
<td>- unsafe blood transfusion, or sex with prostitutes</td>
<td></td>
</tr>
<tr>
<td>- sharing sharp objects,</td>
<td>1.3</td>
</tr>
<tr>
<td>- practice sex with out condoms,</td>
<td></td>
</tr>
<tr>
<td>- husband/ wife has other partners-or sex with prostitutes-</td>
<td></td>
</tr>
<tr>
<td>- sharing sharp objects, (needles, raisers, etc.)</td>
<td>0.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>3.1</strong></td>
</tr>
</tbody>
</table>

*Source: Own construction from survey data (2010)*
Table (3-3-5) Distribution of knowledge about HIV/AIDS practice posing low or no risk at all

<table>
<thead>
<tr>
<th>Reasons of having low or no risk at all</th>
<th>percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>- because of these (eleven) reasons: abstaining from sex, trust my partner, I practice sex with only one partner, and I practice sex only with my spouse who have no other partner, avoid sex with sex workers, sterile needles, safe blood, condoms use, traditional healers, god’s protection.</td>
<td>1.1</td>
</tr>
<tr>
<td>- Who chose ten reasons from the above.</td>
<td>4.0</td>
</tr>
<tr>
<td>- Who chose nine reasons from the above.</td>
<td>0.9</td>
</tr>
<tr>
<td>- Who chose six reasons from the above.</td>
<td>1.3</td>
</tr>
<tr>
<td>- Who chose five reasons from the above.</td>
<td>1.6</td>
</tr>
<tr>
<td>- Who chose four reasons from the above.</td>
<td>4.2</td>
</tr>
<tr>
<td>- Who chose three reasons</td>
<td>4.7</td>
</tr>
<tr>
<td>- Who chose two reasons (from the eleven reasons)</td>
<td>11.4</td>
</tr>
<tr>
<td>- Who chose only one reason from the following: God protection from getting AIDS, or use of condom every time, or use of sterile needles, or use of safe blood, or avoiding stigma, or avoiding sex with sex workers.</td>
<td>4.7</td>
</tr>
<tr>
<td>- chose abstaining from sex</td>
<td>10.9</td>
</tr>
<tr>
<td>- practice sex only with spouse</td>
<td>3.6</td>
</tr>
<tr>
<td>- practice sex with only one partner</td>
<td>3.8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>87.3</strong></td>
</tr>
</tbody>
</table>

Source: Own construction from survey data (2010)

*Notice: In table (3-3-2), the 2.7% didn’t hear about HIV/AIDS; 6.9% didn’t know the ways of transmission; in table (3-3-3), 3.1% believed that they were at high risk and in table (3-3-4) 87.3% believed that they were at low or no risk at all; consequently, this brings the total in both tables to 100%.*
Cross tabulation between school levels and possibility of getting HIV/AIDS indicates that those who think they are at high risk are as follows; primary school (2.9%), high school (2.0%), university (0.9%), khalwah (0.7%), secondary school (0.0%), while respondents who did not attend any school or any type of education are (0.2%). Those who believe that they are at low risk or no risk at all are as follows: (1.3%) khalwah, (10%) primary school, (10%) high school, (1.1%) secondary school, (3.3%) university. Who said they have no risk at all are of university education (4.4%), high school (16.2%), secondary school (1.8%), primary school (22.2%), and those who never attending school and think they are safe are (9.1%). Since chi-square is 14.614, and df. is 10 and p.value is 0.147, that means the relationship between respondents believes about the possibility of getting HIV/AIDS and the level of education is independent.

3.3.6 Knowledge about the possibility of a healthy looking person may be infected with HIV

Table 3-3-6 below shows the level of knowledge about the occupation period of infections and whether respondents can differentiate between HIV positive and AIDS patient and other diseases symptoms. 34.7% said a person with HIV can look healthy. 34.4% said he/she cannot look healthy. 30.9% do not know how he/she looks.
Table (3-3-6) A healthy looking person can be infected with the HIV

<table>
<thead>
<tr>
<th>Healthy looking</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>34.7</td>
</tr>
<tr>
<td>No</td>
<td>34.4</td>
</tr>
<tr>
<td>I do not know</td>
<td>30.9</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
</tr>
</tbody>
</table>

*Source: Own construction from survey data (2010)*

Figure (3-3-6) Distribution of respondents’ answer to whether a healthy looking person can be infected with HIV

*Source: Own construction from survey data (2010)*

3.3.7 Knowledge about respondents ever been tested for HIV/AIDS

The results presented below in table 3-3-7 show whether the respondent had ever been tested. 6% of respondents said yes and 3.6% of them received the result. 2.7% asked for it, while 1.8% was required to have it and 1.3% offered to them and they accepted. This very low percentage indicates that the respondents don’t know where they can get HIV test. This will appear in the next section
Table (3-3-7) Distribution of the respondents ever been tested for HIV/AIDS

<table>
<thead>
<tr>
<th>Ever been tested</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>6</td>
</tr>
<tr>
<td>Asked for it</td>
<td>2.7</td>
</tr>
<tr>
<td>Required to have it</td>
<td>1.8</td>
</tr>
<tr>
<td>Offered and I accepted</td>
<td>1.3</td>
</tr>
<tr>
<td>Not applicable</td>
<td>94</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Own construction from survey data (2010)

Figure (3-3-7) Distribution of study respondents ever been tested for HIV/AIDS

Source: Own construction from survey data (2010)

3.3.8 The respondent’s reasons of having HIV Test

Table below shows the attitudes of respondents towards why they would like to have a test or wouldn’t. 46.4% would likes to have a test to know if they are infected. 10% would like to have it to reduce the fear and anxiety. Followed by those who needed the test for marriage purposes at 2.9%; and 1% required the test for the purpose of employment.
Table (3-3-8) Distribution of respondents knowledge about the reasons of having HIV test

<table>
<thead>
<tr>
<th>The main reason</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>To reduce fear &amp; anxiety</td>
<td>10.0</td>
</tr>
<tr>
<td>Required for employment</td>
<td>1.0</td>
</tr>
<tr>
<td>For marriage purposes</td>
<td>2.9</td>
</tr>
<tr>
<td>To know my status</td>
<td>46.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>60.3</strong></td>
</tr>
</tbody>
</table>

*Source: Own construction from survey data (2010)*

Figure (3-3-8) distribution of respondents’ knowledge about the reasons of having HIV test

*Source: Own construction from survey data (2010)*

3.3.9 The attitudes towards not having HIV Test

This table below shows the attitudes towards not having a test. The result shows that 22.4% of respondents feel it is not necessary. 9.1% are afraid of knowing the result. 6% don’t want to know if they were infected or not, and 3.3% can’t afford the cost of test (compared to their economic situation).
Table (3-3-9) The distribution of no desire to have HIV Test

<table>
<thead>
<tr>
<th>The main reason</th>
<th>percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel it is not necessary</td>
<td>22.4</td>
</tr>
<tr>
<td>Fear &amp; anxiety</td>
<td>9.1</td>
</tr>
<tr>
<td>I don’t want to know my status</td>
<td>6.0</td>
</tr>
<tr>
<td>I cannot afford its cost</td>
<td>3.3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>40.8</strong></td>
</tr>
</tbody>
</table>

*Source: Own construction from survey data (2010)*

Figure (3-3-9) The distribution of respondents who have no desire to have HIV test

*Source: Own construction from survey data (2010)*

3.3.10 Knowledge about where to get an HIV test

This table below shows that 67.6%, majority of respondents, do not know where they can get HIV/AIDS test, while 32.4% know where they can have the test.
Table (3-3-10) Distribution of knowledge about where respondents can have the HIV test

<table>
<thead>
<tr>
<th>Respond</th>
<th>percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes I know</td>
<td>32.4</td>
</tr>
<tr>
<td>No I don’t know</td>
<td>67.6</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Own construction from survey data (2010)

Figure (3-3-10) Distribution of knowledge about where respondents can have the HIV test

Source: Own construction from survey data (2010)

3.3.11 Rate of chances getting HIV/AIDS according to education level

Table 3.3-11 below shows that 63.6% of the total number believed they are not at risk at all. Of these, 54.4% attended school. 29.7% of the total believed they are at low risk; 25.8% of them attended school. 6.7% of the total believed that they are in danger or high risk, 6.4% of them attended school. Since chi-square = 2.846,
df. is 2 and p. value = 0.241 that means there relationship between the respondents beliefs about chances of getting HIV/AIDS and their education is independent.

Table (3-3-11) Distribution of respondents chances of getting HIV/AIDS according to their education

<table>
<thead>
<tr>
<th>Chance rate</th>
<th>Percentage</th>
<th>Attended school%</th>
</tr>
</thead>
<tbody>
<tr>
<td>High risk</td>
<td>6.7</td>
<td>6.4</td>
</tr>
<tr>
<td>Low risk</td>
<td>29.7</td>
<td>25.8</td>
</tr>
<tr>
<td>No risk at all</td>
<td>63.6</td>
<td>54.5</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>86.7</td>
</tr>
</tbody>
</table>

*Source: Own construction from survey data (2010)*

Figure (3-3-11) Distribution of respondents chances getting HIV according to education level

*Source: Own construction from survey data (2010)*
3.3.12 The level of stigma and discrimination

In most of developing countries, including Sudan, stigma and discrimination are the two major problems facing people living with HIV/AIDS. Due to the fear of discrimination, individuals living with HIV/AIDS may be less inclined to live freely, openly acknowledging their HIV status. This can lead to under-reporting the epidemic and to resistance to the use of voluntary counseling and test.

Table 3-3-12 A, B, C, D, E, F, and G, shows the respondents attitudes and behaviours towards people with HIV/AIDS.

Table (3-3-12) Distribution of respondents who would be willing to eat with HIV positive

<table>
<thead>
<tr>
<th>Response</th>
<th>Percentages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>50.7</td>
</tr>
<tr>
<td>No</td>
<td>43.8</td>
</tr>
<tr>
<td>I do not know</td>
<td>5.6</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Own construction from survey data (2010)

Table A (3-3-12) above shows when respondents were asked whether they would be willing to eat with somebody who has HIV, 50.7% of them said yes, while 43.8% said no and 5.6% said they do not know.
Figure A (3-3-12) distribution of respondents who would be willing to eat with peoples has HIV

Source: Own construction from survey data (2010)

Table B (3-3-12) this table represents the attitudes of students towards a co-student infected with HIV but not sick. 56.7% of respondents reported that an infected student should be allowed to go to the school with them, while 36.9% said no, and 6.4% said they do not know.

Table B (3-3-12) Distribution of respondents about whether a student who has the virus but not sick should be allowed to go to school with them

<table>
<thead>
<tr>
<th>Response</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>56.7</td>
</tr>
<tr>
<td>No</td>
<td>36.9</td>
</tr>
<tr>
<td>I do not know</td>
<td>6.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Source: Own construction from survey data (2010)
Figure B (3-3-12) Distribution of respondents about whether a student who has the virus but not sick should be allowed to go to school with them

Source: Own construction from survey data (2010)

Table C (3-3-12) 50.4% of the respondents accepted HIV positive teachers to continue teaching in their schools, while 41.2% said no and 8.4% said they do not know.

Table C (3-3-12) Distribution of respondents’ response about accepting HIV positive teachers continuing teaching in their school

<table>
<thead>
<tr>
<th>Response</th>
<th>percentages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>50.4</td>
</tr>
<tr>
<td>No</td>
<td>41.2</td>
</tr>
<tr>
<td>I do not know</td>
<td>8.4</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Own construction from survey data (2010)
Figure C (3-3-12) Distribution of respondents’ response about accepting HIV positive teachers continue teaching in their school

Source: Own construction from survey data (2010)

Table D (3-3-12) below shows 62.2% of respondents reported that they will not buy anything from a shopkeeper who is infected with the virus. 32% said yes they will buy from HIV positive shopkeepers, and 5.8% said they do not know.

Table D (3-3-12) Distribution of respondents’ response about buying from a shopkeeper who is HIV positive

<table>
<thead>
<tr>
<th>Response</th>
<th>Percentages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>32.0</td>
</tr>
<tr>
<td>No</td>
<td>62.2</td>
</tr>
<tr>
<td>I do not know</td>
<td>5.8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Source: Own construction from survey data (2010)
Figure D (3-3-12) Distribution of respondents’ response about buying from a shopkeeper who is HIV positive

Source: Own construction from survey data (2010)

Table E (3-3-12) indicates the percentage of the respondent’s attitudes towards their colleague at work places if he/she has HIV. 47.1% said yes they will continue working with a colleague who is infected while 41.1% said no, and 11.8% said they do not know.

Table E (3-3-12) Distribution of respondent’s attitudes towards a colleague at work place having HIV

<table>
<thead>
<tr>
<th>Response</th>
<th>Percentages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>47.1</td>
</tr>
<tr>
<td>No</td>
<td>41.1</td>
</tr>
<tr>
<td>I do not know</td>
<td>11.8</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Own construction from survey data (2010)
Figure E (3-3-12) distribution of respondents’ attitudes towards a co-worker with HIV

Source: Own construction from survey data (2010)

Table F (3-3-12) below shows the result of how the respondents behave if a family member has HIV/AIDS. 50% said no it shouldn’t remain secret. 42.9% said it should be kept secret, and 7.1% they do not know.

Table F (3-3-12) Distribution of attitudes towards a family member has HIV/AIDS, would you want it to remain secret

<table>
<thead>
<tr>
<th>Response</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>yes</td>
<td>42.9</td>
</tr>
<tr>
<td>no</td>
<td>50.0</td>
</tr>
<tr>
<td>I do not know</td>
<td>7.1</td>
</tr>
<tr>
<td><strong>total</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Source: Own construction from survey data (2010)
Figure F (3-3-12) distribution of respondents attitudes towards a family member has HIV/AIDS, would you want it to remain secret

*Source: Own construction from survey data (2010)*

Table G (3-3-12) if your relative has HIV/AIDS would you be willing to take care of him/her? 69.6% said yes, 24.9% said no, while 5.6% they do not know.

Table G (3-3-12) distribution of respondents attitude towards relative has HIV/AIDS would you be willing to take care of him/her?

<table>
<thead>
<tr>
<th>Response</th>
<th>percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>69.6</td>
</tr>
<tr>
<td>No</td>
<td>24.8</td>
</tr>
<tr>
<td>I do not know</td>
<td>5.6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

*Source: Own construction from survey data (2010)*
Figure G (3-3-12) Distribution of respondents’ attitude towards whether they would you be willing or not to take care of relative with HIV/AIDS?

*Source: Own construction from survey data (2010)*

3.3.13 The respondent’s beliefs about health care that should be given to the people with HIV/AIDS.

Table 3-3-13 below shows the respondents beliefs about health care that should be given to the people with HIV/AIDS. 66.9% believed that people with HIV/AIDS should be given more health care than others infected with other diseases. 16.2% believed they should have equal care, and 11.3% said they should have less care, while 5.6% said they do not know.
Table (3-3-13) Distribution of respondent’s knowledge about whether more health care should be given to the people with HIV/AIDS

<table>
<thead>
<tr>
<th>Health care should be given</th>
<th>Percentages</th>
</tr>
</thead>
<tbody>
<tr>
<td>More health care</td>
<td>66.9</td>
</tr>
<tr>
<td>Equal health care</td>
<td>16.2</td>
</tr>
<tr>
<td>Less health care</td>
<td>11.3</td>
</tr>
<tr>
<td>I do not know</td>
<td>5.6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

*Source: Own construction from survey data (2010)*

Figure (3-3-13) Distribution of respondent’s knowledge about whether more health care that should be given to the people with HIV/AIDS

*Source: Own construction from survey data (2010)*
Chapter Four

Conclusions and Recommendations

4.1 Conclusions

The challenge of addressing the rising threat of the spread of HIV/AIDS in Muslim countries/societies is significant. The most effective public health method of controlling the spread of AIDS is education and changing the way people behave. Political, financial, and social barriers have often kept the most effective prevention and treatment strategies from reaching persons at the highest risk.

The study shows that;

- Population movements in Sudan contribute to the sexual mixing of various groups and may be related to the spread of AIDS. There is unprotected sex practice with partner whose HIV status is unknown. Multiple sex partner increases the risk of exposure to HIV/AIDS, especially among young people in the camp. Some females go downtown looking for work and they practice sex with individuals from cities. The reasons for this include lack of sexual satisfaction with a regular partner or / and sickness.

- Commercial sex is practiced in and outside the camp. In the camp, it is connected with alcohol drinking; outside, sex is practiced with wealthier men, old or young doesn’t matter. Some girls enter the prostitution for reasons related to poverty and lack of education.
- Alcoholism is a risk factor that can lead to having unprotected sex. As witnesses said, there are three days of continued drinking ceremonies, Thursday, Friday and Saturday and of course prostitution is included.

- Lack of health care facilities and HIV/AIDS clinics remains the most important problem in Sudan. Inaccessibility of services is often due to:

  * Lack of awareness of whether the service is available or not.
  * If available, it is inaccessible, because of distance.
  * Or they cannot afford the cost of test or other factors.

- People who are infected may also be reluctant to adopt behaviour that might signal their HIV- positive status to others. For example, a married HIV-positive man may not use a condom to have sex with his wife; An HIV-positive mother may continue to breastfeed her baby, because she didn’t know the methods of transmission. Many people do not want to get tested for fear of their community finding out.

- Lack of knowledge and misconceptions about HIV/AIDS. It appears that there are still many people unaware of the risks, especially those with low levels of formal education and who lack access to accurate, relevant information on HIV/AIDS and sexuality.

- Dangerous myths and misconceptions about HIV/AIDS, These include believing that the virus can be contracted by sharing food, hugs, kisses, sharing toilets, with the infected people and through mosquitoes and bugs bites. Beliefs such as this
give people a false sense of their level of risk, and contribute to confusion about how HIV is transmitted or prevented.(example, God will protect me).

- People who do possess some knowledge about HIV often do not protect themselves because they lack the skills, support or incentives to adopt safe behaviours.

- Young people may lack the skills to negotiate abstinence or condom use, or be fearful of talking with their partner about sex. So, many young people pick up misinformation from their peers instead.

- Negative attitudes towards condoms, as well as difficulties negotiating and following through with their use. Men regularly do not want to use condoms, because of beliefs such as “flesh to flesh” sex. Condoms also have strong associations of unfaithfulness, lack of trust and love.

- The importance of high fertility in the communities may hinder the practice of safer sex, and therefore people do not use condoms or abstain from sex.

From the results, the socio-cultural issues identified and are possibly connected with increased virus transmission and can contribute to the spread of HIV/AIDS:-

- Traditionally family encourage girls to have sexual intercourse only after marriage; boys can have sex in order to practice and to avoid not being described as homosexual (gay) so a boy can practice sex with adult women and sometimes with sex workers. If these women are infected these boys will be infected and they transmit this virus to their wives in the future and vice verse.
- Polygamous marriages, having more than one wife is a normal practice for the Moslem groups and it is culturally and socially practised among others, and also for different reasons.(for example; sickness, desires on more kids, female sterility (infertility).

- Traditional marriages in rural areas within the same tribe are a mode to protect the group, and should be chosen by the parents. The one chosen is not known whether HIV-infected and may be infected.

- Cross Marriage or sisters’ exchange (if you married our daughter, our son should marry your sister) could also have the same effect because nobody knows if one of them or both are infected or not.

- Widow inheritance, or substitution of wife/ husband, by remarriage upon the death of one of the couple (who might have died of HIV/AIDS) increases the risk of infection of the new bride (often a young girl who has not yet been engaged in sexual relations), if the man is HIV positive. The risk is even higher if the man further engages in polygamous marriages.

- Body piercing for earring or nose or any parts according to the tribal cultures is still practiced with unsterile instruments.

- Some herbalists the re-use of unsterile instruments the (knives, razors, seizers) to circumcise the males and that is why some parents collect some money to go to private doctor for circumcision. Sexual intercourse shortly at or shortly after the time of circumcision or recicumcision, when wounds are still open, is a less likely
factor contributing to infection with HIV.

- *Hijamah* and *Fissadah*, the practice involves a practitioner's using sharp objects (unsterile and reused) to make cuts deep enough to allow blood to flow freely. The practitioner then takes a mixture of ashes from leaves and rubs it into the wound, potentially exposing himself to the patient's blood which may be unknown HIV infected or AIDS patient.

- Bloodletting: Traditional rural healers and midwives also are occasionally exposed to blood during their duties, sometimes family members when taking care of AIDS patient.

- Gender inequality and male dominance perpetuate women’s inferior status and afford them little or no power to protect themselves by insisting on condom use or refusing sex.

- The stigma and discrimination against people with HIV/AIDS seem to be stronger, and even more so within some groups. As a result and due to the fear of stigma and discrimination, individuals living with HIV/AIDS are less inclined to live freely, declaring and acknowledging their HIV status. This leads to continued under-reporting of the epidemic, a resistance to the use of voluntary confidential counseling and testing services when available.

- Many people do not know the transmission methods because of unclear messages or the language. Most of the HIV/AIDS messages were translated from scientific version or provided by external organizations. Even if it is provided by
the local organizations, it is confusing and not understandable for groups like those residents in this camp and they used to exchange the information they learned, even if it is not correct.

- The influence of religion is quite strong among some ethnic groups which states that a man should have sex only with his wife/wives, but in reality they don’t.

- The difficulty in establishing effective HIV/AIDS programs comes from a lack of openness in many societies, regarding sexuality, male-female relationships, illness and death, taboo subjects deeply rooted in the cultures.

- Finally, we could affirm that the results of this case study confirm the hypothesis asserting that certain socio-cultural practices, particularly regarding sexuality, and traditional practices, could seriously obstruct the prevention campaigns and fight against HIV/AIDS. This situation is beyond the intervention of health professionals.
Recommendations

4.2 Recommendations

* There is an urgent need for developing and implementing policy and programs that provide AIDS education and awareness, prohibit stigmatization. Though the most important means of protection is obviously abstinence from sex and to remain faithful to the marriage partner, Muslims must recognize that in many instances there is a gap between religious teaching and practice; risky behaviors that may not be allowed by Islam are indeed practiced. The main challenge is how to bridge this gap.

* Addressing the underlying societal problems such as poverty, lack of education and gender imbalance is of the utmost importance.

* Developing collaborative prevention and care models (including all possible stakeholders such as, religious leaders, policymakers, health professionals, academics, local and international nongovernmental organizations, and people living with HIV.

* Development and provision of appropriate healthcare resources and infrastructure including:
  - Blood safety and infection control
  - Appropriate surveillance and reporting mechanisms
  - Drug abuse prevention and rehabilitation services
  - Medical care and social support including HIV counseling, testing and treatment facilities
• Adequate number of trained health care workforce
• Appropriate reproductive health care programs
• Broader efforts directed at enhancing information, education and communication.

* Changing dangerous or risky behaviors that support the transmission of HIV/AIDS elsewhere with unknown partner’s HIV status. In order to reach desirable behavioural changes among the population to stop the spread of the HIV/AIDS epidemic, interventions should address relevant socio-cultural factors.

* All traditional healers or health care providers should be educated on sterilization techniques, and protection methods.

* Fatalism (The role of religious and traditional healers) god will protect me should be minimized.

* Counseling and education or psycho therapists effectiveness, should be connected to the hospitals, reproductive health centers included family planning, not to AIDS programmes or centers, because of stigma and shame.

* Educating families about the risks, as well as safe and responsible sexual behaviours, and eradicate risky Initiation ceremonies through the tribe’s leaders or religious leaders.

* The elimination of all legal, regulatory, financial and socio-cultural barriers to the universal access to condoms should be facilitated by the government.

* Free distribution of condoms by the ministry of health as the surest way of preventing transmission of HIV and other sexually transmitted diseases, and proposed as protection and not for prevention of sexual desire or family planning,
and accessed in a confidential way, especially for groups at risk.

* Women empowerment to protect themselves from sexual violence and unsafe sex.

* Identify the specific needs of these groups and develop methods of intervention so as to design social and culturally acceptable solutions. The messages must be specific and adapted to the type of language and dialect appropriate to each group and giving respect to other areas with different socio-cultural beliefs, values and practices when designing the message.

* Voluntary counseling and testing should be routinely offered to all women attending ante-natal care clinics. Voluntary confidential testing with pre and post-test counseling should be an integral part of primary health care services.

* Provide free treatment of STIs for such high risk groups as sex workers, long distance truck drivers, homosexuals, poor students living away from home, internal displaced persons, refugees, prison inmates and members of armed forces are some of the groups believed to be particularly vulnerable to HIV infection.

* Let the people be aware of the importance of the routine checkup, particularly those that has other STIs, because HIV spreads more easily where populations have high levels of other STDs.

* Early diagnosis and prompt effective treatment of STIs as a priority social service.

* More studies should be conducted to further understand their risk profile.

* Extra activities should be organized by social workers or local groups which have the potential of keeping youth occupied (e.g. social clubs, sports and
tournaments, ) can be organized and supported on a small scale in some areas in the camp to give residents hope for their own future.

* Develop HIV/AIDS peer education programs for in-school and out-of-school youth, sex workers, military, and the police force.

* School-based programs that focus on abstinence delay sexual practices and provide information on protection should be encouraged.

* The ministry of health, with the assistance of the ministry of culture and information, ministry of education and other relevant local and international organizations and institutions, should use the knowledge of socio-cultural factors in the design, monitoring and evaluation of their educational materials and programmes.

* Co-ordinate activities together with local Radio stations in order to deliver or disseminate information on AIDS in the different national languages and dialects, focusing on the traditional practices and socio-cultural behaviours that could facilitate the transmission and spread of HIV, message should express the view of religious and federal government that abstinence and mutual fidelity remain the best protection against HIV/AIDS.

* Government officials, private sector, opinion leaders, and the general population are in need of increased formal and informal education focused on HIV/AIDS’ ethical and legal issues.

* The results of this study together with others on behaviour formations should be used to (re) design an advocacy and communication strategy aimed at behaviour change.
* Activate the role of human rights organization to advocate for legislations to protect the human rights of women as well as the rights of people living with HIV/ AIDS.

* More In-depth studies needed on the impact of the cultural differences on the HIV/AIDS to identify the economic, political and socio-cultural factors that influence sexual and reproductive health behaviors that facilitate the spread of HIV in Sudan.

* Substantive efforts are clearly needed to introduce more effective HIV prevention strategies.

* Policy efforts should be intensified and focused on areas of high risk and addressing as much as possible the factors contributing to vulnerability to risk behaviors.

None of the above will be successful without reducing the stigma associated with HIV and AIDS, developing compassion for those afflicted and designing harm reduction strategies which would be conceptually integrated within the existing social, cultural, and religious frameworks in Muslim countries.
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الأسئلة

المرتبة المتسلسلة: (.........)

معلومات شخصية:

1 / كم عمرك؟ (بالسنوات)............( )

(ضع علامة √ على الإجابة التي ترغب)

2 / النوع: (1) ذكر (2) أنثى

3 / ما هو عملك، أي ما هو نوع العمل الذي تقوم به بشكل أساسي؟

(1) مهني (2) أعمال حرة تجارية (3) أعمال حرة هامشية (4) حرفي (5) موظف (6) عامل (7) مزارع (8) طالب (9) قوات نظامية (10) ربة منزل

4 / هل سبق أن التحقت بالمدرسة؟

(1) نعم (2) لا

5 / ما هو أعلى مستوى تعليمي تحصلت عليه؟

(1) الخالصة (2) ابتدائي (3) متوسط ( عام ) (4) ثانوي عالي (5) جامعي

6 / كم عدد سنوات الدراسة؟.................................................

المعرفة والسلوك:

7 / هل سمعت بالايدز أو الفيروس الذي يسبب الايدز؟

(1) نعم (2) لا

8 / هل تعرف/تعرف أي شخص مصاب بالفيروس المسبب للايدز او مريض بالايدز او مات نتيجة إصابته بالايدز؟

(1) نعم (2) لا
9/ كيف يصاب الإنسان بالفيروس المسبب للايدز؟

1. عن طريق ممارسة الجنس
2. عن طريق نقل الدم
3. من الأم للطفل
4. المشاركة في المرحاض
5. المشاركة في استخدام الإبر
6. عن طريق لسع البعوضة أو المروقات
7. عن طريق أعمال السحر
8. عن طريق الفحصات
9. عن طريق السلام بالأحضان

10/ هل يمكن أن يبدو الشخص بصحة جيدة مع أنه مصاب بالفيروس المسبب للايدز؟

1. نعم
2. لا
3. لا أعلم

11/ ماذا يستطيع الشخص العادي أن يفعل لتجنب الإصابة بالفيروس المسبب للايدز؟

1. البقاء مع شريك مخلص وغير مصاب
2. استعمال العازل الذكري عند ممارسة الجنس
3. الامتناع عن ممارسة الجنس
4. تأجيل بدء الممارسات الجنسية
5. تقليل عدد الشركاء
6. تجنب ممارسة الجنس مع الأشخاص الذين يمارسون الجنس مع أكثر من شخص
7. تجنب المشاركة في استعمال الأدوات الحادة كالإبر والأمواس
8. الصلاة والدعاء
9. إجراء الفحوصات
10. البحث عن الوقاية من المعالجين التقليدية

12/ هل تعلم/ تعلمين بأي مكان يمكنك فيه إجراء الفحص عن الإيدز؟

1. نعم
2. لا
3. لا أعلم

13/ لايريد معرفة النتيجة لكن هل تم فحصك للتأكد مما إذا كنت مصاباً بالفيروس المسبب للايدز؟

1. نعم
2. لا
هل ترغب/ترغبين في إجراء فحص لمعرفة ماذا كنت حاملاً للفيروس المسبب للإيدز؟
(1) نعم ( ) (2) لا ( ) أذهب للسؤال 16

ما هو السبب الرئيسي في رغبتك في إجراء الفحص؟
(1) للحد من القلق والخوف ( ) (2) مطلوب للتعيين في وظيفة ( )
(3) بغرض الزواج ( ) (4) لمعرفة ما إذا كنت مصاباً ( )

لماذا لا ترغب/ترغبي في إجراء الفحص؟
(1) لا أريد معرفة ماذا كنت مصاباً أم لا ( )
(2) الخوف ( )
(3) غير ضروري ( ) (4) لا استطيع تحمل تكلفة الفحص ( )
أذهب للسؤال 19

في آخر مرة أجريت فحصاً، هل طلبت إجراء الفحص من تلقاء نفسك أم اقترح عليك إجراءه فوافقته؟
(1) طلبت إجراء الفحص ( ) (2) اقترح على فوافقته ( )
(3) طلب مني ( )

لا أريد معرفة النتيجة ولكن هل استلمت نتيجة الفحص؟
(1) نعم ( ) (2) لا ( )

كيف تقدر فرصة تعرضك للإصابة بالإيدز بالفيروس المسبب له، هل هي فرصة كبيرة أم ضئيلة أم معدومة؟
(1) كبيرة ( ) (2) ضئيلة ( ) (3) معدومة ( )
(4) مصاب بالفيروس أو مريض بالإيدز فعلًا ( ) (5) لا إجابة ( )
إذا كانت الإجابة: ضئيلة أو معدومة أذهب للسؤال (21)

لماذا تعتقد أن فرصة إصابتك بالإيدز أو الفيروس المسبب له فرصة كبيرة؟
(1) المشاركة في استعمال الآلات الحادة.................................
(2) عدم استخدام العازل الذكري..............................................
(3) ممارس الجنس مع أكثر من شريك........................................
(4) ممارس الجنس مع المومسات..............................................

16. شريك أو شريكة
32. ممارس الجنس مع شريكين
64. عمليات نقل الدم

لماذا تعتقد أن فرصتك إصابة بالإيدز أو الفيروس المسبب له فرصة ضئيلة أو معدومة؟
1. امتنع عن ممارسة الجنس
2. استعمل العازل الذكري
4. أثق بشريكي
8. أماز الجنس مع شريك واحد
16. ابحث ممارسة الجنس مع المومسات
32. زوجي أو زوجين لشريكٍ أخر
64. أتأكد من سلامة الدم المنقول
128. أتأكد من الحقن بإبر معقمة
256. أبحث عن الحماية من المعالجين التقليديين
512. أخصى الوضوء والعوار
1024. أثق بحفظ الله وبأن الإصابة ليس تؤدي للايدز

هل تقبل بالأكل في إناء واحد مع شخص تعلم أنه مصاب بالفيروس المسبب للإيدز؟
(1) نعم (2) لا (3) لا أعلم

إذا كان هناك طالب مصاب بالفيروس المسبب للإيدز وليس مريضاً هل ينبغي أن يسمح بمواصلة الاتحاق بالمدرسة؟
(1) نعم (2) لا (3) لا أعلم

إذا قريبك/ قريبتك مصاب بالايدز هل أنت مستعد للعناية به/بها في أسرتك؟
(1) نعم (2) لا (3) لا أعلم

إذا كان الأستاذ / الإستاذة مصاباً مصابة بالفيروس المسبب للإيدز ولكن ليس مريضاً مريضة هل ينبغي أن يسمح له/ لها بمواصلة التدريس في المدرسة؟
(1) نعم (2) لا (3) لا أعلم

إذا كنت تعرف / صاحب متجر أو بائع / بانعة أطعمة مصاب مصاباً بالفيروس المسبب للإيدز أو الحالة التي أشارت إليها في الأسئلة السابقة، هل تعتقد أن الفيروس المسبب للإيدز يمكنه أن ينتقل من مصابة إلى مصابة أخرى؟
(1) نعم (2) لا (3) لا أعلم
للإيدز، هل تتعامل معه معها؟

(1) نعم ( ) (2) لا ( ) (3) لا أعلم ( )

لإذا أصيب أحد أفراد أسرتك مصاباً بالإيدز أو الفيروس المسبب له، هل تريد أن يبقى الأمر سراً أم لا؟

(1) يبقى سراً ( ) (2) لا يبقى سراً ( ) (3) لا أعلم ( )

إذا كان زميلك/ زميلتك في العمل مصاباً / مصابة بالفيروس المسبب للإيدز ولكن ليس مريضاً/ مريضة به، هل ينبغي أن يسمح له / لها بواصلة العمل معك؟

(1) نعم يسمح له/ لها بالعمل ( ) (2) لا يسمح له/ لها بالعمل ( ) (3) لا أعلم ( )

هل ينبغي تقديم المزيد من الرعاية الصحية أو رعاية صحية مساوية أو أقل لمريض الإيدز من التي تقدم للمصابين بالأمراض الخطيرة الأخرى؟

(1) المزيد من الرعاية الصحية ( ) (2) المساواة في الرعاية الصحية ( ) (3) رعاية صحية أقل ( ) (4) لا أعلم ( )

الممارسات الثقافية الاجتماعية:

هل شاهدت أو سمعت من عائلتك أو الذين حولك عن أي من الممارسات التالية؟

(1) الفصاد ( ) (2) الحجامة ( ) (3) الوشم ( )

(4) خمر الأذن الألواح الشفه (اخت..) (5) تعدد الزوجات (الزواج) (6) تبديل الأخوات في الزواج (صققات) (7) العوض في الزواج (الزوجين) (8) المعاشة الجنسية بغض الالتفاف (أح القوام مع زوجة اخيه في اثناء غيابه)...

شكراً على وقتك وصبرك وتعاونك.