The Australian National University's Health Transition Centre was established to foster the study of the cultural, social and behavioural determinants of health, especially in the Third World. The Centre has had particularly strong historic links with sub-Saharan Africa. Consequently, when that region became the world's major theatre of the AIDS epidemic, it was inevitable that a prime focus of the research program would be the Third World AIDS epidemic.

Apart from continuing support from the Australian National University, especially from its National Centre for Epidemiology and Population Health, *Health Transition Review* and the centre have been funded by the Rockefeller Foundation and the Ford Foundation.

The majority of funding for AIDS research in Africa has come from the Swedish Agency for Research Cooperation in the Third World (SAREC/SIDA) with other support from the Rockefeller Foundation and the Australian National University.

This supplement to *Health Transition Review, The Third World AIDS Epidemic*, is the fourth book published on AIDS research by the Centre.

In 1993 we published *Sexual Networking and HIV/AIDS in West Africa*, edited by John Caldwell, Gigi Santow, I.O. Orubuloye, Pat Caldwell and John Anarfi as a supplement to Volume 3 of *Health Transition Review*. This volume presents the work of the West African Research Group on Sexual Networking (WARGSN) which extended previously more geographically focused research throughout most of anglophone West Africa.

Then we published *Sexual Networking and AIDS in Sub-Saharan Africa: Behavioural Research and the Social Context*, edited by I.O. Orubuloye, John C. Caldwell, Pat Caldwell and Gigi Santow. This volume comprises 14 key papers on an intensive research program in southwest Nigeria, based in Ondo State University, Nigeria.

It was followed by the supplement to Volume 4 of *Health Transition Review, AIDS Impact and Prevention in the Developing World: Demographic and Social Science Perspectives*, edited by John Cleland and Peter Way. This book is global in scope, and was published in conjunction with the International Union for the Scientific Study of Population and funded by the Population Investigation Committee of Britain.

The present book differs from its predecessors in that it is a collection of papers resulting from research produced from across the African continent, carried out between 1992 and 1995. The papers have been selected from four workshops held between 1994 and 1995. These were held in Kampala (Uganda), Cape Coast (Ghana), Ado-Ekiti (Nigeria) and Canberra (Australia).

The authors range from much published researchers to a considerable number who have never been published before, but who know their scenes intimately. All the papers focus on the social and behavioural aspects of AIDS, as in the Centre's previous AIDS books.

This collection, like the previous ones, also emphasizes the social, sexual and economic context of the disease both in the general population and in high-risk groups. However, there is here even greater stress on the social effects of the disease, on interventions and on care and counselling.
The collection ends with glances at areas which may well become more important in the future. The first emphasizes legal issues which the epidemic makes it imperative to face. The second is the more recent invasion of Asia by the epidemic. In that continent, the lessons learnt in sub-Saharan Africa may prove to be important guides.

Our thanks to Scott and Dorothy Campbell who assisted in the editing.

I. O. Orubuloye
John C. Caldwell
Pat Caldwell
Shail Jain

Acknowledgements

The papers in this supplement by L.A. Adeokun et al., M. Nag, C. Oppong, E. Preston-Whyte and P. Setel were presented at a conference entitled The Continuing Demographic Transition: The John C. Caldwell Seminar, 14-17 August 1995, at the Australian National University in Canberra.

We warmly acknowledge the generous support of the Ford Foundation, the Rockefeller Foundation and the National Health Advancement Program of the Commonwealth Department of Human Services and Health.
Social context of HIV infection in Uganda*

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Abstract

Some of the important policy and research implications of accumulating HIV/AIDS data are being ignored because of the attraction of social science research focused on the ‘multiple sexual mechanism’ of infection and transmission. Attention is drawn to the other policy and research issues relating to information on the timing of infection through a re-analysis of existing data on cumulative AIDS cases. The most urgent need is to supplement the mainstream research on risk groups with studies of the timing and circumstances of entry into sexual activity in the pre-teen years.

Social science response to the epidemic

The initial social science research response to the appearance of HIV/AIDS in Africa was based on the broad information that heterosexual intercourse was the dominant channel of HIV transmission (Piot and Carael 1988; Carael et al. 1992; Carael and Piot 1992). Studies of the patterns of sexual behaviour and associated cultural practices soon confirmed that, like the epidemics of STDs before it, HIV was being rapidly propagated through the high numbers and dense networks of sexual partners (Musgrave et al. 1990; Orubuloye, Caldwell and Caldwell 1991; Katsivo and Muthami 1991; Somse, Chapko and Hawkins 1993; Orubuloye 1993). But after that initial observation of the role of multiple sexual partners in the evolution of the epidemic, not much has changed in the agenda of research on the dynamics of sexual behaviour.

The main directions of investigation and the main findings can be summarized as follows:

1. Why do Africans have many sexual partners? There is no general sense of shame about multiple sexual relations, the romantic notion of love is not idealized and the status of women is often precarious with respect to their own control of their sexuality (Caldwell, Caldwell and Quiggin 1989). In addition, there are a number of persistent cultural practices that encourage dense networks of sexual contact (Ntozi and Lubega 1992; Orubuloye et al. 1994).

2. Given the predominance of multiple sexual partnerships, what groups constitute the reservoir and what groups the channels of diffusion? The concept of high risk based on having multiple sexual partners draws attention to the fairly obvious groups such as ‘sex workers’, workers in the entertainment industry, and people of ‘easy virtue’. The long distance truck drivers served as the conduit through which the virus moved from the foci, in the main urban centres, to the secondary nodes in trading centres, and from there, through local migrant population, into the rural areas (Bwayo et al. 1991; Orubuloye, Caldwell and Caldwell 1993; Orubuloye, 1993).

3. Given the apparent difficulty of effecting changes in sexual behaviour (Musgrave et al. 1990; Wilson et al. 1991), what option is there for controlling the spread of the epidemic? The resounding answer to this question was that the condom offered the only option: an unfortunate answer for Sub-Saharan Africa, given the very limited success that had been achieved in the propagation of condoms as a contraceptive in family planning programs and the qualified success achieved among high-risk groups who have been tested and counselled appropriately (Ngugi and Plummer 1991; Wilson et al 1991).

Meanwhile two sets of information were accumulating that point to the significance of other elements in the epidemiological equation of the reproduction of infection, namely, the density and the duration of exposure.

The first set is the reported cases of so-called adult AIDS, so called because, as will be discussed, the term ‘adult’ only fitted the early stages of the epidemic. Less than a decade after the first adult cases, paediatric and pre-teen cases were emerging. The second set of data, mostly from developed countries, sheds light on the natural history of HIV by identifying the timing of infection, progression to AIDS Related Conditions (ARC), and AIDS and eventual death.

With reference to these sets of data the response of social science research to new stimuli has been less than rapid. The first set of data, especially those coming from countries that have a policy of openness about the epidemic, strongly suggests that apart from having multiple sexual partners, the early stages of exposure to a rising density of infected population could well sustain the epidemic even if multiple sexual partnership was on the decline. The second set of data reinforces the reported data by confirming that the age at entry and the circumstances of that very first sexual act are important to an understanding of the reproduction of infection and equally important to the design of programs of control.

**Objectives, materials and methods**

The main purpose of this chapter is to broaden the scope of discussion of the socio-economic context of the rapid reproduction of infections and to focus on the role of early, that is, pre-teen girl-child sexuality in the dynamics of the epidemic. The materials involved in the discussion are drawn from a number of sources.

The first is a re-analysis of the cumulative total of 42,000 adult AIDS cases, defined as those aged 12 years and above, reported between 1982 and 1994 (STD/ACP 1995), and constituting one of the most consistent AIDS data sets in Africa. The purpose of that re-analysis will be to clarify the relationship between the time of infection and the time of appearance of infected persons in AIDS case files to gain some idea of the volume and significance of pre-teen infection in the sustenance of the levels of new infection. The validity of that estimation of the timing of infection is further reinforced with a brief review of data on pre-teen and early teen pregnancy, which is a form of risk similar to, and sexually sustained in the same way as, STDs and HIV/AIDS infection.

A third set of material is drawn from the review of the findings from studies of adolescence in Eastern and Southern Africa and from findings from a recent study carried out in school populations in Pallisa and Tororo Districts of Uganda (Mbunda 1988; Helitzer-
Allen and Makhamberta 1993; Twa-Twa 1995). A fourth set of data is drawn from the information about the preparation of young girls for womanhood among various tribes of Uganda, with particular attention to the practices among the Baganda. These practices will be related to the upsurge of concern for the defilement of minors in Uganda and to the point that a significant proportion of female HIV infections occur in very young girls, and that the circumstances of those infections require greater attention than is possible within a research focus on adult sexual practices. The bulk of the information comes from the qualitative study of ‘Household Functioning in the age of AIDS’ being conducted in the districts of Rukungiri, Masaka and Kabarole (see Map 1).

Map 1
Uganda districts

Course of HIV/AIDS

Central to the exercise of estimating the timing of infection from reported AIDS cases is the understanding of how the natural history of HIV/AIDS can assist the establishment of some
broad parameters upon which the exercise can be based. The landmarks in the course of infection from HIV and the progression to AIDS-related conditions (ARC) and the development of full-blown AIDS are based on scientific information which is constantly under review, because of the complex nature of the virus and the associated diseases. But in general the landmarks are as follows:

**Exposure and infection**

Sexual contact between an infected individual and an uninfected person (a discordant couple) is not a guarantee of infection. This is because of the relative difficulty of transmission of infection under some conditions which are not fully known. But the outcome of those conditions is that it is easier to pass the virus from an infected male to a female in a heterosexual contact than vice versa. The probability of infection from a sexual contact (Sewankambo et al. 1987) varies with such other considerations as the circumcision or noncircumcision of males, the presence or absence of genital tract infections, and the stage of progression, and consequently, the infectivity of the person to whom the sexual partner is being exposed (Hyman and Stanley 1988).

In effect, it is often impossible to tell which particular episode of sexual contact produced infection, especially, when individuals have a fairly active sexual life and have a number of partners within short periods of time. The situation is further compounded by the fact that people do not usually get themselves tested after every sexual contact and AIDS does not have a short incubation period as is the case with some other STDs. In spite of these difficulties in establishing the specific occasion of exposure, it is now well established that the next stage of the infection is of seroconversion.

**Seroconversion**

This takes place at a period of three to six weeks after infection. The event of seroconversion is marked by a flu-like episode which soon clears and may not be remarkable in any other way until viewed in retrospect, when the individual may have moved on to other stages of the disease. It is doubtful therefore that, other than in a longitudinal clinical study of a population, the event of seroconversion can be accurately recorded. In such a study, the presence of antibodies to the virus in the blood, which establishes the fact of infection, would not have reached a level where they can be easily detected by routine tests.

**‘Window period of infection’**

The time between infection and the presence of detectable levels of antibodies is the period often described as the ‘window period of infection’ through which an individual, who in reality is infected, may escape with a false ‘negative’ blood test. It is when the ‘negative’ result has been confirmed after an interval of six months that the assurance of being HIV-negative can be accepted, that is, provided no other occasion of exposure has taken place in the interval.

**Latent period and infectivity**

After infection has taken place, the virus can lie dormant in a person for periods that have been documented to be as short as six months and as long as over ten years in some people, without any adverse effect of the HIV infection. However, it is equally established that those people are, in fact, infective. The infectivity of such individuals also varies through the course of the infection (Anderson et al. 1989, 1992; Palloni and Glicklich 1991). The
determinants of the duration of this latent period are not well documented in African populations; what information there is, suggests that the amount of viral ‘load’ at infection, the infectivity of the infecting persons and the immune status of the infected are all involved (Palloni and Glicklich 1991).

**AIDS Related Conditions (ARC)**

Because of the depletion of T-cells in the infected individual, the ability to fight off infection declines and the end of the latent period is marked by increasing episodes of common ailments and infections. The frequency and severity of these infections increase and draw attention to the likelihood of immune compromise. When the fact of infection has been established in those suffering these conditions, they are then recognized as being at the ARC stage of the disease; otherwise, the onset of ARC may go unrecognized. The duration of this stage can be prolonged by effective treatment of each episode, or shortened by the rapidity of health status decline which is a function of the socio-economic status of the individual. The poor, the nutritionally deprived, those with low initial health status, and the immune compromised on account of other diseases, or on account of pregnancy, run a higher risk of rapidly progressing to the full stage of AIDS (Palloni and Glicklich 1991).

**AIDS**

Full-blown AIDS is reached when the immune system has virtually collapsed and the individual has no capacity at all for warding off infections. This stage can also be prolonged by all of the same factors which affect the duration of the ARC stage. The most frequently associated diseases at the final stage of AIDS in Africa include tuberculosis, meningitis, chronic diarrhoea and weight loss or ‘slim’ (Palloni and Glicklich 1991). According to the WHO guidelines, a number of markers of the syndrome must be present before persons are reported as AIDS cases. Whilst these guidelines do not rule out the inflation of AIDS cases from other causes, they somewhat prolong the progression of the disease before they are reported and somewhat shorten the survival time for persons who are documented as AIDS cases.

**Death from AIDS**

In the absence of a ‘cure’ by either reversing the fact of infection or preventing the total collapse of the immune system, death is a certainty. Although no large-scale follow-up of AIDS cases is available for African countries, a study in Zaire of a small sample of patients admitted to hospital provides an estimate that case fatality was 50 per cent three months after diagnosis (Piot et al. 1984 in Palloni and Glicklich 1991). However, death comes more precipitately for some than for others, depending on the opportunistic infection which serves as the last straw. Some conditions kill faster than others, and the susceptibility of the individual is again a function of the various factors cited earlier.

**Variability of progression**

In addition to these grim facts of the course of HIV/AIDS, the following should be borne in mind in the interpretation of the stages of the diseases. The movement of any individual through the stages to death will tend to be unpredictable (Anderson et al. 1989); for example, one person may be dead within a year of infection and another at the end of a decade of infection. It is strongly suggested that Africans move through the stages rather more rapidly than is indicated for some other populations. It is not certain if the socio-economic variables
are the only explanations or if there are other environmental factors, but the result is that the AIDS cases data provide a shadow effect of the real parameter needed for effective education, motivation and change of behaviour for halting the epidemic.

Consequently, the data on individual experiences offer very limited guidance to public health response to the disease. What is required then is the aggregated experience of a representative sample of persons. The next section is devoted to an estimation of the timing of HIV infection based on a re-analysis of such a group experience.


Apart from the clinical problems of interpreting the AIDS cases data, there is a less critical problem of the under-reporting of the cases. Less critical, because there is no reason to believe that the under-reporting is systematically biased against any one group. Consequently, the main point of this section is that the reported cases are representative of the pattern of occurrence of AIDS cases in the population. Attention will, therefore, be focused on the validity of the demographic pattern of cases and how the pattern may form the basis of estimating the timing of infection.

In the very early stages of the epidemic or of the reporting of AIDS cases, the pattern is bound to be sketchy, but the cumulation of increasing numbers of cases and a clearer understanding of the dynamics of the epidemic soon alert the observer to the emerging pattern. Among the strongest evidence of the representativeness of the AIDS cases is that, with the advanced stage of the epidemic, the pattern of cases shows a convergence from country to country, although there are some very telling differences.

Figure 1
Adult AIDS cases by age, Zimbabwe 1993; South Africa 1982-93; Uganda 1982-94
Figure 1 shows the pattern of adult AIDS cases for three African countries and for different time frames. Data for July to September 1993 in Zimbabwe cover 1,613 cases. Data for South Africa cover a ten-year period and involve 1,657 adult cases. The data for Uganda cover a 12-year period and involve about 42,000 adult cases. In spite of these differences, there is an astonishing similarity in the general shape of the curves of cumulated adult AIDS cases in these countries. This is largely a product of the predominance of sexual transmission of the HIV in the region. For all three countries, the overall male to female ratio is about 1:1.

The superficial interpretation of the pattern of cases is that because of early age of entry into sexual activity in all three countries, the cases show up in the teens, rise rapidly thereafter to a peak in the late twenties and early thirties and decline in the older ages. But then there are significant differences in the curves of cases and in the sex ratio at different age groups. The modal age group is 20-29 in both Uganda and South Africa but Zimbabwe has the modal group in the 30-39 age group; however, when the breakdown of AIDS cases is displayed by sex, some rather disturbing patterns emerge which draw attention to the potential for misinterpretation of gross data on adult cases.

Figure 2
Zimbabwe AIDS cases by age and sex July-September 1993
Figure 2 shows the Zimbabwe AIDS cases by sex and by age group. The female curve is very different from the male curve: whilst the male curve is nearly a normal curve, the female curve is skewed to the left and shows a peak of female AIDS cases in the 20-29 age group. An inspection of the Uganda data in Figure 3 reveals a greater similarity in the male and female curves except that the female curve shows a five-year shift to the left. In both countries, however, the major observation is the predominance of young people in their teens and early twenties.

Figure 3
Uganda AIDS cases by age and sex 1982-94 STD/ACP, MOH, 1995
The policy response to this pattern of AIDS cases has been the aiming of some IEC programs at these young people (Ndlovu and Sihlangu 1992; Wilson, Mparadzi and Lavelle 1992); some policy concession is also made to the fact that cases occur at other ages and that everyone is at risk. However, because of the moral and religious prejudices about advocating the use of the condom, there is a hesitation to tackle the issue of just when sexual activity begins and when infection takes place so that the preventive strategies can be much better focused at the appropriate ages and institutions in society. These prejudices are strong enough to override the overwhelming evidence from demographic and sexual behaviour studies that marriage and childbearing come very early in Africa (Kajukka et al., 1989); that there is a rapid rise in the proportion of people who are sexually active in their early teens (Konde-Lule 1994a); and that a major proportion of the reported sexual activities, including those that produce infection of STDs and AIDS, occur within marriage, and involve couples who have introduced infection through the extra-marital contacts of one of the partners, most often the males (Carael et al. 1992).

The graphic estimation procedure

After a search of the international data on infection and course of HIV/AIDS, the conclusion is inescapable that for practical purposes the variability of the course of the disease cannot be easily built into an estimation of age at infection with any great precision (United Nations 1991). But two alternatives present themselves. The first and simpler procedure adopted in this paper is to assume a uniform time of progression from HIV infection to AIDS case and eventual death; that approach takes a mean time for all cases as applicable to each case. The choice as to which duration to use is based on the pragmatic consideration that for some time to come, there is not likely to be clinical information for Uganda (F. A. Mmiro, personal
communication 1994), or for any large population for that matter, on this parameter (Piot et al. 1987). The other consideration is that a mean of five years is not only demographically convenient but conforms with the clinical impressions reported for parts of Africa which place the duration from infection to death at a mean of 6.3 years (Whiteside and Wood 1994). In effect, the mean survival from the time of reporting as AIDS case to AIDS death is assumed to be about another year and a half.

**Figure 4**

Age at infection and as AIDS case: Ugandan females based on five year incubation

The alternative approach calls for a more subtle modelling of the relationship between the fact of infection and progression to death from AIDS, taking into account the underlying probability of the likelihood of death at given ages, if AIDS were not a factor. The nature of deaths resulting from HIV/AIDS, arising from a systematic collapse of the immune system, suggests that the probability of that death is likely to be a mathematical function of the status of the immune health of the patient before infection. In other words, the healthier a person is at the time of infection, the longer the person lives. That function can reasonably be expressed as similar to the probability of dying at any given age, before the advent of the epidemic. The life table function $p_d x$ is a rough approximation that can be adopted.

It is also possible that the fact of infection may alter the determinants of survival by altering the patient’s employment, income and other socio-economic parameters. Such a reality further complicates the modelling. But for the policy and program orientation of this chapter, the general assumption of a five-year incubation period from infection to reporting as AIDS case is adopted to illustrate the main message. The outcome amounts to a shift of the curve of adult cases by five years to the left on the X-axis. The resulting curves of infection for females and males are shown on Figures 4 and 5 respectively.

In spite of the simplicity of the estimation procedure adopted, a number of implications are obvious from the curves of infection. The peak of infection comes five years earlier than the peak of AIDS cases and seven years before AIDS deaths. The peak of female infection is at age-group 15-19 and that for males 20-24. For both sexes, the gap of five to seven years
makes significant differences to the lifestyle that can be associated with each sex at the time of infection and at the time of death. For example, the Uganda Demographic and Health Survey, 1988/89, shows that a significant proportion of females aged 15-19 could be in some form of schooling; and that just over a quarter of them were married at the time of the survey, a proportion which increases sharply to 56.3 per cent of those women aged 20-24 (Kajjuka et al. 1989). In contrast to the one in ten of the 15-19 age group who were living together with sexual partners, the proportion for age group 20-24 was 15.8 per cent. The implication of these lifestyle circumstances for HIV infection at the respective ages includes the probability that most females could be infected before marriage while still in educational institutions. Another group of females may eventually be infected very soon after marriage in the age group 20-24.

*Cumulative curve of infections*
When the estimated levels of HIV infection are cumulated from age ten onwards (see Figure 6), then one in ten of the female AIDS cases acquired their infection by the time they were 14
and 64 per cent by age 24. Among males, the proportion infected at the respective ages is considerably less, below 3 per cent by age 14 and at 43.5 per cent by age 24. By age 29, 80.4 per cent of female and 66.9 per cent of male infections are accounted for. More than a third of male HIV infections and a fifth of female infections take place after age 30 when virtually all those infected are in marital unions (Kaijuka et al. 1989).

Figure 6
Cumulated per cent infected by given age and by sex based on estimation

Evidence of early exposure to sexual and reproductive risks

Once confronted with the startling observation of how predominant early female infection is, the next step is to look for corroborative evidence that reinforces the validity of that observation. Apart from the DHS data to which reference has been made, attention was turned to two types of information: studies of sex behaviour and contraception carried out before the advent of the HIV/AIDS epidemic which define the age criterion generously enough to include the pre-teens; and recent sexual behaviour studies, some of which have been mounted in response to the epidemic.

Sexual behaviour and contraceptive studies

Before the advent of the HIV/AIDS epidemic, the circumstances which tended to draw attention to the pre-teen girl-child were the changes in physical growth and the onset of menarche. Interest in these dimensions grew out of concern for the reproductive health of the girl (Arkutu 1978a, b). That concern was consistent with the level of adolescent marriage and pregnancy in Sub-Saharan Africa and its role in the determination of maternal health.
Countries of Sub-Saharan Africa have the highest levels of early child bearing in the World. In Cameroon, 23% of all births are to women aged 15-19. It is the norm in traditional African society for women to marry young. Recent surveys in northern Nigeria showed that 43% of girls aged 14 were married. Ten percent of women of reproductive age reported that they had their first child before the age of 14, and nearly one in five infants born to mothers aged 17 or under die during the perinatal period (Ladipo, Omu). A major problem is that very young mothers have not finished growing. Thus, the young mother's pelvis is relative small, and pregnancy-related complications, including obstructed labor and cephalopelvic disproportion, are more common (World Federation of Health Agencies 1987: 9-10).

These figures are confirmed in the multi-country surveys in which the data on premarital childbearing, which is a proxy for these early sexual experiences, varies from 20 per cent of all childbirths in Kenya, through 30 per cent in Liberia to 50 per cent in Botswana (Caldwell et al. 1989; van de Walle 1993; Gage and Meekers 1994).

Another area of reproductive health concern is the risk of infection from STDs arising from early sexual activity and childbearing. The risk is the direct outcome of the biological and sexual anatomical immaturity of the pre-teen girl: not only is the pelvis small, but the breaking of the hymen and the bruising of the epithelium of the vagina are other trauma that increase the risk of infection. The other co-factors of infection are of social origin: they include the age gap between girls and their first sexual partners; the density of existing infection in that older age group; and the unlikelihood that the girl will seek treatment, even if she knows of the fact of an infection. This last issue is related to the clandestine nature of some of these premarital sexual activities even if the first sexual partner is the one the girl eventually marries.

Concern with early pregnancy in Tanzania, resulting in part from very low levels of contraception in that country, drew attention to the issue of sexual activity of those under 15 (Arkutu 1978a, b). Although these studies came well before the HIV/AIDS epidemic, they provide a much needed insight into the risks that very early sexual activity constituted for young people.

Another dimension of early sexuality in Tanzania that attracted attention was that of physical growth and onset of menarche (Hautvast 1971); these two aspects of human biology are also relevant to the culture of early sexual activity and marriage in Sub-Saharan Africa. The quick development of secondary sexual organs in females, especially those who are exposed to the improved care associated with going to school, is further complication of the sexual attitudes to this age group.

The most pertinent of the Tanzania studies was the 1985 Adolescent Fertility Survey (Mbunda 1988) in which the sexual experiences of some 3,200 adolescent males and females were investigated. Although the study was focused on the conventional 12 to 24 age group (p.10), the actual range covered was much wider, being from 6 to ‘over 25 years’. The tabulation of information on age at first sexual intercourse allows an appreciation of how early such intercourse was being experienced (Mbunda 1988: 30, 31). Both the youngest female and youngest male reporting such experience were in the 6-9 age group. About one in every five of males under 15 had sexual experience and the corresponding female proportion was over one in every 10. For both sexes the median age was 14.8 years. This again illustrates the weakness of the analytical strategy of taking age 15 as an entry point as opposed to the midpoint of entry into sexuality. The proportions that had had sexual experience rose to 64.6 per cent for the 15-19 age group, 83.9 per cent for the 20-24 and 77.7 per cent for those over 25 years, but that is beside the point.
Turning to Uganda, there are only a handful of studies that have addressed the sexual activity of youth in school and at a level of disaggregation that allows an appreciation of the timing of entry into sexuality (Arya and Bennett, 1967; Kisekka, 1976). In a study of new students of Makerere University, the majority of whom would have been in their late teens and early twenties, Arya and Bennett (1967) found one in four infected with STDs; and the study of Senior Six students around Kampala between 1970 and 1971 by Kisekka (1976) found that nearly all the males and just over two-thirds of the females had had sexual intercourse.

Another study among Primary 6-7 pupils around Kampala in the late 1980s reveal early initiation of sexual activity: by the age of 13 and 14, 10 per cent had had sexual intercourse (Ankrah and Rwabukwali 1987). Much more recently also, Agyei and his collaborators drew attention to the sexual behaviour of teenagers and youths and their contraceptive behaviour (Agyei and Epema 1992; Agyei, Epema and Lubega 1992; Agyei, Mukiza-Gapere and Epema 1994). But in the delimitation of the boundaries of adolescence, the studies make a cut-off at age 15; consequently, they do not form a basis for understanding the preparatory years of sexual activity which produce a given teenage and youth pattern. A recent analysis of attendance at an STD clinic in Uganda points out that 33 per cent of females and 12 per cent of males attending are aged 12-19 years (Uganda, Edith Mukisa National STD Control Program 1992).

**Sexual behaviour and HIV/AIDS**

Most of the studies of sexual behaviour made in Sub-Saharan Africa in response to the AIDS epidemic were on the conservative side in addressing the early stages of sexuality (Carael et al 1992). One of the notable exceptions is a study of initiation of Malawi girls (Helitzer-Allen and Makhambera 1993):

From 1991 to 1992, we conducted research involving almost 600 young females, ages 10 to 18. First we lived in two villages and worked with 258 girls. We held in-depth interviews with the girls, their mothers and grandmothers; observed the girls in their daily activities; attended initiation ceremonies; talked with the village leaders, male and female; and held focus group discussions on questions of reproductive health, sex and STD/HIV/AIDS prevention. From that work, we then developed several hypotheses, which we tested through a survey of 300 adolescents in 10 other villages.

However, from the generous interpretation of age range to be involved in the study, the authors turn to the safety of the ‘adolescent’ category in testing their hypotheses. Nevertheless, a number of the findings give enough indication of the onset of sexual activity to be of importance to the present discussion:

A girl is not supposed to have sex before menstruation or before initiation, according to social norms, yet seven of every 10 girls had sex before one of these occurred. The average age at first intercourse is 13.6 years (Helitzer-Allen and Makhambera 1993).

This statistic suggests that half the respondents had their first intercourse before the age of 14 years. In other words, defining the teenage or adolescent population from age 15 effectively leaves out half the population who satisfy the minimum requirement of exposure to the risk of pregnancy, STDs and HIV/AIDS.

In Uganda, the earliest case of adult AIDS was reported in Rakai District in 1982 (Sserwadda et al. 1985). That event and the rapid evolution of the epidemic from the District as a possible point of entry and outgrowth has attracted the attention of the clinical and
epidemiological community to the area; the attention has yielded a number of helpful observations on the natural history of HIV/AIDS in that district of Uganda. There are significant variations in HIV seroprevalence from area to area and from village to village (Wawer et al. 1991). Information is available about the production of new infections and about the possibility of some behaviour change, especially in the extent of multiple sexual partnership. However, there is, as yet, only limited information on the central issue of the timing and correlates of infection (Konde-Lule 1994b).

School-based studies of sexual behaviour and risks

There are various ways of establishing the patterns of pre-teen and teenage sexual behaviour and risk taking. One approach is to study the institutionalized population in schools (Owuamanam 1982; Wilson, Greenspan and Wilson 1989; AMREF 1993) and in other organized groups (Wilson, Lavelle and Hood 1990). Although this omits the out-of-school population who may be significantly different in behaviour, it is a simpler alternative for the methodological convenience it offers. However, the cultural and social barrier between researchers and the study population may be the real problem that has set a limit on the study of young adolescents in or out of school. Researchers assume an arbitrary cut-off point of anything between 15 and 18 years as the entry point for eligibility for sexual behaviour studies. Parents, especially in this era of AIDS, would like to believe that their children are too young to be involved in voluntary or involuntary sexual activity, and put an arbitrary age limit on their participation in sexual behaviour surveys. Meanwhile, mass media reports of school-based sexual activities and resulting pregnancies are on the increase. It is against the background of the varied interests that the studies of school-age sexual behaviour in Uganda must be seen. The decision to rely on information on school population studies, however, can be justified in the case of rural-based schools where the gap between the in-school and out-of-school youth behaviour is not as great as that postulated between rural and urban youth (Agyei et al. 1992).

The Pallisa/Tororo districts school studies

Using self-reported sexual history of 670 primary and post-primary school children aged between 11 and 24, and ‘best friend’ sexual history from 633 of these respondents, the study explored sexual experiences and practices among primary and secondary school pupils in the districts of Pallisa and Tororo in Eastern Uganda (Twa-Twa 1995). Of this number a fifth (123) were below the age of 15. In contrast to the usual truncation of this age group into a general under-15 category, the discussion in this paper focuses on this very category as a way of illustrating the extent of their participation in sexual activity and the predictors of such participation.

The two multi-ethnic rural districts (see Map 1) are peopled by the Bantu-speaking tribes of Bagwere, Basamia and Banyole and the Nilotic-speaking Iteso and Adhola tribes. Over 85 per cent are Christians and about 12 per cent are Muslims (Uganda Population and Housing Census, 1991). Primary education services in the districts were rated amongst the best in Uganda during the 1960s, but twenty years of political and social unrest have affected the area and only a quarter of the 6-24 year olds are enrolled in schools. Nearly all the primary and post-primary institutions in the area, and also those included in the study, are day-schools and mixed schools; there are a few single-sex and boarding schools in the area as well as in the study. Because there are few such schools, most children are ten or more kilometres from the nearest educational institution; consequently, many children of both sexes in secondary schools rent rooms in the nearest trading centres. This pattern of accommodation has some implications for the sexual experiences of the school children; the AIDS literature from
Uganda has highlighted the role of these trading centres in the dynamics of the epidemic (Berkley et al. 1989).

Table 1
Age range and mean age of some sexual practices among Pallisa/Tororo districts students

<table>
<thead>
<tr>
<th>Sexual activity</th>
<th>Age range, both sexes</th>
<th>Mean age, both sexes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Masturbation</td>
<td>11-22</td>
<td>15.3</td>
</tr>
<tr>
<td>Kissing</td>
<td>8-23</td>
<td>14.7</td>
</tr>
<tr>
<td>Embrace</td>
<td>8-23</td>
<td>15.7</td>
</tr>
<tr>
<td>Sexual Intercourse</td>
<td>7-23</td>
<td>15.8</td>
</tr>
</tbody>
</table>

Table 1 illustrates the problem of the mean statistic in the study of such incremental behaviour as becoming sexually active. The age range of transition from not being sexually experienced and becoming active is 7 to 23 for the present data set (see Agyei and Epema 1992 for the out-of-school data). The mean of 15.8 years consequently draws attention away from the real danger posed by much earlier sexual experiences, especially among females. Another consideration also is that even this distribution may still be biased against the early female sexual experience initiators who would experience a higher dropout rate than late initiators, all things being equal.

Table 2
Percentage reporting various sexual experiences by sex and age groups (own sex history)

<table>
<thead>
<tr>
<th>Sexual experience and age groups</th>
<th>Male students</th>
<th>Female students</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number responding</td>
<td>Percentage experience</td>
</tr>
<tr>
<td>Masturbation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11-14</td>
<td>37</td>
<td>5</td>
</tr>
<tr>
<td>15-19</td>
<td>151</td>
<td>14</td>
</tr>
<tr>
<td>20-24</td>
<td>86</td>
<td>31</td>
</tr>
<tr>
<td>Total</td>
<td>274</td>
<td>18</td>
</tr>
<tr>
<td>Ever had sexual intercourse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11-14</td>
<td>43</td>
<td>47</td>
</tr>
<tr>
<td>15-19</td>
<td>179</td>
<td>55</td>
</tr>
<tr>
<td>20-24</td>
<td>99</td>
<td>91</td>
</tr>
<tr>
<td>Total</td>
<td>321</td>
<td>65</td>
</tr>
<tr>
<td>Sexually active last 3 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11-14</td>
<td>20</td>
<td>40</td>
</tr>
<tr>
<td>15-19</td>
<td>98</td>
<td>43</td>
</tr>
<tr>
<td>20-24</td>
<td>90</td>
<td>42</td>
</tr>
<tr>
<td>Total</td>
<td>208</td>
<td>42</td>
</tr>
<tr>
<td>Condom use last sex act</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11-14</td>
<td>20</td>
<td>15</td>
</tr>
<tr>
<td>15-19</td>
<td>98</td>
<td>20</td>
</tr>
<tr>
<td>20-24</td>
<td>90</td>
<td>21</td>
</tr>
<tr>
<td>Total</td>
<td>208</td>
<td>20</td>
</tr>
</tbody>
</table>
Bearing this statistical artifact in mind, Table 2 illustrates the extent to which the 11-14 year olds are involved in various sexual activities, and the comparison with the older age groups. The point of the comparison is not the pattern of increases in various proportions participating in a particular activity as age increases, but to show that these activities start at early ages and do not dramatically materialize at age 15.

The amazing observation is that with the exception of masturbation which produced an increasing incidence with age among males, all the other sexual experiences show almost similar levels of occurrence among males of all age groups. In contrast, the pattern among female respondents is interesting and in some sense unexpected from general stereotypes. In the case of masturbation the increases with age replicate the pattern for males. But in contrast to the flat curve for males the increases in sexual experience among females are directly related to age. However, that is not the main point of the exercise; the revelation is the 16 per cent of 11-14 year old females who have had sexual experience. By the time of the survey, the distinction in levels of ever having had sexual intercourse disappears and all age groups are currently equally active with regard to the last three-month time frame. In fact, the youngest age group reported the highest level of current activity.

With regard to other HIV/AIDS co-factors, Table 3 shows the 11-14 year-olds are not more likely than the older males to have multiple partners, the level of this practice being about 50 per cent for all age groups. In contrast, the female report about a quarter of those having sexual experience having two or more partners. Again the very young do not differentiate themselves from the older females in this pattern.

The level of condom use with the most recent sexual intercourse is about the same for both sexes at 20 per cent for males and 24 per cent for females. However, there is the interesting departure that the overall lowest level of use is among the very young females with just under one in every ten reporting use of the condom at their last sexual intercourse. The youngest males also report the next lowest level of use.

### Table 3

<table>
<thead>
<tr>
<th></th>
<th>Male students</th>
<th></th>
<th>Female students</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>One</td>
<td>Two +</td>
<td>One</td>
<td>Two +</td>
</tr>
<tr>
<td>11-14</td>
<td>7</td>
<td>43</td>
<td>57</td>
<td>4</td>
</tr>
<tr>
<td>15-19</td>
<td>46</td>
<td>44</td>
<td>56</td>
<td>29</td>
</tr>
<tr>
<td>20-24</td>
<td>54</td>
<td>59</td>
<td>41</td>
<td>26</td>
</tr>
<tr>
<td>Total</td>
<td>107</td>
<td>51</td>
<td>49</td>
<td>59</td>
</tr>
</tbody>
</table>

When attention is turned to the practice of some of the covariants of sexual experience, the very young students again reveal a pattern of behaviour which does not set them apart as being less at risk even though a small number and proportion of their age group may be involved in the activities. Using smoking, drinking and the use of drugs as three such covariants, Table 4 shows the degree of involvement of the different age groups in these three habits.

The overall use of alcohol is probably the most interesting of the three habits under consideration, not only because of its ready availability from home brewing but because of its general acceptability in the society. For some communities, it is part of the adult diet. Consequently, it is not surprising that just over a fifth of the male students report previous consumption of alcohol but 15.6 per cent of the female students also consume alcohol.
Table 4
Percentage reporting various social ‘vices’ by sex (own history)

<table>
<thead>
<tr>
<th>Social ‘vice’</th>
<th>Male students</th>
<th>Female students</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Ever drank alcohol</td>
<td>313</td>
<td>21.4</td>
</tr>
<tr>
<td>Ever smoked</td>
<td>302</td>
<td>9.3</td>
</tr>
<tr>
<td>Ever used drugs</td>
<td>306</td>
<td>2.6</td>
</tr>
</tbody>
</table>

The tobacco smoking habit is predictably higher among the males though 3.2 of the girls report a smoking habit, strange for a largely rural community and considering the relatively high cost. The habit-forming drug reported is marijuana which is grown locally and used as therapy for influenza.

At this point of the discussion, therefore, the relatively low levels of sexual experience at the very early ages are not as important as the establishment of sexual and social behavioural patterns which are to be observed almost universally later in adult life. One factor of interest is that schooling seems to create an opportunity for early initiation into these behavioural patterns. The study under discussion also confirms that the absence of parents, and the commuting from school to home offer opportunities for school students to engage in sexual encounters and participate in social activities conducive to risk taking. These patterns of childhood and teenage behaviour and their predictors have also been documented elsewhere (Elegbeleye and Femi-Pearse 1976; Kaur 1978; Mott and Maxwell 1979; Adeyanju 1981; Oronsaye, Ogbeide and Unuigbe 1982; Owuamanam 1982; Oshodin 1984; Population Reference Bureau 1992).

Initiation ceremonies: recruitment into sexuality?

The school-age sexual behaviour described above is to be viewed against the background of the community’s attitude to early sexuality and in the context of the preparation of children, especially girls, for sexuality. The starting point of such a discussion is the presence in most Sub-Saharan African communities of formal and informal traditional initiations for the transition of girls into womanhood. The West African forms of these initiation ceremonies include the Bundu ceremony in Sierra Leone, the fattening houses of the Annang of Nigeria (Brink 1989) and the Obutun Dance of the Ondo sub-group of the Yoruba in Nigeria. In all of these ceremonies, there are sexually explicit and implicit symbolism. The public display of the female body in minimal clothing, the instructions on how to be a good housewife and sexual partner and the appreciative response of the audience at the ‘graduation ceremony’ of the girls are invariable components. The occasion may also be used for the circumcision of the boys and girls in the initiation cohort (Adeokun 1990). In East and Southern Africa, the survival of these ceremonies is in its most dramatic form in the annual ‘Reed Dance’ in Swaziland. Here, the basic elements are present, but in addition, the cultural practice had acquired an international reputation as a tourist attraction, encouraging the development of potential porno-tourism. It has been established that the annual dance carries the actual risk of higher incidence of school-age pregnancy for the participants. The follow-up drop-out due to Reed Dance pregnancy extends to the university population.

In Uganda, the practice of a formal initiation is not universal and the substance of the ceremony varies. The practice of female circumcision for example is limited to one tribe in Eastern Uganda, the Sabiny of Kapchowa District. The Langi, Madi, Teso and the Mutoro do not have any prescribed ceremonies (Molnos 1973). Among the Bantu tribes in the south of Uganda, initiation into motherhood starts early with the elongation of the labia. This is
Social context of HIV infection in Uganda

achieved by pulling the labia and rubbing various herbs and wild fruits into them (Neema 1994). Among the Baganda, this elongation is a precondition for marriage and is carried out before the onset of menstruation. Arrangements will be hurriedly made for effecting the elongation if it is discovered that a prospective bride has not been prepared in this way. Traditionally the aunt, that is, the father’s sister (senga) or cousin was responsible for effecting the elongation; in the absence of this category of relations, the grandmother may carry out the procedure. This procedure can take place as early as at age eight, but with schooling and distance between daughters and their parents it may occur much later. Another effect of schooling, especially for girls in boarding schools, is that the procedure may occur in school, performed by older female fellow students. The occasion of informal sex education talks organized by teachers for the growing girls may be the trigger for the practice of the elongation procedure.

It is believed that the process of menstruation or such physical activities as riding a bicycle may result in the shrinking of the labia; consequently, a periodic repeat of the procedure may be effected. The belief is that the elongation is good for the male partner’s sexual satisfaction. Ironically this elongation of the labia, particularly when they protrude, is reported to be a nuisance in the process of childbirth. The point of these details of initiation in southern Uganda is that they draw attention to a substantial handling of the labia by others. The procedure, we are informed, can be painful, but it can also be pleasurable: the response may be a function of the category of persons performing the procedure. It is possible that this patently sexually oriented preparation of young females increases their self awareness and their response to sexual stimuli earlier than would have been the case. This precocity is a possible factor in the incidence of defilement of minors which is either increasing or is better reported or both.

Among the Sabiny, the initiation into motherhood starts by the removal of the labia during circumcision; for this group, the removal is aimed at limiting sexual stimulation and satisfaction. Among the Batoro, there is neither circumcision nor elongation; however, this is the group which is perceived to be very sexually responsive and active. In this connection, the proposition can be made that the circumcision status of women may have something or nothing to do with their level of sexual activity, although the test of such a proposition will not be easy.

In the meantime, the information from a qualitative stage of a continuing project on ‘Household Functioning in the Age of AIDS’ in three districts of Uganda (Rukungiri, Masaka and Kabarole) is providing evidence of the general role of sexual activity between minors and adult males in the development of the epidemic. In-depth interviews with key informants in the Districts of Rukungiri and Masaka in southwest and Central Uganda were conducted during January and March 1995. The District Cultural Officer (DCO), the District Probation Officer (DPO) and the District Rehabilitation Officers (DRO) were among those interviewed. According to a DPO in one of the districts, the traditional elongation of the labia among the Baganda is an experience of very young girls and it could demystify sex and create a level of curiosity in the girls to the extent that they would have no resistance or reservation when approached for sex by adults. She believes that the sentimental value attached to the practice by the Baganda is so strong that it will not be easy to eradicate; she remarked that even the educated still appreciate the practice and take it into consideration in their decision as to whom to marry.

Another cultural practice to which some sexual construction has been attached is the tendency for young girls and women in general to kneel down to older persons, especially older males. According to one of the informants, a DCO, this act of symbolic submission

1 Known elsewhere as ‘carnal knowledge’ or ‘statutory rape’.
makes it very difficult for women to refuse advances from those whom they have acknowledged as superior. It is against the background of the potential relationship between the early initiation procedure and the submissive position of women that the issue of defilement as the real basis of recruitment into sexual activity must be viewed.

**Extent of defilement**

There is some evidence of the occurrence of defilement in the accounts given in the press and in court cases. Discussions held with the DCO, DRO and DPO in Masaka district revealed that it is increasing and occurring in the different socio-economic levels of society in the district. Many cases are reported to the probation office but the DPO believes that the majority of cases are not reported to any legal office. The situation in Rukungiri district was not any better: the Criminal Information Division officer has had at least one case of defilement reported to his office every month in the past year. At one point, five cases were reported within two weeks. However, he also believed that many cases are settled locally in the lowest administrative unit, Resistance Council courts.

The circumstances of defilement in schools among teachers and their students and in households among male adults and orphans and house-girls were judged to be pathetic. The teachers threaten the minors with expulsion and the girls end up not revealing their problems; a similar dependence and desperation of house-girls make it difficult for them to report cases against their masters. In effect, establishing the extent of the problem is not going to be easy and the press accounts of defilement cases are but the tip of the iceberg.

In Buganda where a man is free to have sexual relations with any woman with whom he has no blood relationship, the common traditional practice of older married women fostering their young sisters puts these growing girls at risk of being sexually exploited by their in-laws. The young sisters are usually fostered by their relatives mainly to have access to better education and to help with some of the domestic chores. Another form of defilement in Masaka District was that of young boys by elderly ‘reconditioned’ women. The affluence of some of the women, some of them AIDS widows, makes it possible for them to lure the young boys into equally cohesive and illegal sexual relationships. Such cases are, however, hardly reported.

There is a view that the advent of the HIV/AIDS epidemic is increasing the cases of defilement through the belief of some adults that young girls are still free from the virus; but this is not accepted by our key informants. They point out that most cases that are reported involve people who are not very knowledgeable about the virus and are not in a position to make the intellectual connection between avoiding infection and having sex with minors.

**Traditional and modern legal management of defilement cases**

There are traditional arrangements for settling defilement cases in both districts. A curse and excommunication from the clan are two of the punishments given to the offenders. It should be noted that the society is more worried about the social misfortunes believed to result from the incidence of defilement for both parties than the legal rights of the victims; for instance in Mbale District there are rituals which are performed after the discovery of defilement: a sheep is offered, victims are washed with special herbs and certain food is cooked and eaten by the affected families.

The modern legal system sentences the guilty defiler to death and anybody suspected of attempted defilement is sentenced to a prison term of from 19 years to life. In spite of the severity of the punishment or perhaps because of it, the officers expressed their concern about the difficulty of enforcing the laws. The need to have corroborative adult evidence and medical evidence to convict, makes it almost impossible for cases to succeed in the courts of
law. In both Rukungiri and Masaka Districts, parents of victims first try to settle the cases through the RC system. It is after they fail to agree upon a just decision among the parties that they refer the cases to the courts of law. The DCO in Masaka observed that ever since defilement became a capital offence, the reporting of cases in Masaka District has dropped drastically. The DPO in the same district expressed serious concern about the frustrations of litigants when cases of actual and demonstrable defilement are reduced to attempted defilement by colluding medical examiners. On the basis of the false medical reports the courts are forced to give lighter sentences. Another way in which the legal system is compromised is that the prevailing levels of poverty encourage parents to accept out-of-court settlement of cases because the accused are prepared to pay ‘damages’ as an alternative to facing the courts and a possible death sentence.

Social disruption and sexual exploitation

Given the prevailing cultural climate of early sexuality and the ambivalence about the criminalization of ‘defilement’, it is pertinent to explore the impact of the more than two decades of social disruption through which Uganda has passed and the degree to which that disruption is aggravating the problem of early entry into sexuality through voluntary or involuntary sexual relations. The disruption affected, in one way or the other, the lives of more than two-thirds of the total population born before the advent of the NRM regime in 1986. The elements of that disruption include wars, refugee movement within and across national boundaries, military movement and a rapid electronic dissemination of pronography.

In the case of Uganda, these events in conjunction with the HIV/AIDS epidemic produced a huge orphan population, probably unmatched elsewhere in Sub-Saharan Africa. An inspection of parental survival status from the 1991 census (Figure 7) reveals the extent of the problem (Uganda Population and Housing Census 1991). The result is the need to operate various forms of child placement arrangements under traditional, governmental as well as non-governmental organizations. These child placement arrangements can produce, and are producing some opportunity for sexual exploitation of minors, especially female ones. As the HIV/AIDS epidemic devastates families and households, calls are made on increasingly distant links to find succour for orphans. This includes the use of such orphans as house help and child minders. In the private initiatives for establishing some form of homes for the orphans, a number of inadequately supervised facilities are springing up. In both of these situations, some evidence is emerging of the role of some male adult care givers in the exploitation of the children in their care. The prevailing culture of the submissiveness of young females to their superiors makes resistance to the attentions of the adults very difficult.

At the other extreme of the orphanhood problem are the huge numbers of young orphans of both sexes who have no living arrangements made for them. The state of destitution of such children makes them prime target for those who, through force or inducement, obtain their sexual services. What these minors do after their exploitation is a matter of speculation: if they leave the service of the exploiting male they have very limited options other than seeking marginal employment in the service sector, often in sexually exploited positions. In effect, those who acquired infection without having had multiple sexual partnerships turn to acquiring further sexual partners for survival.
Figure 7
1991 parental survival status (percentage of population in age group)

Research and policy implications

Study of pre-teen sexual practices and contacts

The one major research implication is the need to supplement the present emphasis on multiple sexual patterns with some understanding of the circumstances of entry into sexual activity by young people. This will involve a study of pre-pubertal sexual practices and contacts with adult partners. The methods will of necessity be multi-disciplinary as the domain of childhood sexuality cuts across the psychological, medical and population sciences. The coverage of such studies must be comprehensive and include ‘street kids’ as well home based and institutionalized children.

Helping teenagers to postpone sexual involvement

The real possibility of using the school system as a means of helping teenagers postpone sexual involvement is one which both family planning objectives, modernization and demographic transition arguments and HIV/AIDS control targets should suggest. The logic goes beyond integration of family life education into the school curriculum or the passing on of IEC messages to the school youth. It requires a program of behaviour change in which the increases in knowledge are matched by the free access to contraceptive services. The
graduates of the school-based program will benefit not only from a reduced risk of pregnancy (Howard and McCabe 1990) and infection, but from an increased likelihood of completing their education and entering adult life with a less pronatal view of reproduction.

With the close link established between alcohol consumption, drug use and the level of sexual activity elsewhere (Mott and Haurin 1988), and in Uganda (Twa-Twa 1995), one way of reducing risky sexual behaviour is to approach this objective through the indirect control of the adverse and deviant social behaviour associated with risk taking. This approach calls for an improvement of the school environment and the discipline of both students and staff of these institutions.

**Kids should know about condoms**

TOULOUSE, France — Paris mayor Jacques Chirac, the frontrunner in the French presidential election campaign, feels children should be taught ‘at a fairly early age’ how to use condoms to prevent AIDS. ‘Let’s speak frankly, even [if] I know this can shock many families,’ Chirac said during an election campaign stop in the southern city of Toulouse. ‘AIDS is a dramatic reality and is getting worse. There is a risk of death. We must therefore explain to young people at a fairly early age how to use a condom.’ France has the highest rate of AIDS infection in Europe. (New Vision, 16 April 1995:14).

It is apparent that the idea of introducing preventive measures at early ages makes sense. It is equally obvious that such measures are going to be resisted by conservatives and by religious groups. However, the rage of the epidemic in a country like Uganda is such that the logic of what appears, at first, to be a panic reaction may become inescapable. How this program of aggressive social engineering can be implemented needs no re-invention. It is operational in Thailand where the condom is being introduced into nurseries.

**Resolving the conflict between culture and the law on defilement**

A number of reproductive health issues in sub-Saharan Africa bring cultural practices into direct conflict with desirable medical options; attempts at resolving the conflict through legislation have not been very successful. In the case of defilement, the culture of early marriage and early childbearing makes the implementation of laws so much more difficult; the solution will appear in the education of the public in the medical as well as the social problems of such early sexual activity. Reducing the ways by which minors are exposed to exploitation appears to be a supplementary policy and program option. Attractive as same-sex schools are, the inequality of the sexes at all levels of school registration and in the provision of teachers make such an option inpracticable.

**Better documentation of AIDS cases**

The openness of the Ugandan Government has been a catalyst in the documentation of AIDS cases in the country. A logical next step is to make sure that some effort is made at establishing the clinical information that may assist the estimation of the time of infection since the information is important to a further clarification of the role of the onset of sexual activity in the propagation of the epidemic.
References


Social context of HIV infection in Uganda


*Supplement to Health Transition Review Volume 5, 1995*


The declining HIV seroprevalence in Uganda: what evidence?

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Institute of Public Health, Makerere University, Kampala

Papers presented at the ninth International Conference on AIDS and STDs in Africa, held at Kampala in December 1995, show that HIV prevalence has apparently been on a downward trend in several sectors of the population of Uganda over the past few years. This article reviews the relevant presentations.

Background

Uganda is a landlocked country in East Africa astride the equator with a population of about 18 million people increasing at an annual rate of 2.5 per cent. The country is divided into 39 administrative districts, each with an average population of about half a million. The population structure is similar to that of other countries in the region where half the population is below 16 years old. Uganda is one of the countries in Africa where AIDS was recognized as a public health problem relatively early, in the mid-1980s. HIV seroprevalence among pregnant women in the capital city, Kampala, was found to be about 15 per cent in 1986 when HIV screening was first done. The prevalence levels rose steadily until 1989-1990 when levels in various prenatal clinics in Kampala city stabilized between 25 and 30 per cent. Reports of falling HIV prevalence rates in 1995 were therefore received as very good news in a society where virtually everyone has in some way been affected by the epidemic and where health workers, public leaders and the general public have all been severely demoralized by the epidemic.

Sources of available evidence

The downward trend in HIV seroprevalence was reported from the following sources: studies of HIV among pregnant women in Mulago hospital, which is the main referral hospital in Kampala; sentinel surveillance data from antenatal clinics around the country; community-based studies of HIV in Masaka and Rakai districts; and persons attending voluntary HIV screening centres.

Studies among pregnant women in Mulago hospital, Kampala

Information on pregnant women in Mulago hospital is obtained from a presentation made by the Human Reproduction Research Unit, Department of Obstetrics and Gynaecology, Makerere University, Kampala (Bagenda et al. 1995). This paper had two sets of data. The first data set showed HIV seroprevalence figures from persons attending various prenatal clinics in Kampala during 1993, and demonstrated the variation of HIV infection rates by age and other socio-demographic variables. The overall HIV prevalence among all women attending eleven prenatal clinics in the city in 1993 was 20.5 per cent (95% CI 18%-23.1%).
The second set of data was obtained from the Mulago hospital prenatal clinic alone and it compared the 1993 HIV-1 prevalence figures with earlier, 1989 screening data from the same clinic. The data show that during the 1989 screening HIV seroprevalence among pregnant women attending this unit was 28.1 per cent (95% CI 26.6%-29.6%). In contrast, during 1993, the HIV seroprevalence among pregnant women attending the clinic was 16.2 per cent (95% CI 12.2%-20.8%). The age distribution of HIV prevalence in 1993 was similar to that in 1989, with pregnant women aged 20-22 years having the highest HIV prevalence rate. Levels in 1989 and 1993 are shown in Table 1.

<table>
<thead>
<tr>
<th>Age group</th>
<th>1989-90</th>
<th>1993</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 17</td>
<td>23.5 (20.3-27.1)</td>
<td>8.2 (2.3-19.6)</td>
</tr>
<tr>
<td>17-19</td>
<td>32.3 (29.4-35.2)</td>
<td>12.6 (6.9-20.6)</td>
</tr>
<tr>
<td>20-22</td>
<td>37.9 (33.6-42.2)</td>
<td>29.7 (15.9-47.0)</td>
</tr>
<tr>
<td>23-25</td>
<td>27.4 (23.0-31.8)</td>
<td>26.9 (11.6-47.8)</td>
</tr>
<tr>
<td>26-28</td>
<td>25.4 (21.2-29.6)</td>
<td>20.8 (7.1-42.1)</td>
</tr>
<tr>
<td>29-31</td>
<td>24.8 (20.0-29.6)</td>
<td>14.7 (4.9-31.0)</td>
</tr>
<tr>
<td>32-34</td>
<td>21.8 (15.5-28.1)</td>
<td>12.5 (1.5-38.3)</td>
</tr>
<tr>
<td>35-37</td>
<td>16.3 (9.9-22.7)</td>
<td>11.1 (0.3-48.2)</td>
</tr>
<tr>
<td>38+</td>
<td>14.1 (6.7-21.5)</td>
<td>14.7 (0.4-64.1)</td>
</tr>
<tr>
<td>Total</td>
<td>28.1 (26.6-29.6)</td>
<td>16.2 (12.2-20.8)</td>
</tr>
</tbody>
</table>

There was a decline in HIV prevalence in all age groups except in persons aged 38 years and above. The decline, however, was only statistically significant in the youngest age groups below 17 and 17-19 years of age and in the overall rate. The presenters concluded that there was a significant decline in the HIV prevalence rate of persons attending the Mulago hospital prenatal clinic and that the biggest decline occurred in the youngest age groups.

**Sentinel surveillance data**

The HIV trends in sentinel surveillance sites were present in a paper from the STD/AIDS control program of the Uganda Ministry of Health in collaboration with the WHO/GPA (Asiimwe-Okiror et al. 1995). The team also provided the following background information on sentinel surveillance in Uganda.

Sentinel surveillance for HIV was instituted by the Ministry of Health AIDS Control Programme in 1989 with the aim of monitoring HIV prevalence trends in Uganda. In 1992 it was observed that HIV prevalence rates at some urban sites were declining. In view of this the surveillance unit planned an evaluation of the HIV sentinel surveillance system in 1994 to determine whether the procedures used still adhered to the WHO protocol.

The evaluation showed that the procedures which were used in the surveillance system were still in line with the recommended WHO protocol at all the sites. The results from all six sites showed a statistically significant decline in HIV prevalence rates. HIV infection rates between 1991 and 1994 at the sentinel surveillance sites which were evaluated are shown in Table 2; there are 20 surveillance sites in the country but only six were evaluated.

The first two sites, Nsambya and Rubaga, are situated in different parts of Kampala city. All sites show a declining trend in HIV prevalence rates between 1992 and 1994. The
The declining HIV seroprevalence in Uganda: what evidence? 29

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Presenters concluded that the decline of HIV prevalence rates is real, although the rates are still high.

Table 2
HIV infection rates (%) among pregnant women attending clinics at sentinel surveillance sites in Uganda 1991-1994

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Nsambya</td>
<td>27.8</td>
<td>29.5</td>
<td>26.6</td>
<td>21.8</td>
</tr>
<tr>
<td>Rubaga</td>
<td>27.3</td>
<td>29.4</td>
<td>24.4</td>
<td>16.5</td>
</tr>
<tr>
<td>Mbarara</td>
<td>24.4</td>
<td>29.4</td>
<td>18.1</td>
<td>17.3</td>
</tr>
<tr>
<td>Jinja</td>
<td>22.0</td>
<td>19.9</td>
<td>16.7</td>
<td>16.3</td>
</tr>
<tr>
<td>Tororo</td>
<td>12.8</td>
<td>13.2</td>
<td>11.3</td>
<td>10.2</td>
</tr>
<tr>
<td>Mbale</td>
<td>12.0</td>
<td>14.8</td>
<td>8.7</td>
<td>10.2</td>
</tr>
</tbody>
</table>

Community-based study of HIV in Masaka district

Data from the Masaka cohort were presented by researchers from a collaboration of the Medical Research Council (UK) program on AIDS in Uganda and the Uganda Virus Research Institute (Kengeya-Kayondo et al. 1995). The presentation had details of the dynamics of HIV-1 and associated mortality among adults. The study is conducted in a rural area of Masaka district, in 15 neighbouring villages with a total population of about 10,000. Since 1989 all consenting adults aged 13 years and over resident in the villages, about 4,000, have been kept under surveillance through annual demographic and serological surveys.

Results

1. Overall adult HIV-1 seroprevalence rates have remained stable at about eight per cent during the course of five annual screenings (rounds).
2. Prevalence rates in young men 13-24 years declined significantly with the figures from the five rounds being 3.4, 3.6, 2.3, 1.6 and 1 per cent. The trend is significant (p<0.001).
3. Prevalence rates in young women 13-24 also declined but the trend was not significant. The figures in the five rounds were 9.9, 8.2, 7.8, 8.1 and 7.3 per cent.
4. Incidence rates do not show a clear trend but are around 8 per 1,000 person-years. The incidence figures in the periods between the five rounds are 8.1, 6.8, 6.0, 9.4 cases per 1,000 person-years.
5. Death rates overall, calculated per 1,000 person-years, show a rising trend in the four one-year periods between the five rounds. The figures are 16.4, 19.5, 22.1 and 24.3 deaths per 1,000 person-years.

The researchers concluded that the decline in seroprevalence in young people is encouraging, although there is little change in other indicators.

Community-based study in Rakai district

Data from the Rakai district cohort were presented by researchers from Rakai Project which is a long-term collaboration between Makerere University (Uganda), Uganda Ministry of Health, Columbia University (USA), Johns Hopkins University (USA) and the Uganda Virus Research Institute in Entebbe, Uganda where the project is based (Serwadda et al. 1995).
The purpose of the presentation was to assess the trends of HIV incidence and prevalence in rural Rakai district, Uganda between 1990 and 1992. Data were obtained from 1945 households in 31 randomly selected clusters.

Results

1. Prevalence. Adult prevalence declined in the general cohort from 23.4 per cent to 20.9 per cent between 1990 and 1992 (p<0.04). The decline was most pronounced in the main road trading centres where prevalence fell from 37.8 per cent in 1990 to 31.1 per cent in 1992 (p<0.02). There was less change in trading villages (25.7% to 22.7%) and in rural villages (13.6% to 13.1%), both not significant.

2. HIV incidence. Among persons 15-59 incidence declined in main road trading centres and trading villages from 3.3 per 100 person-years of observation in 1990 to 2.1 per 100 in 1992; but this was not significant. In agricultural villages incidence increased from 1.1 to 1.9 per 100 person-years (not significant).


4. Persons 13-24 years old. In this age group, combining both sexes, prevalence declined from 17.3 per cent in 1990 to 15.7 per cent in 1991 and to 12.6 per cent in 1992 (p<0.001). The trends were similar in both sexes although prevalence was higher in females. Incidence rates, however, remained constant in both sexes, being 1.4 per cent among males in both follow-up years, while in females they were 3 per cent in the first and 3.1 per cent in the second follow-up year. Significant declines in prevalence among the young are not associated with any change in HIV incidence: serial prevalence measures may be misleading indicators.

Conclusions

HIV prevalence declined significantly in both open and closed cohorts in Rakai district; HIV incidence did not decline in the cohort. Mortality among HIV-infected persons exceeded HIV incidence in each follow-up year and influenced the observed secular decline of HIV prevalence. Surveillance of the epidemic based on HIV prevalence figures alone can be misleading in the absence of information on the balance between incidence, mortality, migration and compliance.

Persons attending voluntary HIV testing in Uganda towns

Voluntary testing for HIV infection is conducted by a local private organization, the AIDS Information Centre, which submitted no abstract or paper concerning HIV trends to the main conference, but during the satellite meeting some data were presented from their records (AIC 1995). The centre started to offer HIV screening services for a modest fee in Kampala in 1990. Demand grew rapidly and three other branches were opened in provincial towns. The people seeking the screening service commonly include those who suspect themselves to be infected with HIV, or those planning to get married. The service is currently offered to over 30,000 people every year.

The data presented showed HIV prevalence for all the persons screened in each year. Beginning in 1990 the annual HIV prevalence rates for all persons who attended the voluntary screening sites were 29, 28, 28 and 22 per cent, and 23 per cent in 1994. There was a fall in HIV prevalence especially after 1992. The AIDS Information Centre shares its data with any interested groups but goes to great lengths to explain that the data are not generalizable to any other population since the persons who were screened are self-selected.
The observed fall in HIV prevalence rates can be explained in many ways, including that high-risk persons sought HIV screening earlier than others, and that more persons from rural areas may be seeking HIV screening: their infection rates are known to be lower than those of people from the towns.

Whereas the correct explanations probably include these and many others, it is notable that there was a big drop in HIV prevalence after 1992, a trend which is not very different from that observed in the other ‘properly’ designed studies. There was also a decline in HIV seroprevalence among the youth aged 15-19 years. In this age group the prevalence figures are available for three consecutive years beginning with 1992. Among males the prevalence rate was 4.0 per cent in 1992, 3.2 per cent in 1993 and 3.1 per cent in 1994. Among females the corresponding rates are 12, 12.2 and 10 per cent.

Discussion

All the five presentations under review report declining trends in HIV prevalence in the populations which were studied. Two critical questions need to be answered: whether these findings represent what is happening in the general population, and what the explanation is for the downward trend in HIV seroprevalence. Of particular interest is whether the downward trend is the result of a declining incidence rate of HIV which has in turn been brought about by changes in behaviour.

Whereas most of the data presented come from urban areas, about 90 per cent of the Uganda population live in rural areas. On the basis of the presentations which were made during the conference it appears that the main factors which are affecting HIV seroprevalence trends include HIV incidence, HIV-related mortality and demographic changes. The role of each of these is now discussed in light of the available evidence.

Incidence

The very high prevalence rates observed in urban areas indicate that at some stage in the past, HIV incidence rates must have been higher than those currently prevailing. The available incidence figures were all measured at different times after 1990. Many workers in the field agree that the current levels of incidence cannot sustain such high prevalence rates as are seen in Kampala and other urban areas in Uganda. There is therefore some general consensus that although HIV incidence levels must have declined, the main decline probably occurred before the studies of HIV incidence. No one knows what the incidence rate in Kampala, Rakai or any other part of Uganda was in the period 1985-1990. The community-based studies in Masaka and Rakai show stable incidence rates in the period 1990-1993. If there has been any big decline in incidence, then it is very likely to have predated this period.

The research team which presented the sentinel surveillance data worked on the assumption that the downward trend in HIV sero-prevalence was the result of concurrently declining incidence rates. They developed a model which attempted to explain the observed sero-prevalence trends in terms of reduced incidence rates. Unfortunately there has not been any measure of HIV incidence in Kampala or in any of the sentinel surveillance sites which would validate the assumption. If the incidence pattern which is reported from Rakai and Masaka is generally similar to that which obtains in Kampala, or in the other areas where sentinel sites are based, then we may have to search for another explanation of the falling HIV seroprevalence levels than concurrently declining HIV incidence rates.
Mortality

In the community-based studies which measured HIV incidence and HIV-related mortality, it is quite clear that the numbers of HIV-positive persons dying each year far exceed the new (incident) HIV infections during the same periods (Kengeya-Kayondo et al.; Serwadda et al.) The researchers from the Rakai cohort felt that excess mortality among HIV-positive persons could almost entirely explain the decline in HIV prevalence (Serwadda et al. 1995).

HIV-related mortality in Kampala or in any other urban areas in Uganda has not been measured, but it is known to be quite high. The extent to which this is affecting HIV seroprevalence is not known, but if findings from Masaka and Rakai are anything to go by, then it is likely to be substantial. The HIV epidemic in Uganda started in urban areas and later spread to rural areas, a process which is probably still continuing.

The districts of Masaka and Rakai are some of the few rural districts in Uganda where HIV infection happened to spread fairly early. The epidemic in these two districts has therefore ‘matured’. This is reflected in the high HIV-related mortality figures and stable or declining HIV prevalence rates. In areas where HIV infection is newly introduced there is very little HIV-related mortality and prevalence figures can only rise even when incidence rates are very low. A ‘young’ HIV epidemic is little influenced by mortality, while a ‘mature’ one, which is the type of epidemic in many of the areas where the studies under review are based, is heavily affected by mortality. At this stage, the HIV epidemic in most parts of Uganda, including the rural areas, is becoming mature and the situation may be getting generally similar to that in the study area.

Demographic transition

This term is used in reference to the continuous movement of young persons below 13 years of age into the ‘adult’ category of persons 13 years old and above. Many studies have shown that persons aged 5-15 years in the African region are essentially free of HIV infection, and some workers have labelled this age group ‘window of hope’. If with time these people move into the ‘adult’ category while retaining their HIV-negative status, then they could conceivably be in a position to pull down the general HIV seroprevalence rate. This appears to have happened in some parts of Uganda. During the period 1986-1990, persons in the age group 15-24 were driving the epidemic, and many surveys showed that this age-group had the highest HIV prevalence rates. This was particularly true for females. The individuals who were in this age group have now moved into the older age groups. The younger people who replaced them appear to have largely retained their HIV-negative status. This may be a major factor in the decline of HIV prevalence. The drastic fall in HIV prevalence among those aged 13-24 has been reflected in all studies which have HIV infection rates by age (Bagenda et al. 1995; Kengeya-Kayondo et al. 1995; Serwadda et al. 1995; AIC 1995). In the Mulago hospital data, the decline in seroprevalence among the youth below 20 years was the only statistically significant age-specific decline.

The fall in HIV prevalence in persons aged 13-24 years probably reflects behaviour change, and it may reflect the impact of the various intervention measures. The effect is easier to demonstrate among young people in this age group because they join the adult group when they are uninfected. Safe behaviour is therefore easily translated into remaining HIV-negative. The older age groups may have had a change in behaviour but since they already have high rates of HIV seroprevalence, behaviour changes among them take much longer to be reflected in lower HIV seroprevalence rates.

HIV seroprevalence in the Mulago hospital prenatal clinic during 1993 was found to be 16.2 per cent, while the prevalence rate in all eleven clinics which were studied was 20.5 per
cent. One of the possible explanations for the lower rate in Mulago hospital is that being a referral hospital, Mulago gets many young pregnant women. Small units routinely refer first pregnancies (primigravidae) to the hospital, and this gives the referral hospital a higher proportion of pregnant women below 20 years old. The large numbers of these young mothers probably pulled down the overall HIV seroprevalence at the unit. If this should be the real explanation for the lower HIV prevalence rate in Mulago hospital when compared to all the other prenatal clinics which were studied in the city, then the youth factor may be playing a very significant role in the downward trend of HIV seroprevalence, not just in Mulago hospital pregnant women, but in many other parts of the country. Both hospital-based and community-based data appear to give this impression.

Conclusions

There appears to be a real decline in HIV seroprevalence in some population groups in Uganda. The explanations are many and they vary between population groups. These include a very high HIV-related mortality, demographic changes with many young persons joining the adult category while retaining their HIV-negative status, and probably a lower HIV incidence rate than that prevailing before 1990.

References

Unpublished data


Papers presented at Ninth International Conference on AIDS and STD in Africa, Kampala, 10-14 December


A high price to pay: for education, subsistence or a place in the job market

Christine Oppong

This chapter cursorily reviews a variety of evidence, mainly from Sub-Saharan Africa, related to the current incidence and speed of spread of HIV/AIDS. It draws and builds upon an array of previous work. It calls attention to some of the discussions and data-supporting hypotheses which link more rapid sexual transmission of the virus to the degree of prevalence of several documented, changing, gender-role attributes. The latter are involved in the economic, political, military and social crises transforming familial and non-familial institutions. They are associated with widespread social and spatial dislocation of populations; escalating impoverishment and increasingly sharp divergences in wealth and power. They concern aspects of what has been loosely termed in the past 'women's status'. These include on the one hand the degrees of inequality, subordination, dependence, neglect, deprivation, irresponsibility, coercion and even violence, suffered by girls and women in a variety of role relationships; for example as daughters, wives, community members, employees. On the other hand they include the types of socio-legal protection which they do or do not enjoy in their various capacities and their relative access to and control of resources required for sustainable livelihoods and human development.

These status attributes are associated in a number of ways with the types of sexual behaviour and relationships in which they are involved, especially the extent to which girls and women have to engage in sexual intercourse through necessity: to pass school examinations or obtain training places; to retain access to their children; to get access to farming land; to get money and food for daily subsistence; to get jobs and stay in them (see Ulin 1992). The text accordingly focuses attention on connections between escalating female socio-economic inequality, insecurity, poverty and powerlessness on the one hand and health outcomes on the other. It draws attention in particular to the evidence pointing to links between types of sexual behaviour and the incidence and spread of sexually transmitted disease and death including HIV/AIDS (cf. Gordon and Kanstrup 1992). The discussion thus takes up and documents a theme of the International Conference on Population and Development enunciated in Cairo in 1994, that is the need for health policies and programs to take sufficiently into account the economic, demographic, socio-cultural (and gender) dimensions of reproductive health protection. Already a number of countries in the region have begun to address HIV/AIDS in public discourse which goes beyond a purely medical approach and is gender-sensitive, and to develop programs which recognize the need for multifaceted approaches. In line with the current WHO (1995) global health report the discussion stresses the crucial links between poverty, inequality and morbidity and mortality. In the final analysis the latter rates are the prime indices of the former.

1 For example Caldwell, Caldwell and Quiggin 1989; Caldwell, Orubuloye and Caldwell 1991; Caldwell, Caldwell and Orubuloye 1992; Ankrah 1991; Cleland and Way 1994; Anderson 1994.
Space constraints prevent a discussion of the effects of girls' and women's unequal access to education, training, agricultural resources and employment opportunities and the discounting and neglect of women's work in labour records, agricultural plans and policies; and this chapter does not describe the agricultural crises, the devastating terms of trade, the pervasive effects of the rapidly increasing supply of job-seekers, the effects of harsh retrenchments in the public sector, the informalization of employment and increases in precarious labour contracts, the apparent declines in recorded female employment and widespread feminization of unemployment and poverty. These issues have recently been addressed in several ILO and other publications (Oppong 1992; Singh and Tabatabai 1993; Mhone 1995; Date-Bah forthcoming).

The changes in gender roles and relationships referred to in this discussion and resulting from such processes are implicated in several transformations, even crises, occurring in demographic and socio-economic systems of production and social reproduction on the African continent. Among these are the weakening and relative disintegration of traditional, often descent-group and farm based, structures of subsistence and support and the consequent collapse or inadequacy of customary social safety nets and survival mechanisms including substitutability of actors in the domestic domain. Results include increasing streams of labour migration, both national and international. An outcome is more people searching anxiously for often non-existent jobs, compelled to set up micro-enterprises in urban areas as survival strategies.

The spatial, social and familial dislocation of populations so entailed is immense. The suffering and degradation of the ceaseless to and fro of migrants is not well documented (Standing 1985:xl). Instead of being enmeshed in lifelong systems of morally binding transactions of kinship and affinity, ensuring group solidarity and some measure of security across the generations for young and old, individuals are forced more and more to rely upon precarious forms of livelihoods in strange environments. They are drawn to engage in forms of short-term, unprotected, deregulated, opportunistic, economic and sexual behaviour, which are entailed by such forms of survival and associated life styles and constraints when institutions and frameworks promoting and regulating employment and procreation are lacking or in their infancy. Both productive and reproductive (sexual) behaviour and relationships are being stripped of their moral, long-term, responsible contractual framework and being recast in daily, nightly, or hourly rated modes of operation, including exploitation, with consequent effects on the dignity of labour, individual security and the outcomes in terms of child survival and development (see Oppong 1993a).

Various macro-economic and legal policies and political as well as demographic phenomena are implicated in the micro-change processes discussed. They are shaping labour market demands, supplies and opportunities, the legal frameworks within which these operate and the public resource allocations and private patterns of expenditure affecting them. Lachaud (1994) has recently compared poverty levels and labour market issues in the region, stressing the rapid escalation of proportions and numbers in poverty through excess labour supply and little labour demand. For the region's socio-economic context is one of significant, if not catastrophic, economic deterioration during the past decade and a half, in which internal and international factors precipitating crises and decline have been aggravated by disastrous domestic policies, including Structural Adjustment Policies (SAPS), of which the gender dimensions and potential effects on social reproduction remain largely ignored and misunderstood. At the same time there is widespread recognition at the national level of the

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2 It has been estimated that Africa has 10 per cent of the world population and around half of the world's nationals abroad (Stalker 1994). In addition much migration is internal, either cyclical or one way (e.g. Collier et al. 1990 on Tanzania).
need for legal reform, to reconcile customary laws and contemporary practices, to promote the equality of citizens appropriate to modern states and to provide the kinds of legal redress and protection needed by the oppressed and wronged.

World Bank publications have argued that in the light of current knowledge, discussion of links between macro-economic adjustment policies and deteriorating health status, including vulnerability to HIV infection, is speculative (Elmendorf and Roseberry 1993). They have also propounded that there is much that reform-oriented public policies can do, within an adjustment framework, to address HIV risks. These include expenditure reallocations to ensure essential public and preventive care services, including STD screening and public education. However, some analysts of political economy and demographic trends in the African region view the macro-economic policy advice of SAPs as having observed and pervasive negative effects on survival and social reproduction in Africa and elsewhere, whether these effects are intended or unintended (see Singh and Tabatabai 1993).

Persuasive and well documented answers to such questions regarding the effects of macro-economic policies and legal reforms on human survival and development will ultimately depend upon the wider availability and analysis of demographic and health data, together with more systematic cross-cultural and comparative studies of the socio-economic, political, cultural and legal contexts of sexual behaviour and its outcomes, whether the outcomes are conception and procreation, or sickness or death.

This chapter merely adds more fuel by further juxtaposing some of the diverse materials which could be used in such debates. It first looks briefly at the incidence of HIV/AIDS and the kinds of approaches to documentation, analysis and forecasting used by scholars of different disciplines. It then concentrates on diagnosis of vulnerability, highlighting the ways in which individuals' sexual behaviour puts them at risk. This behaviour is seen to be moulded by their resources, power and decision-making ability. The latter largely stem from the resources accruing to occupations or provided by protective and supportive family members. At the same time the lifestyles, including sexual behaviour, associated with various key occupations of females and males are observed to be critical. Moreover places of education, training and employment are highlighted as key areas in which females are sexually at risk. This leads to the widely supported conclusion that approaches to sexually transmitted disease and death, which omit female empowerment and protection and male responsibility and which ignore the effects of poverty and inequality, are likely to be doomed to catastrophic failure.

In the light of the labour and training-related aspect of these discussions some recent evidence is cited from ILO meetings and analyses. These indicate the mounting recognition of the actual and potential implications for ILO's constituents. Simply put the discussion is meant to add more weight to those already advocating the necessity for more sophisticated design of multisectoral population and development policies.

**The HIV/AIDS epidemic: incidence and approaches**

Basic information about the global HIV/AIDS epidemic, the associated sexual behaviour patterns and the worldwide responses, continues to grow rapidly. Certain facts are apparent, such as that no community or country in the world already infected by AIDS can claim that HIV spread has stopped; that HIV is spreading, sometimes quite rapidly, to new communities and countries around the world; that the epidemic is becoming ever more complex as it matures and the major effects are yet to be felt (Mann, Tarantola and Netter 1992:2-3). Projections to the end of the century suggest that a minimum of 38 million adults will have become HIV infected, with a higher estimate of up to 110 million. In this scenario the cumulative number of AIDS cases by the year 2000 will reach 25 million and the majority of
infections will be in Asia and Oceania: 42 per cent, compared to 31 per cent in Sub-Saharan Africa and 14 per cent in Latin America and the Caribbean (Mann et al. 1992:4).

The stark situation in Africa as recently estimated by WHO is that there are nearly six million HIV-infected adults and 800,000 AIDS cases in adults. Among infants and children there are about 900,000 HIV and almost 500,000 AIDS cases. The outcome is that in some urban centres of East, Central and Southern Africa up to one or more in five under 50 years of age are now estimated to be HIV-infected.

The pandemic has been described as composed of multiple epidemics interacting with each other, each developing at its own pace, depending on the size of the group at risk, the rate of contact between individuals and the efficiency of the mode of transmission (Fontanet and Piot 1994).

In the past, several approaches have been taken to document the epidemic and its correlates. These include the geographical approach, the temporal approach — using graphs to illustrate changes in numbers affected over time — and the population approach, describing the pandemic by focusing on apparent high-risk groups especially according to sex, age and occupation.

A number of possible spatial correlates of infection with HIV have been broadly defined in the African region and geographical and sero-epidemiological data have already been compared to assist in the formulation of hypotheses concerning the dynamics of the spread of the epidemic (e.g. Caldwell and Caldwell 1993). These include the location of routes of infection and the processes whereby the infection is distributed in different regions and communities. Important spatial variables are geographic barriers and international borders and their permeability and the location of communication routes and administrative centres. Airports, ports, international highways and railways are all singled out as being important factors, since they affect the flows of people, the intensity, volume and directions of movement.

National capitals and major secondary cities tend to have the highest sero-prevalence rates. Villages with intense relations with areas of high prevalence are more likely to have higher rates than isolated communities. Type of city is relevant, with new cases increasing more rapidly in regional centres of colonial origin and contacts, that is with more ethnically diverse and cosmopolitan populations than for example indigenous centres of West Africa.

Demographic factors associated with speed of spread include migratory movements, rapid urban growth and unbalanced sex ratios. Significant variations have been found in the different subgroups of single national populations, according to mobility and educational status as well as marital status (e.g. Rutenberg, Blanc and Kapiga 1994 on Tanzania).

The evidence considered in examining potential connections between several phenomena and speed of spread of HIV comes from several countries in West, East and Southern Africa. It is part of an accumulating body of socio-economic literature which is scattered and certainly much less rich than the bodies of medical evidence on the basic health issues involved. As Cara’l (1993) has stressed, of the thousands of references on STDs and the relationship between sexuality and health in Africa, the majority focus on clinical aspects, laboratory techniques and problems of medical diagnosis. They are mainly based on data from clinic populations.

A serious drawback is that most of these works have no relevance to behavioural or sociocultural aspects of sexual relationships or marriage. Yet nuptiality, mobility, migration, inequality, and poverty are obviously crucial to the range and types of sexual experience of individuals. The proxies used in most studies to represent risk factors are weak in comparison: age, sex, income, education, marital status, often crudely defined. Surveys can scarcely capture the complexity, multiplicity and changes occurring in heterosexual relationships. Nor can they take cognizance of the fact that in one culture area there may be a
large number of recognized types of marital or sexual relationships, partly differentiated according to the degrees of economic dependency, seduction, power or coercion wielded. Significantly among the countries with the highest and most recently estimated prevalence are those countries in Southern and Eastern Africa which have been most pervasively affected in diverse ways by labour migration, mobility and the marauding military. These factors have traumatically destabilized marriage and the family, by diminishing the protection resident men afford to their wives and daughters and by changing the norms, values and sanctions surrounding sexual encounters. They have also stimulated the commoditization of sexual services. The predictions are that if present trends continue there will be further large increases in numbers and proportions affected.

In view of the fact that heterosexual transmission is the major route of infection in the region a large amount of data has recently been gathered, analysed and published on the self-reported sexual behaviour and habits of women and men in relation to the incidence and spread of HIV. Attention has been drawn to the examination of correlated factors, including sexually transmitted diseases and ‘sexual networking’ which is in part associated with the stability and rate of marriage (Caldwell and Caldwell 1994). Thus while in the decade of the 1980s medical and public health approaches to sexual behaviour and diseases predominated, in the 1990s socio-demographic and even ethnographic perspectives have come more to the fore (e.g. Dyson 1992; Orubuloye, Caldwell and Caldwell 1994 a,b; Cleland and Way 1994). Numerous studies of the reported sexual behaviour patterns of samples of general populations have been undertaken, a topic surprisingly understudied in previous demographic and health surveys examining reproduction.

A large number of such surveys have been carried out under the sponsorship of WHO Global AIDS Programme (Caral, Cleland and Ingham 1994). They have focused on the levels of polygyny and multi-partner sex in different populations and subgroups, the levels of sexual activity before, within, outside and after marriage and the widespread evidence of more sexual partners among men than women. There are however calls to caution in the examination of such self-reported sexual behaviour; moreover there is sometimes very little capacity to link the sexual activity data to political, economic and social processes, transactions and relationships.

Clearly, improved knowledge of sexual behaviour and related practices and beliefs in different cultures and socio-economic and occupational groups is a prerequisite for the design and development of appropriate programs and strategies to combat the spread of HIV/AIDS. Accordingly, since 1989 the WHO Global Programme on AIDS has sponsored national surveys of sexual behaviour in more than 20 developing countries. The methodology has included the development of a standard population survey protocol for use by national AIDS programs. In each country the sample size has consisted of 3,000 adults randomly selected in 70 clusters. The questionnaire has included about 100 items, most of them on first sexual relations, the number and type of sexual partners and condom use in the last year. Analysis of surveys from 14 countries has revealed considerable international variation in patterns of sexual behaviour which have implications for the design of effective interventions. The usefulness of these data for national AIDS programs, their methodological implications and their relevance for cross-national comparisons have been discussed (Caral et al. 1993).

There is no doubt that migration, urbanization, education and the dislocation of customary forms of domestic organization, based on traditional systems of kinship and marriage, are having profound effects upon the sexual behaviour of both women and men. On the one hand declines in customary constraints allow more individual freedom. On the other hand economic constraints and insecurity, in the face of dwindling sources of customary maintenance and security, are providing pressures leading to commoditization of sexual services for the poor and relatively deprived. Dyson (1992) has reviewed anthropological and
socio-cultural evidence on sexual behaviour, networking and transmission of HIV, identifying factors probably linked to declines in customary constraints. Other researchers have viewed current multi-partner sex in the light of traditional sexual practices (e.g. Caldwell et al. 1989; Caldwell, Caldwell and Oruboloye 1992). Women's necessity, through impoverishment and high child dependency rates, to use sex as an economic resource is being widely documented (Ankrah 1991).

In view of its potential as a protection from disease and death there has also been considerable focus of attention on the condom (female or male) and possible negotiations regarding its use. Gender inequalities have also featured prominently in a number of such analyses, with much stress on the levels of ability of women to persuade partners to use condoms according to their relative conjugal or partner power (e.g. Mason 1994).

**Vulnerability to infection: the risk assessment approach**

Attempts continue to be made to identify those social, behavioural and biological factors which put individuals and populations most at risk, so that prevention programs can be designed specifically to combat them. However, there continues to be discussion and differences of opinion with regard to the major risk factors, leading to analyses noting with surprise high levels of seroprevalence in supposedly low-risk populations, for example Caldwell and Caldwell (1994) on Eastern and Southern Africa.

Sexual behaviour considered to be high-risk and associated practices have been the subject of systematic cross-cultural study by among others the WHO Global Programme on AIDS (Carballo et al. 1989); the study of sexual relations is encouraging the more widespread use of anthropological methods (Orubuloye, Caldwell and Caldwell 1991). Risk-prone occupational groups are being seriously targeted by studies; the extra risk involved in being female is also being documented.

New concepts now coming to the fore in this field to facilitate analysis and understanding of the dynamic processes involved in patterns of spread of infection are vulnerability and its opposite, empowerment (Mann et al. 1992:6; Tarantola, Mann and O’Malley 1993). At a popular level the message regarding the links between female empowerment and reproductive health was one of the loudest emanating from the Cairo International Conference on Population and Development.

Vulnerability can be assessed at the individual level, the community level and the societal level. Such an approach is potentially invaluable for diagnosis and forecasting purposes. National vulnerability is being assessed through considering the individual factors which influence the risk of acquiring HIV or of being deprived of adequate care and support should the infection occur; the nature and quality of programs; the societal factors that increase, sustain or reduce empowerment. Three sets of criteria, ‘vulnerability indices’, have been developed. The first is a self-administered questionnaire intended to determine personal vulnerability; versions of such a tool are being effectively used in national AIDS Control programs to heighten individual awareness of risk. The second index was designed to evaluate the strength of collective efforts to prevent and control HIV/AIDS; the third evaluates the societal vulnerability to the pandemic.

The application of a ‘vulnerability index’ has led to the identification of countries most at risk (Tarantola et al. 1993), which include countries which have so far not appeared to be seriously affected. Various kinds of risk-prone situations and behaviour make people vulnerable.
vulnerable, thereby influencing the directions and speed of spread of HIV infection in different populations. In addition to sexual contact and blood transfusions, which may be the cause of up to 25 per cent of children and 10 per cent of adults with AIDS, perinatal transmission is also expected to have a significant negative effect on child survival in Africa. Situational and behavioural factors appear to be more important than biological factors in explaining the sex and age differences in incidence and spread. They also throw light on why and how demographic phenomena, employment-related issues and aspects of systems of kinship and marriage affect pathways of infection. These include such factors as patterns of labour migration, working conditions, types of occupations.

Evidence is accumulating of higher incidence of seropositivity among certain occupational groups. Other crucial factors include extent of kin dispersal, degrees of domestic organization and divisions of parental responsibilities. Such an approach also ultimately makes possible the highlighting of links between impoverishment, inequality, social breakdown, social justice and the potential rate of spread of HIV/AIDS.

Associations between labour migration and mobility and propensity to morbidity and mortality are clear and region-wide, as is the association between the vulnerability of people in certain especially mobile occupations. The latter include mobile professionals and those whose power and prestige emanating from their occupational roles give them access to a wide range of sexual partners, as well as seasonal workers, traders, and lorry drivers. The high levels of incidence and therefore risk in urban centres, which are poles of attraction for migrants who later return home, gives considerable cause for alarm with respect to the influence of spatial mobility. Historically labour migration is known to have facilitated the transmission of sexually transmitted disease. It has created markets for prostitution in mining towns and geographical networks of relationships between urban and rural communities (Jochelson, Mothibeli and Leger 1991). The major communication and travel axes and crossroads are typically found to be hubs of infection and risk-prone sites. Patterns of labour migration and associated health problems have accordingly been documented by, for example, Hamadou (1990) on Niger.

**Female vulnerability and risky relationships**

Certain population groups are already known to be particularly vulnerable and the epidemic has been categorized as increasingly affecting the youth and women, with proportions and numbers in these categories increasing rapidly and young women the most vulnerable group of all (Reid 1990). Data from AIDS prevalence surveys by sex and age have given disturbing and clear evidence that the prevalence of HIV infection is in many cases highest in women aged 15 to 25 but peaks in men ten years later in the 25 to 35 age group. It is a pattern which is consistently different between females and males (Reid 1992).

Women's risk is known to be compounded by a variety of socio-economic and cultural reasons both customary and modern. Thus important matters for study include the ways in which old behaviour patterns, such as conjugal separation and multiple-partner relationships, are continuing in modern guises and may have disastrous results for health and survival. For example the kinds of polygyny and multi-partner sex which were in the past partly by-products of late marriage and long periods of sexual abstinence of wives between births may now prove lethal to couples, as sexual networks become geographically far-flung, reaching for the Southeast Mediterranean and 7 from Asia including China, 4 in the Caribbean and 9 in other regions. Communities which differ from the national aggregate in terms of vulnerability were also identified. These proposed indices underscore elements of remedial action needed to halt the course of the pandemic and to mitigate its impact (Tarantola et al. 1993).
distant centres of infection (Caldwell, Orubuloye and Caldwell 1991; Caldwell and Caldwell 1993).

Cara’l (1993) has examined some of the evidence linking labour mobility and increased propensity for STDs to develop and spread through separation of spouses and facilitation of brief sexual liaisons and commercial sexual contacts. Conjugal separation, whether to protect breast feeding or through labour migration, has been associated in several studies with greater vulnerability to STDs (Caldwell and Caldwell 1983). Accordingly, the evidence from a wide variety of sources to indicate that marriage is becoming less stable and that increasing numbers are not entering stable unions, implies greater vulnerability for women and men to sexually transmitted disease.

Customary practices such as the ritual cleansing of widows through sexual intercourse and the persistence of genital mutilation in all its forms add to the special vulnerability of females. They continue to be a cause for concern among health personnel and others, leading in extreme cases to mass demonstration protests (e.g. Ezeh 1990). Worldwide an estimated 84 million women and girls have been infibulated or circumcised causing genital conditions which put them at high risk of infection, and many of these are in Africa (Reid 1992). Reproduction-related disabilities, including the sequelae of abortion, are also common among poor women and increase the efficacy of HIV transmission. Reid (1992) stresses that many of their reproductive disabilities including sexually transmitted infections are treatable, but some will require changes in cultural practices, including child marriage and pregnancy, rape and incest and other sexual practices causing lesions or inflammation.

Factors recognized as associated with female vulnerability also include poverty, inequality, mobility, insecurity, lack of family support and protection, heavy parental responsibilities, and male dominance and aggression (e.g. Hamadou 1990; Cara’l 1993). At the same time seriously implicated are pressures pushing, pulling and allowing women to trade sexual favours for material considerations. These are linked on the one hand to the breakdown of familial forms of production and maintenance of family members, and on the other hand the failure of modern labour markets to offer opportunities for economic security and family maintenance.

Higher levels of premarital and extramarital sexual activity are reported for men than for women in a number of studies (e.g. Orubuloye et al., 1991). Accordingly the risks women face from their sexual partners are now an important topic of research (Orubuloye et al. 1994a). Relatively little was known until recently about the sexual rights of women and men inside and outside marriage, other than the prescribed rights and duties of marriage partners, and yet the degree of control individuals can exercise over their sexual relationships is obviously now a matter of life and death. This makes more valuable the small but growing number of relevant studies. It means that study of such topics as conjugal power and decision-making is crucial to understanding sexual negotiations, reproductive health outcomes and survival itself. ‘Lack of access to and control of resources for decision-making, particularly in the sexual relationship appears to be one key to the vulnerability of women and children in the AIDS epidemic’ (Ulin 1992; see also Ankrah 1991; Bassett and Mhloyi 1991). This has led to concern to examine the extent to which women can control the terms of their sexual relationships with their partners including husbands4. From a geographical perspective

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4 See for example a recent study of the rights of Ghanaian women over their own bodies. Studies of vulnerable and high-risk women were carried out in 1991 among purposively selected groups in four areas of Ghana (Awusabo-Asare, Anarfi and Agyeman, 1993). The groups selected included prostitutes, itinerant traders, and partners of policemen, soldiers, sailors and miners, long-distance drivers and AIDS/HIV seropositive men. Attention was focused on whether women had the right to refuse sexual relations with a philandering partner, who by this behaviour put them at risk of disease and death; and if they did refuse, what the consequences were.
attention has been called to apparent differences in women’s power between West Africa and Eastern and Southern Africa. A hypothesis formulated is that women in the latter subregions have less power and suffer relatively greater disadvantages regarding decision making vis-à-vis partners than women in West Africa, owing to their more precarious rights in land, children, and property, and to the more widely documented propensity of men to violence against women (e.g. Orubuloye, Caldwell and Caldwell 1993).

The pervasive effects of urbanization and rural migration have included greater numbers of female-headed households: increasing numbers of impoverished women alone in urban communities, adopting various survival strategies, which typically include selling domestic or sexual services for survival5. Further correlates are comparatively high levels of commercial and casual sexual relations and treatment for STDs (Cara’l, 1993).

**Escalating jeopardy**

Just as changes in familial systems and relationships may be associated with increased jeopardy for women’s health, so the number of women potentially sexually vulnerable to harassment and exploitation in workplaces is growing (Oppong 1993 b, c, d). They include migrant women workers spatially separated from kin, husbands and traditional sources of sustenance — land and family labour; lone, unaided mothers with economic pressures of dependent children to maintain and therefore desperate to obtain and keep employment; girls and women in poverty without income-earning skills, training or opportunities and therefore ready to take on any kind of income-earning opportunities they can find; women engaged in legally and socially unprotected, precarious economic activities, including trade, home workers, domestic servants; women in casual, daily rated or piece work in factories, plantations, etc.; women in refugee camps and squatter communities who have fled from political and other crises and have no source of sustenance6.

In sum the result of the combined global, regional and national trends affecting the productive and reproductive roles of women is that there are increasing proportions of female workers who need cash income to support their families, and are in legally, economically and socially precarious conditions. They lack security of all kinds provided by both traditional and more modern institutions. The effects of economic crises are known to be making their situation worse. Meanwhile there is accumulating evidence for their bearing increasingly unequal burdens of responsibility for dependent children, as the numbers and proportions of domestic groups maintained by women continue to increase (Folbre 1991).

**High-risk strategies**

Migration by women for work can be a high-risk strategy involving many problems compounded by their sexual vulnerability. The body of evidence on the movements of female

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5 Lesotho is an example of a situation in which massive male emigration for employment in South Africa has led to the absence of a large proportion of the adult male population. The resulting sex imbalances in population composition have been associated with late marriage, decline of polygyny, increase in divorce and frequent extramarital relationships (Timaeus and Graham 1989).

6 Attempts have been made to rally resources to design research tools to document the sexual vulnerability of women in workplaces, based on elements in a seven-roles framework which would include such indicators as degree of security of employment contract; alternative job opportunities available; level of economic family responsibilities shouldered alone; availability of protection from male family members; type of community protection afforded. The purpose would be to call more urgent attention to those locations and subpopulations of women workers most at risk, in order to target preventive and remedial policies.
migrant workers, though relatively sparse and biased in the past, is currently growing apace (Findlay and Williams 1990). As well as increasing feminization of labour streams there is widespread evidence of discrimination and need for protection. Women’s and girls’ search for jobs in far-away places is often part of a family coping strategy in households in poverty. Internal migrants provide many of the workers employed in seasonal, insecure, agricultural jobs in plantations and the manufacturing industries (e.g. food and drinks processing, textiles, including export promotion zones); they are also absorbed into the new service sectors, including the hotels and tourism.

There is consequently in many countries a rapidly growing number of female migrant workers, girls and women in seasonal, insecure, casual, part-time, piece-rate work; they are often unprotected either by labour laws and workplace mechanisms or by family members and community sanctions. Their workplaces outside the home are almost entirely controlled by men: their livelihood and that of their families may depend entirely upon the favour of male managers. Fear, and lack of alternative sources of livelihood in situations of high unemployment rates, may be effective in promoting docility and silencing potential complaints. The position of girls and women in Export Processing Zones is known to be particularly acute. This situation is potentially conducive to vulnerability of larger numbers of female workers, girls and women, to sexual as well as economic abuse. A recent report of the Workers’ Education Branch on Equal Opportunity and Women’s Participation in Unions has highlighted the concern for vulnerable migrant women workers’ reproductive health in Africa, if they remain unprotected from both the spread of AIDS and unwanted pregnancies. Their vulnerability to sexual harassment and these consequences was noted to result from their economic desperation to get work to feed their families (ILO 1993).

**Female sexual vulnerability at work and school**

There is an accumulating body of information concerning sexual harassment of girls and women in places of training and work in the African region and other parts of the developing world.

Numerous women state that they are required to extend sexual services to employers as a condition of employment and promotion. Some husbands refuse to allow their wives to work for wages because of this. Their refusal renders vulnerable many women who might otherwise have been able to earn a living without resorting to sexual strategies upon finding themselves divorced or widowed (Schoepf et al. 1991:191).

Studies in a number of countries have uncovered the dimensions of the problems involved and highlighted the means to combat them (e.g. ILO 1993). Campaigns to raise awareness of sexual harassment have been recommended or conducted in several countries.

It is already known that problems of sexual abuse can be particularly severe in countries in which community and workplace environments lack protective laws, norms, and practices and effective sanctions, which would serve to deter the worst kinds of abuse and their economic, demographic, social and psychological sequelae. Men may have only worked before in close contact with women who are their wives; sexual harassment may serve to perpetuate the expected exchange of sexual favours for economic support, which underlies the conjugal relationship (e.g. Caines 1992). Sexual harassment is also recognized as being one of the ways of reminding women continually of their inferior position in the workplace, and prevents them from being treated as workers on the same terms as men.

Girls in school are not immune. Reid (1992) has restated the question: why do girls and young women (15-25) have such significantly higher rates of infection, when in fact young men are more sexually active than girls and have more STDs? One response to this question
is that they are clearly becoming more and more frequent sexual targets of old infected men, who view school-girls as safe partners. The economic vulnerability of girls is often also linked to their sexual vulnerability.7

Documentation of well publicized, individual cases from schools and workplaces, the gradual accumulation of anecdotal evidence and several surveys have begun to show that the problems are not rare or individual. They may in fact be revealing only the tip of an iceberg and be describing a problem which is part of a whole syndrome of discrimination and exploitation to which women are subjected.

The economic consequences for women and their families are clear. Victims report serious effects on their job security and prospects. Effects on victims’ health are cited, including depression and physical ailments thought to result from stress; cases of nervous breakdown and hospitalization have been documented. For the women who do not want to be victimized the pressure is not to offer themselves for employment in such hazardous conditions. A recent ILO (1992) compendium of evidence on sexual harassment and sexual protection in the work place in 23 industrialized countries showed that it is becoming increasingly recognized as a serious problem for both victims and employers. Informal as well as formal-sector workers are vulnerable often through isolation and dependency upon male links to formal systems, for example police, customs officials, and middlemen. Informal-sector workers do not have available to them the legal redress which may be available to women in formal-sector employment.

Export processing zones are among the locations where girls and women are potentially at greatest risk. During the past twenty years there has been a rapid increase in such zones (EPZs) in Africa and elsewhere. The majority of workers in such zones tend to be girls and women, in particular unmarried girls. There are reports of insecurity, marginalization and economic and sexual exploitation. Oodit et al. (1993) in a two-year research project examined the HIV-AIDS risk related behaviour of young women 15 to 25 working in the EPZ of Mauritius which had expanded from 10,000 workers in 1978 to 100,000 workers in 1992: this is ten per cent of the total population of the island. For the first time young women are working outside the home unsupervised by relatives, have earned income and may have relationships with men outside the family context. These relationships are a source of risks of pregnancies and AIDS which have recently been studied in collaboration with the Mauritian Family Planning Association.

ILO constituents’ responses

A working group in a recent ILO (1994) meeting in Uganda on HIV/AIDS and the workplace noted that sexual harassment in the workplace is an abuse of power, which increases the risk of exposure to AIDS and calls for counselling and disciplinary action. Protection from sexual harassment and coercion is increasingly recognized as a legitimate concern for employers and trade unions, at least for women members.8 However, as the ILO Digest of Information admits, given that the majority of trade union members and the majority of office bearers are

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7 E.g. Sharpe et al. (1993). By age 12, 30 per cent of girls in a study were recorded as sexually active and by age 18, 85 per cent were active. Of boys, by age 14 ten per cent were active rising to 70 per cent by age 18, showing a sharp difference in the experiences of girls and boys. Reasons for entering sexual relations included poverty as well as rape, lack of parental supervision and peer pressures.

8 See, for example, FIET Regional Women's Seminar for English-Speaking Africa, Lusaka, Zambia, Nov. 1991. In a resolution on sexual harassment it was resolved that unions should develop policies and negotiate grievance procedures as part of collective bargaining agreements, and that they should develop and distribute educational materials and raise awareness through trade union newsletters and discussions in meetings.

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male, the whole trade union movement is not yet fully at ease with the subject and much yet remains to be done, to raise the awareness of trade union members themselves and to strengthen the attempts of women members to publicize these issues.

In some countries and regions failure to take the issue seriously is more marked. ‘To date unions in Africa have not taken the seriousness of sexual harassment sufficiently into their programmes as an issue which their members are faced with’ (Caines 1992). Moreover only a small proportion of women workers in the African region have opportunities for union membership but this number is likely to grow as women's work based organizations are strengthened to unionize. Furthermore current moves for an increase in the components of workers' education syllabuses on reproductive health and sexual protection issues are clearly strategically important.

As ILO reports have noted, unions themselves have to decide whether they are ready to practise sexual equality and share power and positions between women and men and whether they will tackle issues such as sexual harassment in their negotiations. In this regard information and education will be critical, as will organization of union meetings to ensure active female participation and leadership, as well as education and sensitization of male members.

Ironically sexual harassment is one of the very factors noted as preventing women from fully participating in trade union activities in some countries. At a seminar on workers’ education for women members of rural workers' organizations, organized by the International Federation of Plantation, Agricultural and Allied Workers in Harare in 1992, participants identified five major obstacles to women's full participation in trade union activities. Among them was sexual harassment; the others were lack of education, women's multiple conflicting role responsibilities, their lack of self-confidence and discrimination against women because of cultural and societal attitudes. Given the salience of gender issues as obstacles to equality in trade unions the ILO has been active in providing assistance in this regard, as in the project RAF/88/M09/NOR — Workers' education for women members of rural workers' organizations in Ghana, Uganda and Zimbabwe. There are, however, indications that through lack of awareness only a few unions take the matter very seriously. The problem is still widely considered to be a personal problem and not a general labour issue. This situation is supported by the unwillingness of victims to file formal complaints even with their own unions. Some unions, while including sexual harassment in the list of women workers’ problems, keep no records and take little action; however an increasing number of unions are beginning to include it on the list of women workers’ problems. The Malaysian Trade Union Congress has promoted the collection and dissemination of data and has published a guidebook on sexual harassment at the workplace which provides guidance for both employers and employees. This was part of a women's section campaign for legislation on sexual harassment; it has stepped up its campaign to create awareness. Victims will need to identify sexual harassment as a violation of their rights as workers and to know what personal and legal action they can take to have the support of social opinion for their actions.

Recognition of the close links between speed and directions of spread of HIV/AIDS and the prevalence of sexual harassment in schools and workplaces is likely to increase the urgency of research and action in this sphere in the near future.

The ILO Meeting of Experts on Special Protective Measures for Women and Equality of Opportunity and Treatment concluded in 1989 that sexual harassment is a safety and health problem and this element is beginning to surface in the deliberations of concerned women's organizations. Studies have generally underlined the fact that these are real problems for a considerable number of women workers. So far results of those studies which have been disseminated in the media have stimulated political and legal debate on how to proceed. They have also in many cases paved the way for action (see ILO 1992: 286-289).
Poverty and prostitution

Statistics are lacking but observers have called attention to indications that multiple-partner situations involving various forms of sexual patron-client relationships appear to be increasing as a result of the economic crisis (e.g. Schoepf et al. 1991, on Zaire). Harsh economic conditions have also forced into long-distance trading women who are not customarily involved in such activities. Women traders, especially itinerant traders, are often perceived as promiscuous and with their sexual behaviour beyond male control. A study of sexual relations of market women in Benin City Bendel State Nigeria indicated that the majority had been involved in non-marital sexual relationships, some of this with strangers, and accordingly a high proportion had been susceptible to STDs (Omorodion, 1993). Traders may use sexual strategies to economic advantage (Schoepf et al. 1991.). Regular relationships with officials may facilitate transactions and casual sex can help meet travel and trading expenses.

Faltering economies, widespread unemployment and lack of conjugal and kin support, as well as the kind of ‘development’ policies which cause migration are recognized as linked to the expansion of prostitution and have turned growing numbers of girls and women to temporary and casual sale of sexual services, as the only means they know of surviving in the city (Ulin 1992), with consequent effects on the spread of STDs (Cara’l 1993). This is happening at a time when there has been a cutback in the very medical services needed to stem the tide of sexually transmitted disease (Caldwell and Caldwell 1993).

As yet there are not enough reliable data from which to estimate how many people are involved or how great is their risk, though the literature on prostitution and HIV/AIDS in the region is growing apace. Indeed various data suggest that relationships with prostitutes play a significant role in the spread of STDs and HIV/AIDS in urban and rural areas, and a third to a half or more of prostitutes are judged to be infected with a sexually transmitted disease at any time, with their customers infecting both other prostitutes and their other sexual partners including wives.

Commercial sex has already figured prominently in HIV/AIDS studies, since while there is apparently little evidence to date of its relevance in industrialized countries to speed of spread, in Africa and parts of Asia prostitutes and their customers were among the first groups to experience high levels of HIV infection and are considered to have fuelled the early stages of national epidemics. However, information bases are sex-biased, with the bulk of information from prostitutes and not their clients (Cleland and Way 1994). Only a few studies have examined the multiple relationships obtaining with clients, employers, family members etc. (e.g. Podhista et al. 1994 on Thailand).

Important findings of such studies and highly pertinent to future research and action programs are the facts that prostitutes constitute a very heterogeneous category of workers and that there are marked variations in their behaviour and clientele in different country contexts and sub-regions. Moreover in a number of cases and especially in the African region there is considerable fluidity of sexual and occupational identities (Cleland and Way 1994). Many women selling sexual services do not consider themselves as prostitutes, nor are such sales necessarily their main form of employment or source of sustenance. Life cycle periods of commoditization of sexual services may be interspersed with marriage or may be mixed on a daily and nightly basis.

For many poor women it is not a profession sought after but simply a temporary or longer term survival strategy resorted to when other strategies fail (Schoepf et al. 1991). It may be a strategy temporarily adopted at certain life stages in between more stable conjugal relationships ( e.g. Pittin 1983 on Northern Nigeria; Dinan 1983 on Accra in the eighties). Accordingly the form taken by relationships categorized as prostitution varies considerably,
not only by class but by culture. The sexual exchanges which are given this label include a wide variety of relationships and levels of living (Pickering and Wilkins, 1993).

Women in this category of self employment full time are typically highly mobile, seldom practising their trade in their home areas. Many are married or formerly married and ply the trade for financial reasons, including child support, a responsibility increasingly left to mothers (Chikwem et al. 1988; Onyango et al. 1993). Indeed some reports show that the majority of prostitutes have high burdens of family dependency, whether from parents or children, and few if any other sources of security or income. A study in a Kenyan clinic showed that 70 per cent of the women had three or more dependents and but no access to resources or home other than rented accommodation. The majority depend upon prostitution as their only source of income. The majority were young and most of their clients were truck drivers. They had no access to land and little education. The conclusion of those carrying out the study was that ‘they therefore are bound to engage continuously in unrestricted sexual behaviour with unattached men such as truck drivers unless provided with economic power’ (Gathigi et al. 1993).

Prostitutes often return home to their place of birth with the intention of marrying and settling down: this return migration is itself a serious and significant factor in the heightened spread of HIV infections. This pattern of cyclical migration and infection of rural areas is by now well documented in a number of regions, as caused by both internal and international migrant workers; see Anarfi (1993) on the Akan and Krobo of Southern Ghana and Dada et al. (1993) on high-class Lagos callgirls with an international clientele.

Ghana provides an example of a country in which at first the majority of diagnosed cases were female migrants returning from neighbouring African countries who were believed to be involved in the sex trade (Anarfi, 1990). These women have come predominantly from two ethnic groups in which women are noted for their relative autonomy, mobility and materialism (see Anarfi 1990; Awusabo-Asare et al. 1993).

Approaches to the phenomenon of trade in sexual services frequently neglect the possible macro socio-economic and political factors involved. These include the existence of criminal syndicates trafficking in women. They include the fact that rapid socio-economic and political transformations are taking place which are greatly influenced by macro-economic policies, by international trade flows, by consequent pauperization of whole communities and the presence of large military bases, and tourist industries, creating demands for sexual trade.

**Violence and coercion**

International and regional attention has recently turned more and more to instances of violence against women by men. Recently the UN Commission on Human Rights has appointed a special rapporteur to look into what is described as ‘the alarming situation of violence against women throughout the world’, including its causes and consequences. The violence examined includes violence in the workplace, sexual assault and harassment, and commercialized violence such as trafficking in women, prostitution, labour exploitation and pornography. Violence was firmly placed on the international agenda in December 1993 when the General Assembly adopted resolution 48/104 in which it proclaimed the Declaration on the Elimination of Violence against Women. Cross cultural analyses have demonstrated that economic inequality is a key factor associated with violence.

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9 Two decades ago a study in Mombasa indicated that they came from 40 different ethnic groups including seven countries of West Africa and 40 per cent had lived in the city for less than a year. See Verhaeghen and Gemert 1972.
The spread of sexually transmitted disease and death through sexual coercion and rape has recently surfaced as a matter of serious concern in the African region, especially in the south. In South Africa the incidence of rape is one of the highest in the world. The incidence and prevalence in the whole region has yet to be systematically documented and examined but the AIDS epidemic is urging in this direction. Dr. Eka Esu-Williams, the Nigeria-based General Secretary of the Society of Women and AIDS in Africa (SWAA), has noted that if there were data to show rape is an important route of HIV transmission then some headway could be made to challenge this serious abuse of human rights (World AIDS 1992:2).

Comparative global studies of male violence against women have demonstrated that it is a pervasive and prevalent problem worldwide, touching all aspects of women's lives including their places of work (e.g. Schuler, 1992). The study of this phenomenon on any meaningful scale is recent and expanding rapidly. The debates arising have helped to put the matter onto international and national agendas. There is comparative evidence to suggest that women are most vulnerable to violent actions from men when they are dependent on them and have no alternative options for survival. Important factors diminishing expressions of violence are greater relative autonomy and equality of women and men, and techniques to deal with aggressive feelings as well as mutual respect. Schuler (1992:17) cites a comparative ethnographic analysis by Levinson (1989) which indicates that female economic inequality appears to be the strongest factor linked to wife abuse in the home in addition to male domestic control and female inability to divorce.

Women are most vulnerable to violence and coercion in times of civil strife. Massive dislocations of people from their normal lives in wars, which have been continual in a number of countries, have been clearly associated with the speed of spread of disease. Evidence of this comes from East, West and Southern Africa and indicates many practical, epidemiological and ethical problems (WorldAIDS 1992:5). AIDS is already reputed to have seriously affected some armies in the region and many civilians view soldiers as prime agents of spread of the disease, whether by coercion or through the commercial sex which is typically provided near their camps (see Cliff and Smallman 1991). The plight of women refugees has been poignantly highlighted; they are vulnerable to a variety of traumas affecting their health, including rape (Martin, 1991).

Adolescent girls are especially at risk of sexual coercion as well as economic pressures and seduction by males old enough to be their fathers. Evidence comes from several countries (e.g. Lema 1990 on Kenya). This evidence has led UNICEF to focus special attention and resources on the protection of the youth, especially adolescent girls, as for example in Uganda’s Safeguard Youth from AIDS program aimed specially at girls.

In spite of these issues systematic evidence of sexual coercion is scarce, but in some countries evidence is beginning to accumulate because of the added fear regarding potential mortality.

Research on sex and gender: developing advocacy tools and spurs to action

Scholars prolific in the field admit that a great deal is being written on HIV transmission and sex but that much of it is based on the continuous circulation of a small number of research findings (Caldwell et al. 1993). The seriousness of the issues involved and their effects, actual and potential, make it urgently necessary to design and promote social science research which can meet the demand and provide evidence and insights on which to design appropriate strategies to respond to the crisis.

In designing advocacy tools to change behaviour in order to promote reproductive health and protect human development, it is absolutely necessary to understand the cultural, social, economic, and political as well as biological and demographic factors shaping gender roles
and sexual behaviour. In some instances it may be hypothesized that female dependence and subordination are crucial factors in the spread of AIDS. In other cases it may be female autonomy, mobility and sexual freedom which are associated with their vulnerability. We need to know what makes human behaviour high-risk in different contexts, or what puts individuals in high-risk situations and how these risk factors can be overcome. More attention needs to be paid to the changing roles of women and men in labour markets (and the family), which are leading to the increasing vulnerability of girls and women and their dependence together with their children on insecure, precarious and inadequate sources of support and incomes.

Researchers have already emphasized the need for studies of sexual behaviour to be carried out within the context of social institutions and other forms of behaviour. They have also stressed the need for a broad definition of risk behaviour and sensitive gender considerations and emphasized the urgent need for alternative methods of research (Cara’l et al. 1994). The value of ethnographic studies through participant observation of beliefs, concepts, sexual practices and power relations has already been well demonstrated in a number of locations (e.g. Orubuloye in Ekiti; Oostvogels and Karanade in Bombay).

With regard to sexual harassment and coercion in places of work and training, the Report of the ILO Committee of Experts on Equality in Employment and Occupations noted the difficulties involved in getting information. It stressed the need to carry out surveys which, while very unpleasant, in view of the kinds of information they reveal, yet are necessary to achieve adequate recognition of the existence of the phenomenon, for they will play an important part in the elimination of the problem.

Effort is also needed to develop more scientific research and theory on sexual harassment, to design and develop practical research tools which can be used to identify where, against whom and in what circumstances it is most likely to occur, who are the victims in greatest need of protection, who benefits from it and how, and the human and economic costs. Such studies would help to raise public consciousness. They would help to convince those government policy makers, law makers, employers and unionists who require it, that it is worth formulating real strategies for its prevention. They would help programs to aim protective measures at those most in need; diagnostic tools could be designed to speed analysis of the extent of vulnerability and so to underline the need for protection.

Reid (1992) has argued persuasively and with good evidence that gender biases have pervaded much of the research and program agendas hitherto. Yet since much of the research on HIV impinges on the culturally prescribed roles of females and males and the gender issues — biases, inequalities— involved, it needs to be always in touch with the lives of women as well as men. A striking feature of the responses to the epidemic to date is how few of the policies and programs developed have really taken into account the women's true-life situations (Reid 1992). This has been called a failure of epistemic responsibility, which is a moral imperative, since knowledge of women's experience is especially essential to effective HIV-related research and policy development. Women's sexual relations put them at risk but strategies proposed give them little or no protection: educational messages stressing reduction of numbers of partners, use of condoms and treatment of STDs are designed with males in mind and are inadequate to protect women who mainly only have one partner; if they have more it is frequently through economic pressure or coercion, not necessarily desire.

Woman's faithfulness does not protect her as it has been estimated that half to 80 per cent of infected women in Africa have no other sexual partner than their husband. Moreover women's relative lack of power or alternative sources of social and economic support means they have little ability to negotiate safer sex or abstinence. Cross-cultural studies of sexual relations and the commoditization of services have demonstrated clearly that sexual identities, roles and behaviour are changeable and quite diverse. So it is necessary to
understand local sexual culture to ensure that prevention programs are relevant and practicable (Gillies and Parker 1994).

In this chapter the focus has been on gender issues, concerning inequalities between females and males in access to resources and opportunities, and the consequent vulnerability of the female. The special topics for consideration have included the effects of impoverishment and family dispersal upon the security of females as trainees or workers and the pervasive pressures towards increasing commoditization of both labour and sexual relationships, as opportunities for exploitation increase.

High-risk behaviour may be preceded by poverty, extensive labour migration and consequent dispersal of families, sexual inequality, male dominance, female dependence and regional military instability; if so, then health or population strategies which ignore these factors are not likely to be successful. Efforts to promote individual behaviour change are likely to founder if the broader socio-economic and political issues are not addressed (e.g. Bassett 1993).

As scholars addressing the AIDS crisis for women in the continent have already emphasized, dealing with health issues will not be enough (Ankrah 1991). Strategies will also have to be developed at the national, community and individual level to reverse the deteriorating socio-economic conditions of women’s lives. National policies are needed which will help to stem the floods of labour migration, as rural impoverishment affects increasing millions of families. Community and work-place based institutions, laws and effective sanctions are required which will provide adequate sexual protection for individual girls and women attending schools, or working in markets, plantations and factories.

Girls and women need equal access to education, training in entrepreneurial opportunities, skills and employment, so that if married their conjugal relationships may be more egalitarian. If they are not married they will not depend upon sexual relationships for access to needed resources (see du Guerny and Sjoberg 1992).

Family Planning services must take on the wider implications of sexual and reproductive health promotion. Family Planning programs can provide the appropriate contexts for the prevention activities required to stop HIV transmission. These include STD prevention and control programs, condom promotion and IEC programs directed at changing behaviour which facilitates HIV transmission. Many FP programs are accepting such changes with undoubted benefits for both female and male clients. It will be important to find out what elements can be realistically integrated within programs of varying organizational capacity without compromising their effectiveness (Pachauri 1994).

A major challenge already identified is that of sustaining the impact of modest pilot projects, as demand for services and inputs escalates rapidly although available resources are often static or declining. The real problem is one of replicability of successful initiatives to larger and larger groups of people (Mann et al. 1992:4).

Given the facts that poverty and coercion are seriously implicated in risky behaviour patterns these factors need to be taken into account in any programs promoted to counteract them. For school girls Family Life Education alone is not likely to be sufficient. In view of the many charges of sexual impropriety directed at male teachers, schoolgirls need sexual protection as well as Family Life Education in places of education and training. Indeed greater, more active recognition is necessary of the economic and sexual vulnerability of adolescent girls (See African Rights 1994 and Yeboah 1993).

Accordingly regarding policies and programs a clear message of much of the evidence is that ‘central to the battle against AIDS is the need to empower women’ (Caldwell et al. 1993: 11; see also WHO 1992). This will involve in many cases changing dramatically the nature of relationships between women and men inside and outside the family, in places of work and schooling and the community.
References


A high price to pay: for education, subsistence or a place in the job market


Sexual networking among youth in southwestern Nigeria

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Freud's discussion of infantile sexuality triggered considerable interest in sexual attitudes of boys and girls, particularly those at the age of adolescence. Prominent in the development of knowledge of sexual behaviour and in the attempt to make sexuality a scholarly topic for academic and public discussion are the works of Kinsey (Kinsey, Pomeroy and Martin 1948, 1953). Before Kinsey's research, sexuality was an indecent subject that should be discussed only in private. There is today, however, marked concentration of research efforts on sexuality, made from different perspectives.

In Nigeria, such attempts are not lacking, not even in the southwestern part where the present study was conducted. For example, Orubuloye, Caldwell and Caldwell's (1992a) study designed to examine the status of sexual networking and risk of AIDS in Southwestern Nigeria focused on the general population, particularly the adult group. Oyeneye and Kawonise's (1993) exploratory study of sexual networking in Ijebu-Ode followed the same pattern. Much earlier, studies investigating the sexual behaviour of adolescent students were carried out in the part of Nigeria presently designated as Osun State (for example Esen 1974; Owuamanam 1982; Owuamanam and Olofinsao 1988). These earlier student population researches were conducted from psychological, sex education and human developmental perspectives. The studies took off from the psychological conception that adolescence is a period of intense sexual drive, sexual experimentation and exploration. The sexual behaviour of that period of development was considered to need investigation because it would be false to think that a group so endowed biologically could be insulated from the sexual explosion of the present time. Institution-based adolescents, particularly those in the formal school system, were thought to be particularly predisposed to involvement in sexual activities because of some changes that have taken place in the Nigerian educational system since the civil war. These changes include rapid secularization of schools and removal of religious instruction from the school curriculum; greater emphasis on the co-educational system and gradual phasing out of the boarding system in high school (Owuamanam 1982).

These studies paying special attention to the reproductive and educational implications of school adolescent sexuality paid little attention to the disease transmission implications of sexual networking. For example, contraceptive behaviour was examined in the context of preventing unwanted pregnancies and not in the context of preventing STD transmission. Today things have changed. HIV/AIDS is here with us and while its forerunner STDs, notably gonorrhoea and syphilis, could be taken for granted by the average 'socialized', 'informed' and 'enlightened' school adolescent male, AIDS comes with a different story of consequence. This calls for a reorientation of research direction. A step in the direction of examining the sexual networking of school adolescents as a risk behaviour has been taken by Oloko and Omoboloye (1993) in Lagos State.

A study of the student group, most of whose members are unmarried, is in effect an investigation of premarital sexuality, an issue that has considerable cultural importance in
Nigeria. Premarital sexual experimentation was culturally prohibited in most Nigerian societies although the sanctions had always been less for the males than the females. Adults supervised the sexual lives of their young ones until they married. The result of the cultural sanctions and codes against premarital sex was that the sexual urge of the young was not given opportunity for expression.

Today, the cultural regulations regarding premarital sex are no longer adhered to; the ideal virginal marriage or virginity at marriage no longer exists. Renne (1993) has observed that not only is virginity at marriage no longer perceived as socially desirable in southwestern Nigeria but it is now perceived as 'socially backward', 'antisocial' or even associated with infertility-related diseases such as gonorrhoea and 'epilepsy'. The purpose of the present study was to investigate the sexual networking and contraceptive behaviour of students in southwestern Nigeria, with a view to determining specifically the extent of high-risk behaviour of the subjects in terms of STD and AIDS/HIV transmission; the students' behaviour patterns aimed at preventing STD and AIDS transmission; and the students' degree of awareness of, as well as their attitudes, towards AIDS.

**Method**

**Sample**

The subjects were 593 students in secondary and higher institutions in Ekiti, Ondo State. Of these, 344 were female and 249 were male. Most of the subjects (544) were drawn from institutions located in the urban area. The disproportion is justified as the area is known to be highly urbanized and most institutions have their location in the urban centres. Orubuloye et al. (1990) have in fact stated that by African standards Ekiti is highly urbanized. More importantly, even though 49 of the subjects attended schools located in the rural area, they indicated that in the past ten years they had lived in urban or city centres. This means that it is difficult to get a truly rural sample from educational institutions in the study area.

There were 171 of the students in the secondary school, and 422 in higher institutions, the University, the Polytechnic and the College of Education. The subjects were mainly Yoruba-speaking; only 34 of them were not. Seven of them were married. In terms of religion, 70 of the subjects were Muslims, 496 Christians, two had traditional religious beliefs and one professed no religion. The age range was 14-35 years. Though 61.8 per cent of the rural subjects and 45.4 per cent of the urban subjects come from polygamous homes, the seven married subjects themselves were monogamous.

**Procedure**

The research instrument was the student population version of the Sexual Behaviour, STD and AIDS/HIV Transmission Questionnaire designed for use by the Nigerian Programme.

The questionnaire is an interview guide consisting of 33 open-ended items designed to obtain data on sexual behaviour, family type and structure, contraceptive behaviour and STD and AIDS/HIV transmission.

Data were collected through personal interviews conducted by the author and five other trained interviewers. Though the interview was conducted in English, the interviewers were trained to be clearly conversant with local concepts so as to be able to provide explanations and answer questions where necessary. In every case effort was made to establish rapport with the subject and to assure him or her of confidentiality in the treatment and use of the information obtained.
Results

Age at first sexual experience

As pointed out earlier, this study involves essentially an investigation of premarital sexual behaviour since most of the subjects were unmarried. Of the rural subjects (N=49), 34.7 per cent had had their first sexual experience before 20 years of age. The remaining 65.3 per cent had not had any sexual experience. Of the urban females only 18.4 per cent had never had sexual experience. Of the 81.6 per cent that had had their first sexual experience 0.3 per cent did so at the age of ten years. The modal age of first sexual experience was 20 years at which 14.6 per cent had their first sexual experience. Other age groups of first experience involving a comparatively high percentage of subjects were 17 years (11.9%), 18 years (13.2%), and 19 years (11.9%). The data for the male subjects indicate that 4.4 per cent had never had sexual experience, while 10.6 per cent said they had had their first sexual experience by the age of six years (Table 1).

Table 1
Age at first sexual experience

<table>
<thead>
<tr>
<th>Age in years</th>
<th>Urban Male</th>
<th>Urban Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Below 10</td>
<td>23</td>
<td>9.3</td>
</tr>
<tr>
<td>10</td>
<td>6</td>
<td>2.4</td>
</tr>
<tr>
<td>11</td>
<td>12</td>
<td>4.9</td>
</tr>
<tr>
<td>12</td>
<td>20</td>
<td>8.1</td>
</tr>
<tr>
<td>13</td>
<td>18</td>
<td>7.3</td>
</tr>
<tr>
<td>14</td>
<td>28</td>
<td>11.3</td>
</tr>
<tr>
<td>15</td>
<td>31</td>
<td>12.6</td>
</tr>
<tr>
<td>16</td>
<td>31</td>
<td>12.6</td>
</tr>
<tr>
<td>17</td>
<td>23</td>
<td>9.3</td>
</tr>
<tr>
<td>18</td>
<td>20</td>
<td>8.1</td>
</tr>
<tr>
<td>19</td>
<td>10</td>
<td>4.0</td>
</tr>
<tr>
<td>20</td>
<td>11</td>
<td>4.5</td>
</tr>
<tr>
<td>21</td>
<td>1</td>
<td>0.4</td>
</tr>
<tr>
<td>22</td>
<td>1</td>
<td>0.4</td>
</tr>
<tr>
<td>23</td>
<td>1</td>
<td>0.4</td>
</tr>
<tr>
<td>24</td>
<td>1</td>
<td>0.4</td>
</tr>
<tr>
<td>25</td>
<td>1</td>
<td>0.4</td>
</tr>
<tr>
<td>Never</td>
<td>11</td>
<td>4.0</td>
</tr>
</tbody>
</table>

The modal age was 16 years with 12.9 per cent having their first sexual experience at that age. Eleven per cent of the subjects had their first sexual experience at an average age of 15 years.

It is important to note the differentials in the percentage of rural versus urban and male versus female teenage students' sexual relations, as well as the age differential at first sexual experience of the various subgroups of subjects. While virtually all Nigerian societies are becoming less restrictive than in the past towards premarital sexual relations, there is greater permissiveness to boys than to girls. Up to a certain age, girls have still remained supervised until parents could be sure that the children knew what to do to avoid getting into trouble for example through unwanted pregnancies. The problem of unwanted pregnancy is not
considered seriously adverse to the boys' future, not even to the possibility of securing another woman for marriage. The boy therefore is left alone with minimum supervision of his sexual life. The age of four years for the first sexual experience observed in some males in this study should attract attention since this age is far below pubertal age. Sexual play or sexual rehearsal (sexual acts of immature children) has been discussed as an important phenomenon in the sexual behaviour of African children (Allgeier and Lexington 1991). The behaviour could have important implications for STD and AIDS/HIV transmission since the AIDS virus is known to be present even at the foetal period. This means that sexual networking of immature children could be a means of transmission of congenital AIDS/HIV.

**Sexual partners**

The question of whom the first sexual act is with is an important one. Two (0.8%) of the married males had their first experience with their wives, 73.9 per cent with girl-friends, and 21.3 per cent had their first experience with other people including relatives. As regards the female subjects, 74.9 per cent of urban and 24.5 per cent of rural girls had their first experience with boy-friends while 5.4 per cent of urban and 6.1 per cent of rural girls had it with others including relatives. Only one per cent had the relationship with men-friends. The high percentage of both sexes who had their first sexual experience with girl- or boy-friends points to the gradual demise of the old tradition of parents' strict supervision of the sexual lives of their daughters to ensure that they remained virgins till the time of marriage. In the old tradition whereby girl-friends were not available for sex because of the need to preserve their virginity, unmarried boys would rely mostly on commercial sex workers for sexual gratification. This supports the finding of an earlier study (Orubuloye, Caldwell and Caldwell 1992b) that only two per cent of the subjects' first sexual experience involved commercial sex. The authors observed that the practice of chaperoning girls to maintain their virginity till marriage, causing young men to gain their first experience with prostitutes, is no longer a common pattern among the Yoruba. Although the exact percentage of those involved in sexual relations with relatives was not isolated, some young men reported that their first sexual relations involved relatives — an older brother's wife or father's younger wife — a form of relationship described by Orubuloye et al. (1992a:219) as common in the traditional marriage system in Southwestern Nigeria.

**Table 2**

<table>
<thead>
<tr>
<th>Partner</th>
<th>Urban Male</th>
<th>Rural</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Wife/husband</td>
<td>2</td>
<td>0.8</td>
</tr>
<tr>
<td>Boy/girl-friend</td>
<td>184</td>
<td>73.9</td>
</tr>
<tr>
<td>Man/woman-friend</td>
<td>3</td>
<td>1.0</td>
</tr>
<tr>
<td>Others/relatives</td>
<td>53</td>
<td>21.3</td>
</tr>
<tr>
<td>Not Applicable (No partner)</td>
<td>10</td>
<td>4.0</td>
</tr>
</tbody>
</table>

The most common situation which brought partners together for sexual contact was love and affection: 40.3 per cent for female urban respondents, 48.2 per cent for male urban and 22.4 per cent for rural respondents. This is a further indication of less involvement of commercial sex in the initial sexual experience of youth. Playing together was the least accountable for the act in all groups. As would be expected in premarital sex, enjoyment, fun

*Supplement to Health Transition Review Volume 5, 1995*
and curiosity served as a major motivation for sexual relations among both male and female youth (Table 3). Only two per cent of the female sample indicated that economic or material reward motivated them to engage in sex. That economic or material reward is not an important factor in the respondents' sexual relations is further substantiated by the fact that the majority of the respondents' partners were students, a group that is not sufficiently economically strong to buy sex.

Table 3  
Circumstances for first sexual relations

<table>
<thead>
<tr>
<th>Circumstances</th>
<th>Urban Male N</th>
<th>Urban Male %</th>
<th>Urban Female N</th>
<th>Urban Female %</th>
<th>Rural N</th>
<th>Rural %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Playing together</td>
<td>76</td>
<td>30.8</td>
<td>4</td>
<td>1.4</td>
<td>1</td>
<td>2.0</td>
</tr>
<tr>
<td>Affection/love</td>
<td>120</td>
<td>48.2</td>
<td>119</td>
<td>40.3</td>
<td>11</td>
<td>22.4</td>
</tr>
<tr>
<td>Party/celebration</td>
<td>24</td>
<td>9.6</td>
<td>1</td>
<td>0.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Persuasion</td>
<td>16</td>
<td>6.4</td>
<td>87</td>
<td>29.5</td>
<td>4</td>
<td>8.2</td>
</tr>
<tr>
<td>Forced/rape/lured</td>
<td>1</td>
<td>0.4</td>
<td>25</td>
<td>8.5</td>
<td>3</td>
<td>6.1</td>
</tr>
<tr>
<td>Not Applicable/No</td>
<td>12</td>
<td>4.8</td>
<td>59</td>
<td>20.0</td>
<td>30</td>
<td>61.7</td>
</tr>
</tbody>
</table>

Although most of the respondents maintain only one sexual partner now (66.4% for female urban, 33.7% for male urban and 26.5% for rural youth), a certain percentage (1.4%) of female urban subjects have as many as four sexual partners while one male urban respondent indicated having as many as 23. In general the number of sexual partners for urban males ranges between one and ten (Table 5).

Table 4  
Reasons for first sexual relations

<table>
<thead>
<tr>
<th>Reason</th>
<th>Urban Male N</th>
<th>Urban Male %</th>
<th>Urban Female N</th>
<th>Urban Female %</th>
<th>Rural N</th>
<th>Rural %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting marital life</td>
<td>5</td>
<td>2.0</td>
<td>1</td>
<td>2.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Curiosity</td>
<td>99</td>
<td>39.8</td>
<td>33</td>
<td>11.2</td>
<td>2</td>
<td>4.1</td>
</tr>
<tr>
<td>Test of potency</td>
<td>14</td>
<td>5.6</td>
<td>4</td>
<td>1.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enjoyment/fun</td>
<td>161</td>
<td>54.6</td>
<td>2</td>
<td>4.1</td>
<td>1</td>
<td>22.4</td>
</tr>
<tr>
<td>Economic reward</td>
<td>6</td>
<td>2.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td>17</td>
<td>6.8</td>
<td>25</td>
<td>8.5</td>
<td>11</td>
<td>22.4</td>
</tr>
<tr>
<td>Not Applicable/No</td>
<td>9</td>
<td>3.6</td>
<td>63</td>
<td>21.3</td>
<td>33</td>
<td>67.3</td>
</tr>
</tbody>
</table>

Although most of the respondents maintain only one sexual partner now (66.4% for female urban, 33.7% for male urban and 26.5% for rural youth), a certain percentage (1.4%) of female urban subjects have as many as four sexual partners while one male urban respondent indicated having as many as 23. In general the number of sexual partners for urban males ranges between one and ten (Table 5).
Table 5
Number of sexual partners

<table>
<thead>
<tr>
<th>Number</th>
<th>Urban Male</th>
<th></th>
<th>Urban Female</th>
<th></th>
<th>Rural</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>0</td>
<td>-</td>
<td>-</td>
<td>12</td>
<td>0.7</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>84</td>
<td>33.7</td>
<td>196</td>
<td>36.9</td>
<td>13</td>
</tr>
<tr>
<td>2</td>
<td>69</td>
<td>27.7</td>
<td>35</td>
<td>24.4</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>29</td>
<td>11.6</td>
<td>7</td>
<td>12.3</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>16</td>
<td>6.4</td>
<td>4</td>
<td>6.1</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>13</td>
<td>5.2</td>
<td>-</td>
<td>2.7</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>4</td>
<td>1.6</td>
<td>-</td>
<td>2.4</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>0.7</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>4</td>
<td>1.6</td>
<td>-</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>1</td>
<td>0.4</td>
<td>-</td>
<td>0.7</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>3</td>
<td>1.2</td>
<td>-</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td>More than 10</td>
<td>2</td>
<td>0.8</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Not Applicable/No Response</td>
<td>24</td>
<td>9.6</td>
<td>41</td>
<td>13.9</td>
<td>36</td>
</tr>
</tbody>
</table>

The high percentage of subjects having multiple partners warns of a potential hazard for STD and AIDS/HIV transmission in students particularly in the urban area. The data are more revealing when examined in terms of the number of sexual partners in life. While three of the female urban subjects recorded an average of 14 partners in life, the data contain numbers of total life partners as high as 82 for one male urban respondent. The highest percentage of respondents having multiple partners was 16.9 per cent involving 18 partners since the first sexual experience. That notwithstanding, quite a good percentage of the respondents have maintained one sexual partner since their first sexual experience, while there is a tendency to reduce the number of sexual partners with age. There is a high differential between the percentage of respondents who have maintained one sexual partner since their first sexual experience, while there is a tendency to reduce the number of sexual partners with age. There is a high differential between the percentage of respondents who have maintained one sexual partner throughout life and those who now have one partner. The differentials in the number of sexual partners now and in life and between male and female subjects are a reflection of a polygamous tendency among males in particular, in the society.

There is a possibility of exaggeration in the number of sexual partners reported by male subjects as noted in the case of one respondent who reported having had 82 partners in life. For instance, Pickering (1988), has observed that young single men exaggerate the number of their sexual partners to gain social prestige.

Generally female respondents had older sexual partners than the males. The largest percentage of male respondents reported having sexual partners whose ages range between 16 and 21 years, while those of female respondents range between 19 and 27 years. Premarital sex is one area in which men feel shy about approaching older women for sex, while older women have a sense of loss of respect to be associated in sexual relations with younger persons. The phenomenon of 'sugar mummy' in premarital sexual relations is however known to be common in Nigerian cities. A 'sugar mummy' relationship is a sexual relationship between an older woman and a much younger man.

Of very serious consideration in STD and AIDS/HIV transmission is the degree of sexual involvement with strangers; 27.7 per cent of urban males and 6.4 per cent of urban female subjects have had sex with strangers.
Table 6
Number of sexual partners had in life

<table>
<thead>
<tr>
<th>Partners</th>
<th>Urban Male</th>
<th></th>
<th>Urban Female</th>
<th></th>
<th>Rural</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>1</td>
<td>28</td>
<td>11.2</td>
<td>109</td>
<td>36.9</td>
<td>9</td>
</tr>
<tr>
<td>2</td>
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No Partner/No Response

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<tr>
<th>N</th>
<th>%</th>
<th>N</th>
<th>%</th>
<th>N</th>
<th>%</th>
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<tbody>
<tr>
<td>11</td>
<td>4.4</td>
<td>33</td>
<td>11.1</td>
<td>37</td>
<td>76.5</td>
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</tbody>
</table>

Note: ③Does not total 100% as there were also the following numbers given once (0.4%): 17, 18, 20, 23, 24, 27, 29, 33, 34, 36, 38, 45, 68 and three men (1.2%) gave a number of 19.

Sexual behaviour and contraceptive use

Recently contraceptives have become important in sexual relationships in Nigeria and are given prominence in media programs. Contraceptives are supplied at heavily subsidized rates in family planning clinics in virtually all hospitals. However the efforts are directed mainly to prevention of unwanted pregnancies. Contraceptive programs should include attempts to reduce the risk of STD and AIDS/HIV transmission. The contraceptive behaviour most reliable against STD and AIDS/HIV transmission is probably the use of condoms which has been accepted as capable of giving good protection against STDs and AIDS/HIV transmission.

Of the male urban subjects, 51.4 per cent have used some form of contraception. About the same proportion (52.5%) of female subjects have used contraception. However, pills formed a major part of contraceptive use. Only 3.6 per cent of male urban and 28.1 per cent of female urban respondents indicated that the condom was used by them. Only two per cent of the rural subjects have ever used the condom. The major reason for the use of the condom
was to prevent pregnancy. Relatively low proportions of the respondents used the condom to avoid infection. This could be attributed to the fact that a high percentage of the respondents as reported in this paper have kept their sexual relations to a single partner. When sexual contact is restricted to one partner and there is confidence that the partner does not have another partner, then the individual may not bother to use condoms for the purpose of preventing infection. A possible danger is the multiplier effect of sexual contact. If the partner has a sexual partner other than the respondent, then the respondent is indirectly relating sexually with more than one person.

For all groups, the suggestion to use condoms came most from self (respondent), followed by the partner. Medical personnel ranked lower than expected in the list of those who provided advice for condom use.

### Table 7
Sources of condom supply

<table>
<thead>
<tr>
<th>Source</th>
<th>Urban Male</th>
<th>Urban Female</th>
<th>Rural</th>
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<tbody>
<tr>
<td>N %</td>
<td>N %</td>
<td>N %</td>
<td></td>
</tr>
<tr>
<td>Chemist/supermarket</td>
<td>103 41.4</td>
<td>100 33.9</td>
<td>1 2.0</td>
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<tr>
<td>Private family planning</td>
<td>5 2.0</td>
<td>23 7.8</td>
<td></td>
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<tr>
<td>Government hospital</td>
<td>5 2.0</td>
<td>7 2.4</td>
<td></td>
</tr>
<tr>
<td>School</td>
<td>6 2.4</td>
<td>4 1.4</td>
<td></td>
</tr>
<tr>
<td>Not Applicable/No Response</td>
<td>130 52.2</td>
<td>161 54.5</td>
<td>48 98.0</td>
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</table>

In spite of the wide media publicity given in Nigeria to the use of the condom as a preventive measure against STD and AIDS/HIV, the emphasis on condom use in health clinics is still on contraception. The family planning services provided in clinics are not convenient for people who wish to keep their sexual dealings secret; clients have to register and have case files opened for them. In most cases, a separate consulting room is reserved and a particular day of the week is used for family planning consultation. Thus the confidentiality of the treatment cannot be guaranteed as everybody knows when and why a client is in the clinic. This explains why hospitals ranked low as sources of condoms for the use of respondents. Private family planning clinics were more popularly used than government hospitals but the most common sources of condoms were chemists and supermarkets.

**Sexually transmitted diseases**

High-risk sexual behaviour consists mainly in having sexual relations with multiple partners or strangers, doing so without the use of condoms, having sexual relations when infected or failing to seek adequate medical treatment when infected. Sexual relations with multiple partners, with strangers and without condoms have been reported in this study.

The question then is: has there been or is there STD or AIDS/HIV in the population? The most common forms of sexually transmitted diseases reported by the subjects are gonorrhoea, reported by 12 per cent of urban males and 2.4 per cent of urban females, and syphilis reported by two per cent of urban male respondents. The diseases were reported to have been contracted from girl-friends by 0.4 per cent and women-friends by 8.8 per cent of urban boys. For the urban girls it was 1.4 per cent from boy-friends and 0.3 per cent from men-friends. In each case, the rest of the respondents could not identify the source of the infection. In cases where respondents reported the infection to anybody, more urban male respondents reported
to friends (4.8%), than to relatives (2.8%), partners or doctors (2.4%). Of the urban female subjects, 1.4 per cent reported to their partners, 0.7 per cent to friends and doctors.

There is risk associated with the small number of cases reported to doctors and sexual partners. Adequate medical treatment can best be obtained when a case is reported to a doctor while a report to the partner gives the partner the opportunity to seek medication. It should be noted that, unlike the males, the female respondents did not readily disclose their infection to their friends. The social stigma associated with STD in our culture is more on women than men. The information that a girl has a sexually transmitted disease is an indication of sexual laxity on the part of the girl. She would therefore prefer to take her medication quietly without telling friends her experience, particularly when she cannot guarantee the confidentiality of the report made by her. Thirteen per cent of urban male respondents got medication for the infection; in only 7.6 per cent of the cases was the medication from a doctor or nurse. The rest used self-medication (1.2%) and traditional healers (2.4%). The data for the female subjects were doctors 1.4 per cent, and traditional healers 0.7 per cent. A significant feature of the result is that after infection, two per cent of male subjects continued to have sexual relations, which in 1.6 per cent of cases was with girl-friends. Of the female respondents, 3.1 per cent did not abstain from sex when infected, 0.7 per cent of the cases did so with boy-friends. Of the males, 55.8 per cent indicated that they knew someone who had been treated for STD/AIDS, while 24.7 per cent of females reported knowing such a person.

Modification of sexual behaviour

Of the female subjects 71.9 per cent indicated they had modified their sexual behaviour since learning about AIDS while 2.7 per cent are still ignorant of AIDS. About the same percentage of male subjects, 72.7 per cent, have modified their sexual behaviour while only 0.8 per cent are still ignorant of AIDS. The modification of sexual behaviour among both male and female subjects was principally through reduction in the number of sexual partners and sexual relations, use of condoms and abstinence from sex. This shows that generally, the public education program on AIDS is achieving positive results in changing risky behaviour. For a small percentage of the population, this is not true, as they had not changed their sexual behaviour since becoming aware of AIDS. For the male subjects who had not changed their behaviour, the reasons were that either they believed that AIDS had not yet spread or they were indifferent about the consequences of AIDS.

The subjects were asked to make an assessment of young people's sexual behaviour. They described youth as too promiscuous, as lacking control, indifferent to cultural standards and regulations and having very bad attitudes and behaviour in relation to sex. They attributed the current change in youth sexual behaviour mainly to 'civilization'; 71.1 per cent of males and five per cent of females attributed the change to civilization. Other reasons were economic factors, and awareness of AIDS.

Conclusion

Young people in Southwestern Nigeria are engaged in risky sexual behaviour patterns. Unfortunately they are not quick at taking actions that would prevent or reduce the risk of STD and AIDS/HIV transmission. In these days of the AIDS epidemic, sexual networking should be associated with condom use, and immediate report of infection to medical personnel and to one's partner so that he or she can seek medication. There is also need to worry about a proportion of the population that is still ignorant of AIDS, is indifferent about AIDS or feels that AIDS has not spread. To some extent however, sexual behaviour among the youth has been modified since there is awareness of AIDS. Sex education with emphasis
on appropriate attitudes to AIDS/HIV should be included in the secondary school curriculum to increase young people's understanding of AIDS.

References


Women's attitudes to men's sexual behaviour

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AIDS is viewed as a family tragedy in Africa. Almost 1.5 million Human Immunodeficiency Virus (HIV) - infected women are found in Africa, and between 10 and 30 per cent of these women in some urban cities are of childbearing age. It is estimated that during the 1990s, up to three million women will die of AIDS in Central and East Africa alone leaving at least 5.5 million children under 15 years as orphans by the year 2000 (UNICEF 1990). AIDS strikes, according to Ainsworth (1993), mainly adults in their most productive years; the illness robs families of one or more of their breadwinners. Such loss makes it harder for families to get ahead or break out of the cycle of poverty. A World Bank Study reported by Roseberry (1993) indicated that in Tanzania, rural households spent roughly the equivalent of one year's income on treatment and funerals in 1991. AIDS was not reported in Nigeria until 1986, but its steady rise to a conservative estimate of 962 cases in 1993 prompted the decision to pass a bill to curb its spread by the then Lagos State House of Assembly in 1993. The number, though low when compared with figures from East African countries, presents a gloomy picture, considering the observation made by Mann (1987), that there are about 50-100 HIV-infected persons for each case of frank AIDS. Also, owing to the resilience of extended family ties in absorbing intra-family problems, especially those that could attract stigmas, it is possible that AIDS cases are under-reported. Therefore, it would be wrong to assume that AIDS does not present a serious health risk in Nigeria. In fact Nigeria is believed by the World Bank to be a high priority area for AIDS prevention because of its large mobile population and estimated high levels of other sexually transmitted diseases.

AIDS has particularly adverse effects on women and children, and consequently the family. Women, owing to their status, are increasingly exposed to the risk of HIV infection and also suffer extensively from the social and economic impact of the disease.

Women's status has been a focus of appraisal. All through the ages, in the African and particularly Nigerian culture, women have been given subordinate status in the family and the society. A woman could be an object of enjoyment, given out as a gift to seal friendship or bundled out into a man's house even without her consent. Times have changed, but the status of women has not changed much. The vestiges of these traditional concepts coupled with socially induced factors have made women particularly prone to sex-related diseases and these factors, according to Merson (1992), restrict their ability to protect themselves from sexually transmitted diseases. For instance, studies have shown that expectation of monetary or material gain is a crucial factor in the decision by women to engage in sexual relations (Ososanya and Brieger 1994). Rural women according to Orubuloye, Caldwell and Caldwell (1991) gave the need for financial assistance as the single most important reason for some women engaging in extramarital relations. Some men, according to Orubuloye et al., even expect their wives to support the family financially from gifts and favours obtained in this way.
The deterioration in the economic situation in Nigeria is bound to affect the health and social status of the Nigerian population and especially the women and children. Nakajima (1989) noted that in parts of the world, and the developing countries in particular, morbidity and mortality among mothers and children are still unacceptably high. HIV-related diseases will inevitably augment these rates and impose new demands on the already inadequate health and social services designed for mothers and children. A synergy is likely to exist between low economic condition and low level of awareness in the propagation of AIDS.

The level of awareness of AIDS in rural areas is still quite low (Ososanya and Brieger 1994), and Nigerian men who are aware do not feel vulnerable to it (Onile 1993). The Health Belief Model formulated by Rosenstock (1974) suggested that preventive action is more likely to be engaged in by those who feel vulnerable to a disease. The preventive action in the case of AIDS is likely to affect the life style of the individual.

People's life style has been implicated in the spread of AIDS. Since no cure has yet been found for AIDS, preventing and controlling the disease remains the most viable option to contain it. Meyer (1988) pointed out the need to identify the risk behaviours and practices, their frequency, distribution and the cultural context in which they occur. Nunn (1987) observed that AIDS in Africa is predominantly spread by heterosexual intercourse, materno-foetal transmission and blood transfusion. Other potential risks he gave included poorly sterilized needles and syringes, ritual scarification, circumcision and incisions.

Belief in traditional medicine has made widespread the practice of making incisions on various parts of the body. They are intended for protection, healing, deliverance, acquisition of magical powers and oath taking. Circumcision is however a more widespread practice as male circumcision dates back to the Biblical period. The importance of male circumcision in modern-day medical practice cannot be overemphasized. Cancer of the cervix is found to be lower among women who are married to circumcised spouses than those married to men who were not circumcised (McMillen 1974). Cancer of the penis which is very rare has also been noted among uncircumcised males. However, in Nigeria both male and female children are circumcised, often with grave consequences. Female circumcision is done essentially to prevent promiscuity but it has generated a lot of controversy as female children bleed to death because in some cases, it is not only the hood of the clitoris that is removed but also the prepuce and the glans of the clitoris together with adjacent parts of the labia minora or the whole of them (Olafiminhan 1993). Psychiatric disturbances such as anxiety reactions, chronic irritability, episodes of depression and even frank psychosis have been noted as complications that may arise from female circumcision. However, with the incursion of AIDS, other fears have arisen. Many children who have contracted AIDS through materno-foetal transmission could transmit AIDS to other healthy children during circumcision especially if the procedure is not hygienically carried out.

The purpose of the research therefore was to investigate and analyse female attitudes and activities in relation to sexuality within the context of the family. The focus was on women because they are believed to bear the brunt of the AIDS epidemic and they are potentially a key force for stopping it (Nakajima 1989). It is hoped that this would provide a baseline guide in the choice of focus for educational and other intervention programs to contain AIDS.

Methodology

A three-part structured questionnaire designed in two languages (English and Yoruba) was used to collect the data for this survey.

The first section covered background information on respondents in terms of age, occupation, ethnic group, religion, marital status, number of children and age of husband.
The second section contained questions on sexual activities of men generally and of husbands in particular. They include respondents' attitudes to the following:

(a) The possibility of a man limiting his sexual activities to the wife only.
(b) Men's extramarital relations with women older than wives.
(c) Extramarital relations with prostitutes.
(d) Wife's interference in husband's extramarital affairs.
(e) Son's sexual relations with girls and prostitutes.
(f) A daughter commercializing sex.

Apart from respondents' attitudes to the factors listed above, the respondents' reaction in situations where these had happened were also obtained. Attempts were also made to find out among the respondents who worked in bars and brothels, their attitudes to the job and why they chose it.

The third section attempted to elicit responses on whether respondents circumcised both male and female children, where this was carried out and the level of hygiene maintained for the procedure. Apart from this, questions were asked on respondents' knowledge of occasions when incisions have been made on them or their children.

The study population

The survey was carried out in Badagry Local Government area of Lagos State with a predominantly Egun population. Lagos was, until recently, the administrative capital of both the Federal and Lagos State Government, and is still Nigeria's most important financial, business, commercial and industrial centre. Its population is heterogeneous and of the largest concentration in the whole country. The population combines urban, semi-urban and rural settings. The Badagry local government under investigation presents a combination of both rural and urban population (semi-urban). This is because in recent times, Badagry and its neighbouring villages have experienced an influx of mixed population from the cosmopolitan city of Lagos. These are essentially people who could not cope with the ever-rising cost of living in the city. For the investigation, Badagry town was selected and two other towns, Ikoga and Topo, were randomly picked in order to have a total picture of the Local Government area. For Badagry, the area under study included Ajara. Every street was first identified, and on each street every third house was enumerated and a questionnaire was given to any woman suspected to be above marriageable age to fill in if she was literate enough. Where such a woman was not, the questions were asked in the form of an interview and the appropriate answers supplied were filled in by the interviewer. Three hundred questionnaires were administered in Badagry and one hundred each at Topo and Ikoga.

One important observation made was the eagerness the generality of the women showed in discussing a matter so personal and yet so integral to their lives. Women were willing to ventilate feelings of frustration and marital woes.

Out of the 500 questionnaires, only the information retrieved from 496 respondents provided the data analysed and reported here.

Characteristics of respondents

Of the 496 respondents, 494 stated their religion: 86 per cent claimed to be Christians. In Badagry area, there is a strong allegiance to traditional gods, thus it is possible that many of these Christians practise traditional religion; 13.4 per cent claimed to be Muslims while only 0.2 per cent practised traditional religion and 0.4 had no religious affiliation.

Of the 495 who declared their ethnic groups, 63.4 per cent claimed to be Yoruba (it was difficult to know the percentage of them that were Egun); 2.2 per cent were Hausa, 24 per cent were Ibo and the remaining 10.3 per cent belonged to other ethnic groups.
Those who responded to the question on marital status numbered 478. Since the basis for being given the questionnaire was that the respondent was married or had children, it must be that those who claimed to be single had children; 0.42 per cent belonged to this category. Those who claimed to be married were 94.8 per cent, divorced 1.3 per cent, separated 2.1 per cent, and widowed 1.5 per cent. It is possible that those who did not respond either were not married or had been divorced. Four hundred and ninety responded to the question on their educational status: 8.4 per cent had never been to school; 1.2 per cent had had Koranic education only; 0.6 per cent did not complete primary school and 6.7 per cent did, 2.3 per cent did not complete high school and 35.9 per cent did, 44.9 per cent claimed to have post-secondary education.

Their occupational status revealed that less than one per cent were farmers; 23.4 per cent were traders; 9.6 per cent were artisans; 48.4 per cent were civil servants; 6.3 per cent claimed to be professionals while 12 per cent were housewives.

The mean age for the women was 34 years, while that of their husbands was 43 years.

The number of children the respondents had varied. Only 2.8 per cent were married but without children. The mean number of children was three and 23.7 per cent of the respondents had between one and three children who were above 16 years of age, nine per cent had between four and six children who were above 16 years and only 0.2 per cent had more than six children in this category.

**Survey findings**

**Attitudes to men's sexual activities**

In Nigeria, cultural practices vary from one ethnic and religious group to another. Male sexual transgression has always been considered normal and even encouraged. The choice of more than one wife is not so condemned by the society even if the man involved is married under the Act, thus few people if any have been charged with bigamy in Nigeria. The case however is different for females who are expected to be chaste and be good wives and mothers. With this background therefore, the need for different sexual partners by both sexes was investigated: 55.7 per cent of the women believed women have as much need for different sexual partners as do men and 42.3 per cent felt otherwise. The implication of this is that if they are as biologically predisposed to the same sexual urge as men, they would go out to assuage the urge. Findings in parts of Africa which showed that extramarital relations by wives were the norm and these were emotionally accepted by husbands tend to support this assertion (Powdermaker 1962). However, Caldwell and Caldwell (1981) noted that the assertion would be true for women in certain societies but not true for others. They reported that in their study, 83 per cent of Yoruba wives said they did not miss sex at all during the years of postpartum sexual abstinence. It could be that such women had undergone circumcision in infancy which tends to reduce libido and therefore could have made sex less appealing. This may also be responsible for the fact that only a small percentage of women ever achieved orgasm during sexual encounters as reported by Masters, Johnson and Kolodny (1985). If this is the case then these women would have the tendency to see marital sex as a conjugal duty for procreation rather than for pleasure.

Apart from satisfying the sexual drive, other reasons have been advanced for women's extramarital affairs which include the need for both emotional and financial security especially where the spouse is old and not providing, or where the husband is away most of the time. In the rural areas, it has been reported by Orubuloye et al. (1991) that women keep long-known partners that are themselves sexually careful and selective probably because the towns or villages are small and nearly every one knows the other person. However, in the
Women’s attitudes to men’s sexual behaviour

87.4 per cent of the women believed that men do not generally require more than one wife and the same respondents were also those who would prefer to be the only wife. It is also interesting to note that the 12.4 per cent who agreed that men should have more than one wife said they would not like to be the only wife. This can however be understood when it is observed that 84.2 per cent claimed to be in monogamous unions while the remainder were either in consensual or polygynous unions; 11.1 per cent of the women in the study reported that they were one of two wives; 3.2 per cent indicated they had two co-wives while 0.6 per cent had three co-wives and 0.8 per cent had four. More often than not, there is freedom for extramarital relations when a woman has co-wives. This is because of the economic burden imposed by polygyny on the family: individual wives are forced to fend for themselves and their children such that they have to provide at least 90 per cent of the requirements of themselves and their children.

When asked if they believed their husbands went after other women outside the marriage, 67.4 per cent of them said their husbands did not while 32.6 per cent believed they did. Specifically too, 4.2 per cent of the women believed their husbands were patronizing prostitutes. Many Nigerian men have been known to patronize prostitutes and bar girls. Prostitutes are believed to be single girls or women separated from their husbands who make prostitution their profession. On the other hand, there are girls who are literate, even students, who work the streets soliciting for male clients. In urban areas where polygyny is a little difficult, men have gone for a variant of it which Montgomery (1991) described as surreptitious polygyny in the form of the ‘outside wife’ and the ‘deuxième bureau’. Elite men in urban areas, though educated and successful, are believed to practise this variant of polygyny without the knowledge of their equally well-educated wives.

The ‘outside wives’ of the middle class are said to be young in most cases, relatively well educated, able to converse in English and French, in white-collar employment, and given to enjoying the good life which includes payment for clothes, rent and some money to spend. It also provides an avenue for gaining entrance into the society (Caldwell, Caldwell and Quiggin 1989).

It is generally believed that men cannot live without these women and Temne wives in Ghana preferred not to know the identity of such other women but feel strongly there should be only one so as to prevent the spread of diseases (Dorjahn 1958). It is therefore possible that many of these women who claimed to be in monogamous unions share their husbands with outside wives.

When asked if they felt most husbands have relations with women older than their wives, 39.5 per cent of the women agreed that this usually happened. One of the factors that could be responsible for this is the age disparity between most men and their wives, especially those in polygynous unions. It is probable that some of these men would prefer women who are more experienced and therefore provide more sexual satisfaction. Orubuloye et al. (1991) suggested that divorced women are often preferred. Some men could also prefer women who are in stable unions for security reasons and to avoid unnecessary liability and financial drain that could arise when a young single girl is involved. Since extramarital affairs by wives are tolerated if they are discreet, even secret and not flaunted in such a way as to cause the husband embarrassment, it therefore means that many of these women would be available and patronized. The elite males of East African cities were found to prefer these to bar girls for fear of contracting diseases (Obbo 1987).
When asked if a woman has the right to know and approve of her husband's sexual activities outside marriage, 20.6 per cent of the women believed this was right while 79.4 per cent disagreed. Also 81.5 per cent believed a wife should interfere if her husband went after other women; only 18.5 per cent felt this would not be proper. It is very unlikely that the educated ones would not want to know, and approve of their husband's sexual activities outside the marriage, even though traditionally, a woman is expected to be overtly deferential towards her husband (Adeokun 1991). Dinan (1983), reporting the view of white-collar single women in Accra regarding marriage, said that they believed it was hopeless expecting husbands to be faithful although they were highly critical and resentful of the adulterous behaviour of the men. This is probably why most women believed the issue of approving their husbands' extramarital activities does not arise.

Female education and Christian conversion have been cited as the major forces countering polygyny. Many educated women now share with their husbands the provider role and are therefore no longer content with staying in the background. They would like to share in the everyday activity of their husbands. This was the dilemma faced by the men who opted for Christian marriage during the colonial era in Lagos. According to Mann (1985), the elite women regarded Christian marriages as the best because the church upheld the sanctity of marriage. The women therefore would opt reluctantly for other types of marriage only if they had some blot on their reputation that made them unattractive as Christian wives or if they were widowed or separated. The Christian marriage thus has no place for polygyny and so the elite men, after much debate and frustrations, started having outside wives. This impression must have been in the minds of the participants in a focus group who revealed that women have resigned themselves to fate, believing that no matter what they do, Nigerian men will uphold the culture of polygyny (Adegbola 1991).

**Reasons for men's sexual behaviour from the woman's viewpoint**

The women in this study were asked for the reasons why men go after other women, their reactions and also their husbands' responses to their reactions.

Various reasons have been advanced by the women to explain men's wish for multiple sex partners. It would appear the women did not wish to look at the issue as being culturally induced and approved. Only a small fraction (about one-thirteenth) of the respondents felt more wives would provide more farm-hands. This to some extent could be justified in a predominantly agricultural economy where labour rather than physical or human capital is the principal economic resource (Montgomery 1991). The Lagos State terrain is mostly sandy and cannot sustain the type of agricultural enterprise being considered, and in any case, labour was more a motivation in the past than now and in the rural, not urban, areas.

Another reason proffered was that men's sexual appetite is insatiable and thus, through lack of self control, they will always look out for enjoyment and variation. This was the most popular reason given by the women. This view seems to be reinforced by the assumption noted by Orubuloye et al. (1991) that monogamous men and most polygynous men must have sexual relations with women other than their wives. The prescribed two or three years female abstinence during the postpartum period has been implicated as a major motivating factor for men's extramarital sexual behaviour. Some men however do not seem to share this view. A male participant in a focus group discussion noted that disciplined men abstain from sexual relations if there are no other wives to turn to since not all men are in polygynous unions (Adegbola 1991). It must be emphasized however that the availability of family planning methods has made some of these old practices obsolete. A woman can now space her children the way she likes. Besides, men do have access to their wives even during pregnancy: total abstinence during this period has not been medically recommended except in situations where
the woman has a history of miscarriages or other problems. Sexual intimacy during the first and third trimesters is however not encouraged.

Some of the women in the study also believed that the company a man keeps influences him. Some husbands are believed to have been influenced by their peers (7.1 per cent) to patronize prostitutes, while 4.6 per cent of respondents believed this was the case in their husbands’ taking other women. This view has been confirmed in other studies. Evans-Pritchard’s writing about the Nuer showed male solidarity and peer-group pressure displayed by the men in their readiness to identify with an adulterer rather than the aggrieved husband who has been made a ‘cuckold’ (Douglas 1976).

Men could also start extramarital relations to spite a straying wife. Infidelity on the part of the woman is no longer strange and from Ososanya and Brieger’s (1994) findings, could be initiated by accepting a ‘dash’ from a male customer, where buying and selling is involved, or accepting lifts in cars. It is believed therefore that a woman’s expectation of monetary or material gain is a crucial factor in starting a relationship with a man.

Some of the women believed some category of men engage in extramarital relations to boost their ego. It would appear the men in this category have low self-esteem and perhaps feel inadequate and lack confidence in themselves. They therefore would require relations like this to provide them with the required self confidence (Dintiman and Greenberg 1989).

For some men however, no apparent reason could be found for the extramarital pursuits.

Reactions to men's sexual activity

About 33 per cent of the women said their husbands go after other women. The reactions of these women to their husbands are presented here.

Reactions were found to vary. The majority of those whose husbands were straying claimed they did nothing (53.2 per cent). After further probing, it was found that they reacted in this way to avoid quarrels. In fact, 17.9 per cent of the men were reported to pick quarrels with their wives if they reacted negatively. Other studies in West Africa have shown that women seldom protest about their husband’s extramarital relations (Caldwell and Caldwell 1981). Although none of the women in this category mentioned the idea of getting square with their husbands by selecting their own male friends, the motivation for this seems to have been provided by a man who beats his wife for protesting against his extramarital affairs. Indeed, rebellious women have been known to find occasion to take revenge on their husbands by also having an extramarital relationship. Even in polygynous unions, women who felt cheated that their husband brought a new wife home or who suspected there were other sexual partners outside the marriage were found to seek out other sexual partners of their own (Ososanya and Brieger 1994). In this situation therefore silence could be golden. However, about 4.4 per cent of the women would not advise women to engage in extramarital relations because it would make them age faster. This category of women is not likely to have extramarital affairs.

A few of the women (1.1 per cent) said they had threatened their husbands with divorce if their extramarital relations were repeated. Most researchers like Caldwell et al. (1989) have shown that divorce has not been a common solution for adultery, except that of wives where it is flagrantly provocative and repeated. In Nigeria, however, the colonial era, which highlighted the rights of women, and the growing Christian influence which emphasized only one legal wife, led to a substantial increase in female-initiated divorce (Caldwell, Caldwell and Orubuloye 1990). Divorce cases are steadily increasing while rather than get married, many more women are choosing single motherhood. All these factors have implications for the containment of AIDS.
Other women who do not wish to sue for divorce, claimed they denied their husbands sex as a punishment: 5.6 per cent of them were involved in this while about one-third of the women preferred to express their disgust by getting angry and quarrelling with their husbands. They said they accused their spouse of dishonesty, immorality and lack of self-control. Some others claimed to have pleaded with their husbands and reminded them of various diseases that could be contracted including venereal diseases and AIDS and the likelihood of premature death. It is difficult to know the particular results of each of these strategies. However, 42.3 per cent claimed their husbands promised to turn over a new leaf, 35.9 per cent were indifferent while 3.8 per cent insisted they could take care of themselves. Nevertheless, 7.5 per cent of the women were sure their husbands would never engage in extramarital relations; the reason given was that their husbands feared God. Studies conducted in parts of Africa have now shown much difference between the sexual behaviour of regular church-goers and that of the general population, except a study by Southwold (1973) carried out among the Baganda people. Among these people, those who have really internalized Christian values were said to be devout and somewhat more chaste. This difference could be explained by the fact that a man or woman who has really internalized Christian values would believe in the sanctity of marriage.

Respondents displayed a general awareness and fear of AIDS: 70 per cent said AIDS is deadly and another 29 per cent that it is incurable. However, only 64 per cent believed this could prevent their husbands from carrying on with extramarital relations while others could be stopped by the fear of illegitimate children. The majority of the women were very optimistic that when husbands are given adequate love, care and attention, they surely will reciprocate positively and stay home.

**Women’s attitudes to sexual behaviour in their children**

Traditionally, in sub-Saharan Africa, arranged marriages were common. Men, who were not expected to be chaste, did not marry until their late twenties or beyond, by which time they had set a life pattern of sexual adventures. However, a great value was placed on female chastity.

The situation has however changed tremendously in the past few decades. Girls are no longer married off to prospective husbands very early in life, but in the course of going to school or learning a trade their marriage is delayed. In most West African studies therefore, mention has been made of the sexual freedom of girls with little worry about pregnancy (Caldwell et al. 1989). In this study, parents’ attitudes to sexuality in their children who were above 16 years were investigated.

Only 25.8 per cent of respondents had children aged over 16 years. Of these, 77.4 per cent reported their sons were indulging in sexual relations with girls. It was not possible to determine the ages of these male children, but they must be varied considering the fact that about 2.2 per cent of the women were over 55 years old. Also 8.9 per cent had cause to believe their sons were patronizing prostitutes. As in any city, prostitution is a flourishing business in Lagos and environs, and bars and brothels are found everywhere. Their availability must have provided enough motivation for young men to frequent them since in the long run this might prove more economical than having a steady girl friend.

When the women were asked what their reaction was, only about 38.5 per cent of the 48 who said ‘yes’ condemned the son who had sexual relations with girls and the remaining 62.5 per cent said they advised their sons by telling them the health implications and the need for caution. However 24.4 per cent of the women would not say anything since they did not see anything wrong in their sons’ behaviour. All the women who reported that their sons went after prostitutes said they expressed sadness and warned them about the link between their
Women’s attitudes to men’s sexual behaviour

behaviour and a variety of diseases and even premature death. When all the women were asked what they would do if they were told their sons had been frequenting brothels, 80.4 per cent said their sadness would know no bounds; 11.5 per cent would feel ashamed, baffled and angry; 5.2 per cent would feel proud of the boy while 1.2 per cent believed their son would never do a thing like this.

Most of the women (83.3 per cent) were of the opinion that a mother should control the sexual activities of her son although in reality only 73.1 per cent of them said they could. The need to control the son’s sexual activities is essentially to prevent unwanted pregnancy (69 per cent) and fear of diseases (33.3 per cent). Other women who did not share this view saw sexual indulgence as a proof of manhood (70 per cent) and evidence of sociability (30 per cent). Even if some mothers would want to control their sons, 33.3 per cent did not live with their sons, while for 66.7 per cent, ‘civilization’ would be a force to contend with. It is not surprising therefore that some of the women looked to their husbands to take the necessary action against an erring son. Peer influence was believed to be responsible for their sons’ patronage of prostitutes while 66.7 per cent believed their boys to be self-willed. Those whose children did not involve themselves in this behaviour said their children were decent (73.5 per cent) and did not keep bad company (26.5 per cent).

Although 35 per cent of the fathers of those who are involved with prostitutes considered the behaviour immoral, only 5 per cent scolded their children. In fact, 35 per cent of the fathers would prefer to advise their sons to protect themselves.

A lot of inconsistencies could be detected in the women’s stand on their daughters’ engaging in prostitution. Initially, 81.6 per cent of the women said they would be sad to know that their daughters had taken to prostitution; 7.3 per cent said they would be baffled while only 1.3 per cent expressed delight. Although 88.4 per cent reported that they would warn such a girl seriously and 6.6 per cent even threatened to denounce her, if the same girl obtained wealth through prostitution and was ready to start a business in the village, 45.9 per cent would feel proud of her, while only 39.7 per cent would still remain sad. It is interesting to note that 46.7 per cent of these women still believed such a girl would make a good marriage. Perhaps this may be a general attitude along the West Coast of Africa. Caldwell (1969) reported that although rural families in Ghana were disturbed by what their single daughters would do if they went to Accra, none of these rejected remittances these girls sent them or even refused to have the girls back. Prostitutes are never treated as outcasts in their villages. The lenient attitude of some of these women to prostitution may be due to the fact that 3.5 per cent are currently working in a bar or hotel; most of these, 64.3 per cent, could not get any other job while 7.1 per cent do it because they need money badly; some are doing the job for the sake of doing something.

Male and female circumcision

The women’s attitudes to male and female circumcision were generally fair; 98.6 per cent had circumcised their male children and 93.8 per cent, their female children. It is possible that those who gave negative replies did not have children of their own. The reasons given were cultural 83.9 per cent, Biblical 10.7 per cent and sexual performance 5.4 per cent; and 5.9 per cent reported they circumcised their female children so that their children’s children would live. The general belief is that the baby whose head touches the hood of the clitoris, present in uncircumcised women, will die.

Only 8.8 per cent of the women circumcised their male children themselves and 11.5 per cent their female children. Others patronized a Western trained doctor (55 per cent); nurses or dispensary (10 per cent); traditional doctor (25 per cent); or traditional birth attendant (5 per cent); for females the same group of experts consulted for the male were also consulted and
in almost the same pattern. About half of the women had their sons circumcised in the hospital, 22.4 per cent in their own residence, and 20.9 per cent went to a traditional specialist's home. The pattern observed in female circumcision was similar to this. Invariably those who had their children circumcised in a proper hospital setting were provided with appropriate tools and clean environment. Others reported the use of a knife (16.7 per cent) and scissors (7.1 per cent). Circumcision instruments were merely rinsed in 17.5 per cent of cases, washed with soap by 17.5 per cent and sterilized in 60 per cent of cases. Exposure to AIDS infection is increased if the instruments used are not properly cleaned and disinfected.

**Incisions**

Only 6.5 per cent of the women reported that incisions were made on their children on certain occasions, especially during a local festival (17.4 per cent); admission to school (8.7 per cent); when they were leaving for a new environment (4.3 per cent) or as advised by a diviner (13.5 per cent). When performed during a festival, which appears to be the major reason for it, it is to link the child with the ancestors. However, others use it as a protective measure. Another situation where incisions are made on the body is when an oath is being taken. Half of the women claimed they have heard of this before; 93 per cent claimed it is usually to seal a covenant and seven per cent believed it was to avoid a breach of trust. Only 5.4 per cent had done this before and it was essentially to seal a covenant while about one third of the few who claimed they had done it before said they were forced to do so.

**Implications and conclusion**

Man is not just social but also biological. Man's sexual behaviour is therefore complex. To define the inducement factors for sexual relations in social terms alone may be difficult. Nevertheless some of the social factors have been investigated in this study and their implications discussed.

Prominent among the factors are the following:
(a) The pleasure in having a variety of sexual experience by both men and women.
(b) Material rewards whether formal as in prostitution or informal as relating to those accruing from a steady relationship.
(c) Use of sexual relations outside the home as an emotional release to get square with spouses.
(d) The practice of circumcision especially when carried out unhygienically outside the hospital.

The implications of the above are that, unlike in the developed countries where the incidence of AIDS is elevated in some sub-populations when compared to the population mean, for example homosexuals and intravenous drug users, in Nigeria such high-risk sub-populations do not exist. The risk behaviour and practices are not confined to distinct social groups. Thus the incidence of AIDS may vary only slightly across the population.

With materno-foetal transmission and the practice of circumcision, AIDS is likely to spread first among infants. Heterosexual intercourse and sex commercialization among sexually active adults will also enhance the spread of AIDS in the teenage and adult populations. Thus we have a situation where AIDS can spread laterally and vertically involving virtually every stratum of the society. It is in view of the above that the following conclusions are reached.

The women are generally aware of the connection between sexual relations and sexually transmitted diseases and AIDS and they are afraid of contracting them. There is therefore the need to intensify the public education campaign against AIDS with particular emphasis on safer sex through the use of condoms. Self protection by the women is required since sexual
permissiveness of men is socially acceptable. Although it is generally believed that condoms could prevent AIDS and other sexually transmitted diseases especially when used with the spermicide Monoxynol - 9 (Whyte 1990), attitudes to condoms have not been favourable. They are said to take away the pleasure from sex through their lack of sensitivity. Therefore there could be a resistance against condoms in such a pleasure-seeking population as that of Nigeria. It would be necessary to develop special strategies to motivate people to accept condoms.

The men also should be made a target for AIDS education programs. This could be carried out at the community level which could be the neighbourhood, professional group, or the smaller support network composed of family or friends. All men should be reached and encouraged to use condoms if they indulge in high-risk behaviour.

Although as the women observed, the fear of AIDS might not deter men from extramarital relations, most women in the study were sure that love, care and affection would make many men stay at home. There is the need therefore to strengthen family ties and emphasize the sanctity of marriage. Women need to be provided with both the cognitive and behavioural skills required for making the home happy and inviting so that their husbands can be encouraged to be faithful. Couples should know where to turn, apart from the traditional line of consultation for guidance and assistance in handling family problems, such as marriage counsellors.

The introduction of the Family Support Programme by the government could not have come at a better time. Emphasis should be on consolidating the family and encouraging parents to take the art of child-rearing seriously so that children can grow up in a loving environment, as this will reduce the number of street children and juvenile prostitutes. Vulnerable young children and teenagers should be taught the skills needed to refuse sex or negotiate for safer sex.

Many women also reported that their husbands would never engage in extramarital relations because they feared God. This agrees with the observation of Southwold (1973) that those who have internalized Christian values were more chaste. It would appear that religious faith has a role to play. The religious bodies, especially the church, must assist in stamping out AIDS by promoting those values that promote the sanctity of marriage and chastity.

The Better Life Programme had laudable objectives as it aimed at improving the status of rural women economically, socially and politically. Unfortunately, it did not yield much because of the improper way it was administered. However, the objectives could be pursued vigorously so that the self-esteem of the women and the economic status would improve. This type of forum would also bring about a stronger form of cohesion that would be required for teaching appropriate knowledge and skills in fighting against AIDS.

Schools should be involved by providing not only appropriate knowledge but also skills and attitudes that permit effective communication, responsible decision-making and the development of healthy human relationships. This can be achieved through the school health education programs. It is advisable that such education should commence before the young have their first sexual experience so that they can learn to protect themselves and others from infection. Over 300,000 teachers in rural areas have been trained for this purpose in Thailand to handle school AIDS programs in that country (Global News 1992).

Finally, the fight against AIDS requires political will and commitment by everyone. A 1992 edition of Global News carried a caption ‘Nigeria declares war on AIDS’; AIDS should not be fought on the pages of foreign newspapers. Public education on AIDS has been sporadic and ill-planned in Nigeria; in Thailand, AIDS messages are aired for a minute and a half every hour of the day including prime-time. Advertising agencies and movie producers have volunteered to help with the production of messages (Global News 1992). Nigeria has a greater capacity to do this and the need for it is greater now than ever before.
There is need for a review of the electronic media, especially the entertainment programs. Plays that do not promote the sanctity of marriage or that portray promiscuity as part of the necessities of life should be banned. The media must be made to feature regular programs that provide scientific facts about and skills for preventing AIDS.

Circumcision of female children should be discouraged through the mass media and other interpersonal communication channels. Hospitals should be made to take the responsibility for male circumcision to ensure that hygienic procedures are observed in performing it. It is believed all these would assist in containing AIDS in Nigeria.

References


Sexual networking in Freetown against the background of the AIDS epidemic

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West Africa, since the discovery of the HIV virus, has remained relatively unperturbed by the attendant AIDS epidemic sweeping through the other portions of the continent south of Sahara. The low level, of both the reported and the diagnosed cases of the epidemic at the onset, seem to explain the initial lukewarm and sometimes cynical attitude on the part of both the government and the populace. In recent times, however, emerging revelations from research on sexual behaviour in the region seem to be generating greater concerns about the possibility of continued containment of this scourge. So in many West African countries efforts are being made to generate baseline data to help in assessing the risk of this epidemic, given the background knowledge of the sexual behavioural correlates of AIDS gained elsewhere. However, not all the strategic points in this region have had such an inventory carried out or reported.

Not only does Freetown, the capital of Sierra Leone, fall into this category, it is also confronted with certain challenges at the regional level, as well as some internal peculiarities which underscore the need for the present inventory. One of these is its closeness to Abidjan, the Ivorian capital, which in recent times has been identified as a potential epicentre of AIDS infection in West Africa, given the unusually large number of HIV-positive individuals already diagnosed there \textit{vis-\'\-vis} other cities of comparable status in the region.

The second peculiarity is connected with the increase in recent times in the rate of movement of nationals within the West African region across national boundaries. Such waves of movement which have been impelled by the economic depression ravaging, in varying degrees, some of the countries in this region, are likely to be aggravated by the increasing trends to political instability in some of these countries. The attendant movement may engender certain changes in the patterns of the morbidity variables within individual countries, especially those characterized by volatile epidemic tendencies such as HIV infection; this indicates the need for an assessment of high-risk sexual behaviour patterns among the strategic centres within the region. Locally, research reports on Freetown tend to indicate the prevalence of premarital maternity, a phenomenon that shows a high level of premarital and probably extramarital sexual activity coupled with a low degree of contraception.

An equally important reason for concern is the official disposition in Freetown to health-related matters which is perhaps partly explained by the poor financial capacity of many West African states. Records of the World Health Organization tend to associate some apathy and lukewarmness in the Leonian government towards a number of health-related programs of global concern. The IPPF publication of 1990 states that family planning only receives some support against the possibility of full government support, while the contraceptive prevalence
level is estimated at four per cent, placing it among those countries with the lowest contraceptive levels in the world.

At this point, two questions appear germane. First, to what extent has the worldwide commitment to AIDS containment received effective official acceptance, as reflected by the AIDS awareness level of the populace? Secondly, what relationship is there between the apparent level of awareness of the people and their disposition towards high-risk sexual behaviour? Against this background the phenomenon of sexual networking in Freetown is examined.

**Freetown, the study area**

Freetown, the capital of Sierra Leone, is one of the strategic cities along the West African coast. It is both an entrepôt and a political headquarters. It also serves as a commercial as well as a moderate industrial centre, at least for the larger population in the interior of the country. More of its strategic importance lies in its being perhaps the foremost primate city in the region apart from Banjul in Senegal. It was founded in 1839 by American and British government interests as a resettlement centre for freed slaves after the abolition of the slave trade. Most of the initial freedmen originated from the West African region, others came from other parts of Africa, so an element of plurality has characterized the ethnographic composition of this city right from the start. Over the years, the original population has undergone considerable changes, both in size and in complexity.

Much growth in size has occurred rather significantly within the past 25 years, with a huge influx of diverse ethnic groups from the adjacent continental interior. Consequently, the initial population which primarily consisted of the Creoles has become diluted; the present population consists of the Temne, the Mende, the Limba, the Creoles and a host of others. The initial resettlers were largely Christians, but both immigration and intensive Islamic proselytization have worked simultaneously to impart almost comparable prominence to the Islamic religion. Other reports have highlighted some Freetown features which are common to many underdeveloped cities, and which may exert some influence on sexual behaviour: two of the prominent ones, which are related, are unemployment and dwindling income per capita.

Forde's (1991) study revealed much in these peculiarities. The extant socio-economic and demographic patterns documented in that study portend a strong likelihood for high-risk sexual behaviour similar to what has been documented of other cities with comparable socio-economic circumstances. According to Forde, between 1963 and 1974 the population of Greater Freetown rose from 127,917 to 276,247, a sharp increase of 115.9 per cent in eleven years, while in 1985, the population had increased to 469,776, gaining 70 per cent over the 1974 level.

Much of this increase has been adduced to speculative immigration which has the tendency to enlarge the size of the urban unemployed in the less developed world. Hence, Forde (1991) observed that since 1968 major indices of population welfare have continued to decline significantly for Freetown dwellers. It was also discovered that the proportion of

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1 The 1974 population figures for Sierra Leone show the population of Freetown as 364% the size of the second-order town and 701% the size of the third-order town.

2 In 1968, one-person household units accounted for 15.1% of Freetown's total household units, while those with eight members were 3.9%. By 1985, the former had dropped to 2.2% while the latter rose to 10.7%. Furthermore, a considerable percentage, varying between 25
female-headed households amounted to 12 per cent, while 59 per cent of migrants into Freetown between the two terminal years were females as opposed to 41 per cent males. Furthermore, about 79 per cent of these migrants were between 1 and 39 years of age.

The circumstances described above, against the background of poor economic infrastructural support, may put pressure on individuals, especially unemployed females, to enter direct prostitution or adopt a para-commercial sexual way of life to survive the harsh urban environment. With sexual behaviour thus aligned, it is evident that the risk of contracting and spreading the HIV virus becomes greater.

**Method**

**Data collection and coverage**

The data for this study were collected between July and August 1990, and form part of the pioneering sexual networking research efforts in West Africa. A multi-stage sampling procedure was employed. The first stage involved an imposition of grids upon the metropolitan map of Freetown; the emergent grids were numbered using the table of random numbers, and predetermined numbers of cells were picked. At the second stage, streets within the metropolitan cells were listed and using the book of random numbers, streets were systematically chosen from each of these cells. The houses along each street were listed and varying percentages were chosen based on their relative residential and human densities generally within that urban region as well as for that particular street.

Numbers were written on separate sheets of paper representing each of the household units identified in a sampled residential building. By random selection, a member of that household aged 15 years or above was chosen. For a single-member household, or unmarried households, the choice was often easier than for couples with children and other adults. However, caution was exercised in guaranteeing confidentiality first by separating the day of respondent enlistment from the day of the interview. Prior appointments with respondents also helped in guaranteeing confidentiality, coupled with the fact that only one respondent was interviewed from a sampled house.

The interviewers, both males and females, were trained in what to expect in the field as well as the challenges that might come up and how to overcome them. At the completion of the interviews 300 respondents’ questionnaires were considered admissible for analysis.

**Fieldwork challenges**

Despite all initial efforts, interviewers still met some challenges in the field. Many such problems arose from the novelty of the research theme as well as the questions posed, which sought information on aspects of individual life hitherto considered private.

Although many of those challenges were overcome in varying degrees, as interviewers were trained to emphasize the centrality of reproductive health to the fieldwork exercise, the study sample size would have been larger with greater co-operation. It is expected however that there will be more co-operation in subsequent fieldwork exercises as people become more familiar with this research theme and better persuaded of its social benefits.

**The data**

and 45% of households with large memberships (generally between five and ten individuals) now live in one-room apartments.
The numerous questions that were asked of respondents are in four groups. They include the socio-economic and demographic characteristics, family formation and fertility, sexual networking and knowledge of AIDS as well as experience of some well-known sexually transmitted diseases. The last section elicits information on the respondents' spouses for those who are in marital union.

**Analysis**

The analysis has four major subsections; the first examines the socio-economic and some relevant demographic characteristics of the population categorized by sex. This is followed by the analysis of the knowledge of AIDS as well as perception of the AIDS epidemic. The third section focuses on the sexual behaviour of the never-married respondents by analysing some variables such as the total number of sexual partners, sexual partners within the last year and within the last month, and age at first sexual intercourse.

Sexual behaviour is thus analysed, classifying the population by selected socio-economic variables. A few variables were selected, with minimum categories, to avoid excessively low values per cell. Other variables were subsequently analysed for the never-married respondents; these include the focus in sexual interaction across levels of sexual partnership, as well as perceptions of sexual norms and values and the use of contraception in sexual intercourse.

The second section focuses on sexual behaviour of the ever-married respondents. Specifically, it examines the incidence of extramarital relationship as well as multipartnership derived from responses to the question of sexual partnership within the last year and the last month. Further analysis examines variations in the incidence of extramarital relationships, using some marital and socio-economic variables to examine the possible explanatory factors for extramarital relationships.

The relative smallness of the study sample however restricted numerous classifications, of the respondents as well as of the variables analysed. Variables were therefore generally classified into two or three categories with the additional proviso that between four and five population groups emerge from such variables. The analysis of extramarital sexual relationship was made at three levels: whether a respondent has ever had an extramarital relationship, whether a respondent has had one within the last year and whether he or she has had one within the last week.

Other variables which focus on the awareness of AIDS as well as the different advantages introduced by variations in the temporal pattern of the acquisition of that knowledge, in conjunction with other variables which measure previous experience of STDs, were used to analyse the incidence of 'dropouts' in extramarital sexual behaviour so as to have a clearer insight into extramarital sex. Respondents who claimed to have ever had an extramarital relationship but who had not done so in the last year were separated. The same was also done for those who dropped out in the last month: these were called extramarital dropouts. They were then analysed with some variables on AIDS knowledge as well as previous experience of gonorrhoea.

Thus a temporal sequential perspective is adopted in the analysis of extramarital sexual relationship, to examine the degree of similarities and consistencies among the socio-economic correlates of extramarital sex over time as well as to explore the relationship between the variations in the trends of AIDS awareness and persistence in extramarital sexual behaviour. The focus element in extramarital relationship was also explored, as well as other aspects of sexual values and sexual behaviour analysis.

**Analytical methods**
For the most part, frequency distributions and percentages, and cross-tabulations are employed. In the analysis of extramarital relationships, however, logistic regression is employed only to assess within-group variations in the propensity for extramarital sexual activity.

The study population

Selected socio-economic characteristics

Table 1 illustrates the general pattern of the selected socio-economic characteristics of the sampled population. Males constituted 50.7 per cent, females 49.3 per cent, showing a considerable degree of representation of both sexes. The near-symmetry observed in the gender composition almost characterized the age distribution of respondents by sex. The modal age group for both sexes is 30-39 years which accounted for 46 per cent of males and 44.6 per cent of females. The category which has the least representation is those respondents who have attained or exceeded 50 years of age. Among men they represent 8.6 per cent and among women, 6.1 per cent.

The analysis of marital status shows that a large percentage of the sampled population, 54.6 per cent (males) and 53.4 per cent (females) are currently married, while 12.5 per cent of males and 8.1 per cent of females are separated or divorced. Widows are 5.4 and widowers 2.6 per cent of the sampled population. The percentage composition of unmarried female respondents among the entire female population at 33.1 exceeds that of their male counterparts by almost 3 per cent. The above pattern shows that among men, a greater percentage (15.1) of once-married men are no longer with their spouses compared with 13.5 of the ever-married female respondents who are either widowed or divorced.

The majority of each sex have secondary education: 67.1 per cent of men and 58.8 per cent of women. Those without education are relatively numerous, especially among the female respondents of whom 14.2 per cent are without education; among male respondents the figure is 11.2 per cent. The proportion of respondents with post-secondary education is rather low, when compared with cities of comparable colonial history in West Africa. Of the men, 4.6 had university education compared with two per cent of the women.

The occupational distribution, however, shows the white-collar group as the largest among the five groups classified, for both sexes. The difference between the percentage of the post-secondary educational group and that of the white collar employees may perhaps reflect the classification scheme adopted as well as the phenomenon of vertical mobility associated with a public service career, which allows enhancement in career status over time probably without much change in education status. For example, the clerks have been grouped in this category with those far higher on the career ladder. Other notable occupational groups among men are the skilled production workers (17.8%), the unskilled (14.5%), and the sales and business men (12.5%).

Among the female respondents, the business and sales group is very prominent, 27 per cent against 12.5 per cent of men. Numbers in the ‘other’ category are equally large for both sexes. The percentage of the unemployed seems larger among women, 9.5 per cent, as against 6.6 per cent unemployed males. This pattern of unemployment between the two sexes is similar to the Lagos pattern, except that the levels are fairly high in Freetown for both sexes.

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3 Sexual behaviour was not analysed by occupation, because of the numerous groups that may be identified under the occupational data; for example, the group classified as ‘others’
The ethnographic distribution of respondents looks rather even and perhaps indicates that plurality is a major trait of Freetown’s population. The major ethnic groups are the Mende, Temne, Creoles and Limba; there are many others. Only three groups have been separately categorized to prevent the occurrence of very low values and empty cells in the subsequent Table 1

**Table 1**
Selected socio-economic and demographic characteristics of respondents by sex

<table>
<thead>
<tr>
<th>Major characteristics</th>
<th>Males (N=152)</th>
<th>Females (N=148)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 15 - 29 years</td>
<td>33.6%</td>
<td>37.8%</td>
</tr>
<tr>
<td>30 - 39 years</td>
<td>46.0%</td>
<td>44.6%</td>
</tr>
<tr>
<td>40 - 49 years</td>
<td>11.8%</td>
<td>11.5%</td>
</tr>
<tr>
<td>50+ years</td>
<td>8.6%</td>
<td>6.1%</td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>never married</td>
<td>30.3%</td>
<td>33.1%</td>
</tr>
<tr>
<td>married</td>
<td>54.6%</td>
<td>53.4%</td>
</tr>
<tr>
<td>widowed</td>
<td>2.6%</td>
<td>5.4%</td>
</tr>
<tr>
<td>divorced/separated</td>
<td>12.5%</td>
<td>8.1%</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>none</td>
<td>11.2%</td>
<td>14.2%</td>
</tr>
<tr>
<td>primary</td>
<td>9.2%</td>
<td>14.9%</td>
</tr>
<tr>
<td>secondary</td>
<td>67.1%</td>
<td>58.8%</td>
</tr>
<tr>
<td>pre-univer. vocational</td>
<td>7.9%</td>
<td>10.1%</td>
</tr>
<tr>
<td>university</td>
<td>4.6%</td>
<td>2.0%</td>
</tr>
<tr>
<td>Occupation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>none</td>
<td>6.6%</td>
<td>9.5%</td>
</tr>
<tr>
<td>white collar</td>
<td>31.6%</td>
<td>37.8%</td>
</tr>
<tr>
<td>skilled production</td>
<td>17.8%</td>
<td>7.4%</td>
</tr>
<tr>
<td>sales / business</td>
<td>12.5%</td>
<td>27.0%</td>
</tr>
<tr>
<td>unskilled</td>
<td>14.5%</td>
<td>3.4%</td>
</tr>
<tr>
<td>others</td>
<td>17.1%</td>
<td>14.9%</td>
</tr>
<tr>
<td>Ethnic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Creole</td>
<td>17.1%</td>
<td>23.0%</td>
</tr>
<tr>
<td>Mende</td>
<td>21.7%</td>
<td>25.0%</td>
</tr>
<tr>
<td>Temne</td>
<td>18.4%</td>
<td>16.9%</td>
</tr>
</tbody>
</table>

consisted of four different occupational groups. This reduces the level of reliability of any sexual behaviour analysis by occupational groups.
analysis. These three groups are the Creoles, the Temne, and the Mende, while the other numerous groups were classified together. Among the three, the Mendes have the largest representation, 25.0 per cent of the females and 21.7 per cent of the males; the Creoles follow with 23.1 per cent of females and 17.1 per cent of males; 18.4 per cent of male respondents were Temne, as were 17 per cent of female respondents.

Christianity and Islam are the dominant religions among respondents, but Christians outnumber Muslims. A combined analysis shows that Christians constitute 57 per cent as opposed to 41 per cent of Muslims. However, the gap between the two religions appears closer among males, with male Christians 11.1 per cent more numerous than Muslim males, while Christian females are about 21 per cent more numerous than Muslim females. The distribution of respondents by religion reflects in varying degrees the religious orientations of the dominant ethnic groups in this survey. On a general analysis, the Creoles are predominantly Christians, while the Temne are predominantly Muslims. Though 57.1 per cent of Mende respondents said they were Christians, a gender breakdown shows that 51.5 per cent of Mende males are Muslims while 64.5 per cent of Mende females are Christians. Among the remaining ethnic groups, Christians constitute over 50 per cent of both the male and female respondents, which tends to account for the overall larger Christian population.

Table 1 Continued
Selected socio-economic and demographic characteristics of respondents by sex

<table>
<thead>
<tr>
<th>Major characteristics</th>
<th>Males (N =152)</th>
<th>Females (N =148)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Religion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Christian</td>
<td>82</td>
<td>53.9</td>
</tr>
<tr>
<td>Muslim</td>
<td>65</td>
<td>42.8</td>
</tr>
<tr>
<td>Others</td>
<td>5</td>
<td>3.3</td>
</tr>
<tr>
<td>Budget Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>some budget status</td>
<td>36</td>
<td>23.7</td>
</tr>
<tr>
<td>min. saving budget</td>
<td>41</td>
<td>27.0</td>
</tr>
<tr>
<td>large saving budget</td>
<td>75</td>
<td>49.3</td>
</tr>
<tr>
<td>Co-resident dependants</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>16</td>
<td>10.5</td>
</tr>
<tr>
<td>1-3</td>
<td>71</td>
<td>46.7</td>
</tr>
<tr>
<td>4+</td>
<td>65</td>
<td>42.8</td>
</tr>
<tr>
<td>no response</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
The budget status\(^4\) analysis of respondents significantly differentiates the male from the female respondents: for example, 55.4 per cent of the female respondents have an expenditure pattern which exceeds their regular income, while 23.7 per cent of men are so affected. Only 31.1 per cent of women had savings of over 750 Leone in comparison with 49.3 per cent of male respondents. The incidence of a large percentage with deficit budget status among the women may be connected with their higher level of unemployment, as well as the incidence of ex-nuptial parenthood which seems very common among never-married respondents, of whom 69 per cent of the males and 71.1 per cent of the females had experienced parenthood at least once. The economic burdens of rearing ex-nuptial children often fall more on the mother than her partner.

The pattern of dependants, including the respondents’ own co-resident children, shows that 10.5 per cent of males and 11.2 per cent of females have no dependants with them. About 42.8 per cent of men and 45.9 per cent of women have more than four dependent children and wards. Those with one to three dependants constitute 46.7 per cent of male and 45.9 per cent of female respondents.

Quite a large percentage of the respondents said they were born in Freetown: more than half of both sexes. Those who had their early childhood in one of the few other towns were 26.3 per cent among males and 20.9 per cent among female respondents.

The duration analysis shows that on the average the respondents have stayed about 26 years in Freetown. The modal groups differ between the sexes: 34.5 per cent of female respondents representing those that have spent 20-29 years in Freetown constitute the largest group for females, the largest male group have spent 30 years or more. The metropolitan residential pattern shows that all respondents lived in six of the eight metropolitan electoral areas of Freetown, leaving out Central I and East II electoral areas.

The three electoral areas with the largest percentage of respondents, West II, East III and West I, experienced the largest scale of population change in recent times, especially since

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\(^4\) Three budget groups were classified, based only on the difference between monthly income and expenditure; the response level on supplementary income seemed too low to be included. The first group consists of respondents with deficit-budget status, the second consists of those without a deficit and those with a minimum surplus up to 15 per cent of the median population income; in the third group the monthly budget status is substantial and generally above 15 per cent of the population median income.
the 1970s. They are characterized by a relatively large percentage of recent immigrants and thus have greater chances of having demographic and economic characteristics that may engender high-risk sexual behaviour. The other three, West III, Central II and East I, complement the first groups as they had relatively low levels of intercensal population increase.

Knowledge of AIDS

As this was a baseline study, respondents were asked questions about the AIDS epidemic. Six of those questions and their responses are given in Table 2. Most respondents have heard of AIDS: only 4.6 per cent of males and 6.8 per cent of females had never heard of AIDS in 1990. This level is quite low compared with the level of ignorance in Lagos about the same time; 10.2 per cent of males and 12.3 per cent of females.

Most respondents attributed their first knowledge to the radio and television; however, more men than women chose this source. The second most important source for men is the newspaper, and for women, friends or relations. This seems to corroborate the observed pattern that information is likely to spread faster among women than among men. Other important channels for men are friends and relations, government posters, and health workers or hospitals. For the women, the corresponding information channels are the newspapers, government posters and other government publicity. A large percentage heard of AIDS rather later than expected, so one aspect of the analysis distinguishes between late and early knowers about AIDS. Up till 1987 only 7.9 per cent of men and 3.4 per cent of female respondents had heard of AIDS; two years later, 49.1 per cent of male respondents were yet to know of AIDS. Among the women, the uninformed level at that time was comparably large, 47.3 per cent.

Table 2
Knowledge of AIDS by sex of respondents

<table>
<thead>
<tr>
<th>Questions</th>
<th>Responses</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ever heard of AIDS?</td>
<td>Yes</td>
<td>144</td>
<td>138</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>7</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>No response/unsure</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Sources of information</td>
<td>Radio/Television</td>
<td>69</td>
<td>47</td>
</tr>
<tr>
<td></td>
<td>Newspaper</td>
<td>25</td>
<td>27</td>
</tr>
<tr>
<td></td>
<td>Posters</td>
<td>13</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td>Other govt. publicity</td>
<td>9</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Friends/relations</td>
<td>19</td>
<td>29</td>
</tr>
<tr>
<td></td>
<td>Health workers/hospital</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Don’t know</td>
<td>7</td>
<td>12</td>
</tr>
<tr>
<td>When AIDS was first heard of</td>
<td>1980</td>
<td>3</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>1984-87</td>
<td>9</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>1988</td>
<td>20</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td>1989</td>
<td>47</td>
<td>49</td>
</tr>
<tr>
<td></td>
<td>1990</td>
<td>65</td>
<td>58</td>
</tr>
<tr>
<td></td>
<td>No response</td>
<td>8</td>
<td>12</td>
</tr>
<tr>
<td>What have you heard about its cure?</td>
<td>Incurable</td>
<td>104</td>
<td>103</td>
</tr>
<tr>
<td></td>
<td></td>
<td>68.4</td>
<td>69.6</td>
</tr>
</tbody>
</table>
On the question of what they had heard on AIDS curability, 68.4 per cent of males and 69.6 per cent of females said AIDS was incurable; however, the percentages of both sexes who claimed to have heard of a cure are rather large for a metropolis like Freetown: 15.8 per cent of males and 6.8 per cent of females claimed to have heard of an orthodox medical solution, while 3.3 per cent of males and 6.5 per cent of females claimed to be aware of traditional or spiritual healing options. This pattern of AIDS knowledge seems to have affected their own opinions on the curability of AIDS. In this respect, 64.2 per cent of female respondents maintained that AIDS is incurable. This is about 5.4 per cent below those who when asked what they had heard of a cure for AIDS, said it was incurable. Among the males 58.6 per cent maintained that AIDS is incurable, which is about 10 per cent below those who answered ‘incurable’ to the previous question. The large number of those who believe there is some form of cure raises many questions on the real effectiveness of the various information, education and communication efforts ascribed to the government and other related agencies5.

In spite of this pattern, quite a large percentage of the population was well aware of the infection sources of AIDS, most ascribing AIDS infection to sexual intercourse and blood transfusion.

It seems that men have better information and a clearer knowledge than women about AIDS. Given the pattern of respondents’ knowledge and opinions on AIDS it is interesting to examine the sexual behaviour of the population.

**General sexual behaviour patterns**

Four sexual activity parameters are examined in varying degrees among the entire population. They are age at first sexual intercourse (AGESEX), total sexual partners (TSEXP), sexual partners within the last year (ASEXP), and sexual partners within the last month (MSEXP). For the entire population, the pattern of these variables is illustrated in Table 3. For the entire population, the mean age at first sexual intercourse was 17 years while the median point was the 16th year, showing a relatively mild pattern of fluctuation.

**Table 3**

<table>
<thead>
<tr>
<th>General sexual activity variables by sex</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

5 A similar pattern was observed in the Lagos study. However, it appears that the incidence of wrong opinions and notions of AIDS is more critical in Freetown than in Lagos.
The minimum age recorded is nine years for one respondent. The modal age at first sexual intercourse is the 15th year, and by the 20th year, 89 per cent have had their first sexual intercourse, while about 1.7 per cent delayed their first sexual experience beyond the 25th year. The frequency of total sexual partnership varies between 1 and 97 partners. The

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<table>
<thead>
<tr>
<th>AGESEX</th>
<th>TSEX</th>
<th>ASEX</th>
<th>MSEX</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>M</td>
<td>F</td>
<td>All</td>
</tr>
<tr>
<td>Mean</td>
<td>17</td>
<td>16.9</td>
<td>17.0</td>
</tr>
<tr>
<td>Median</td>
<td>16</td>
<td>17.0</td>
<td>16.0</td>
</tr>
<tr>
<td>Modal freq value</td>
<td>15</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>% above (pop) mean</td>
<td>41.4</td>
<td>34.5</td>
<td>29.3</td>
</tr>
<tr>
<td>Effective number of respondents (N)</td>
<td>152</td>
<td>148</td>
<td>150</td>
</tr>
<tr>
<td>As % of total respondents</td>
<td>100</td>
<td>100</td>
<td>98.7</td>
</tr>
</tbody>
</table>

\*This was the uppermost limit allowed for respondents.
mean and the median values are eight and four partners respectively, an indication of the prevalence of extreme values. However, the modal sexual partnership category is those who have had only two sexual partners in their life time: altogether they account for 20.5 per cent of all valid responses. Most respondents, 82.8 per cent, have had between one and ten sexual partners, while 3.3 per cent claimed to have had 97 or more sexual partners.

Sexual partnership within the last year is also marked by some extreme values, however, the mean and the median values are not very far apart. The mean sexual partners within the last year was three against two for the median partnership point. The largest group of respondents, 40 per cent, have had only two sexual partners within the last year. Most respondents (96.2%) have also had between one and four sexual partners within the last year, and fewer than four per cent have had sexual intercourse with more than four sexual partners. Sexual partnership within the last month varied between zero and five, with one sexual partner being the mean, the median and the modal partnership value. About 12 per cent have had between three and five sexual partners over the same period. Gender analysis of the above pattern shows that the male respondents differ in some respects from the female respondents, although such differences are not uniform across sexuality parameters considered.

Thus the differences between the ages at first sexual intercourse (AGESEX) are not very large. It appears that on the average, the 17th year is the mean age of first sexual intercourse for both sexes. However, in spite of similar mean ages at first sexual experience, a greater percentage of the male respondents (41.4%) wait longer than the 17th year before their first sexual experience. This pattern seems to accord with expectation as the first sexual experience often takes place when a male partner is older than the female partner.

The total sexual partnership shows that 29.3 per cent of men have had more than the eight sexual partners which is the mean for the entire population, while only 6.8 per cent of female respondents exceeded this partnership level, so while the mean TSEX value for men was 13 partners, that for female respondents was four.

The pattern of sexual partnership within the last year appears to be an extension of the previous pattern between the two sexes: for example the average of sexual partners for men over this period was almost twice that of the women, 4 to 2.1. Similarly the percentage of males with above-median annual sexual partners was almost triple that of females: seven per cent of the female respondents and 19.2 per cent of men had more than three sexual partners within the last year. A similar pattern may be observed with respect to sexual partnership within the past month: 41.4 per cent of male respondents have had more than one sexual partner compared to 24.3 per cent of female respondents.

The pattern observed which shows larger sexual activity parameters for men than women is in line with the findings elsewhere. Orubuloye (1994) identified this tendency as a likely source of distortion to an accurate assessment of the real pattern of sexuality estimates within a population. However, in this particular context, the response levels by both the male and female respondents have been comparably high. Furthermore, the differences between the estimates of their sexual activity parameters have not been large, so the usual tendency for females to underreport their sexual behaviour seems to have been minimal.

**Premarital sexual activity**

The patterns of the sexuality parameters estimated among the unmarried respondents vary in some degree from those of the larger population as illustrated in Table 4. It appears that the age at first sexual intercourse is the most uniform for both sexes among the variables examined. The mean for the unmarried males is 16.5 years and it is slightly lower than that
for the never-married females by 0.4 years, while the two groups have the same median age at first sexual intercourse.

Further comparison of the age at first sexual relationship estimates of the never-married groups with that of the entire population as illustrated in Table 3 shows that a greater proportion of never-married male respondents had their first sexual experience before the 17th year. Only 33.3 per cent from this group had a first sexual experience later than the mean age at 17, while the corresponding percentage for the entire male population is 41.4. The pattern is different among the female respondents: on the average, the never-married females had a first sexual experience over a year later than those who are married.

The total sexual partnership parameter of the never-married group deviated only a little from the observed pattern for the larger population. The greater proportion of the unmarried males characterized by above-median partnership size only emphasizes the general pattern identified with the larger population. Hence the mean TSEXP for unmarried males was 11.6 partners and the median was 4.5 partners compared with 4.5 and 4.0 partners for the unmarried female respondents.

<table>
<thead>
<tr>
<th>Table 4</th>
<th>Sexual activity parameters for never-married group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AG</td>
</tr>
<tr>
<td>Population mean (Approx)</td>
<td>17</td>
</tr>
<tr>
<td>Population median value</td>
<td>16</td>
</tr>
<tr>
<td>Modal frequency</td>
<td>15</td>
</tr>
<tr>
<td>M</td>
<td>F</td>
</tr>
<tr>
<td>Mean value</td>
<td>16.5</td>
</tr>
<tr>
<td>Median value</td>
<td>16.0</td>
</tr>
<tr>
<td>% above the mean</td>
<td>33.3</td>
</tr>
<tr>
<td>Effective Respondents (N)</td>
<td>45</td>
</tr>
<tr>
<td>N as % of unmarried males/females</td>
<td>100</td>
</tr>
</tbody>
</table>

The observed patterns of sexual partnership for the periods within the last year and the last month tend to fall in line with the variations observed with the Total Sexual Partnership parameter for the entire population by sex. Thus a greater male percentage, 25.6, had more than the average number of two sexual partners within the last year compared with 6.1 per cent females in this category. Similarly, the mean sexual partnership level of 5.7 within the last year for unmarried men was more than double the mean for the never-married females.

Variations in the pattern of sexual partnership within the last month further emphasized the tendency to larger above-median partnership for men: 46.7 per cent of them had more than one sexual partner within the last month while only 28.6 per cent of the never-married females did. Thus far it is evident from the temporal pattern of sexual partnership that a greater proportion of men than women are characterized by above-median sexual partnership traits.
Sexuality parameters by selected characteristics

Total sexual partnerships

Greater similarities can be observed in the pattern of the total sexual partnerships of the never-married male age cohorts than among the female groups as illustrated in Table 5. Fifty per cent of male respondents under 30 years of age have had more than five sexual partners in their lifetime; the pattern is the same for males aged 30-39 years.

Further comparison however reveals that a larger percentage (11.5%) of the 30-39-year-old males have restricted themselves to only one sexual partner, compared to only 5.5 per cent of the younger cohort. This pattern contrasts with that of the females among whom wide variation is noticeable. The 30-39 years female age group has 4.8 per cent in the large TSEXP category compared with 23.8 per cent and 33.3 per cent for the other two age groups.

Ethnic differentiation in total sexual partnership is somewhat sharper than age group differences, this being more so with male respondents. Most Mende males (85.7%) for example are characterized by large sexual partnership compared to the Temne group with only 33.3 per cent. Creole males tend to have a balanced sexual partnership pattern among the three dominant groups, with 44 per cent in the large and the average sexual partnership categories. The observed patterns with the ‘others’ group which has 50 per cent and 12.5 per cent respondents respectively in average as well as in the minimum sexual partnership categories display a close similarity with the Creole males except that the above-median sexual activity of the Creole group is about five per cent lower.

The patterns with the female respondents tend to highlight the exceptionally large percentage of total sexual partnership of the Temne group. Sixty per cent of Temne females had had over five sexual partners in their lifetime; this is relatively large in comparison with the Creoles and the ‘others’ who had 38 per cent above-median total sexual partnership. The pattern of total sexual partnerships exhibited by the Mende females contrasts significantly with that of their male counterparts: the men had 85 per cent above-median total sexual partnership traits, the women 25 per cent.

Educational analysis of the variable TSEXP shows that those with educational advantages are characterized by large total sexual partnerships. However, it seems to demarcate total sexual partnerships primarily between the uneducated and the educated. For example, the gap between the pre-secondary and post-secondary male groups characterized by large numbers of sexual partners amounted to four per cent compared to 29.5 per cent between the no-education and the pre-secondary groups. The same pattern is observable among the female respondents: those with no education seem to be confined to the minimum and average partnership categories. The other two groups with relatively high education are differentiated by the tendency for large sexual partnership, having 40 per cent of respondents with five or more lifetime sexual partners.

The budget status of the respondents has a peculiar pattern common to both sexes. It shows, perhaps contrary to expectation, that those with surplus budget status are more likely to have a large number of sexual partners than those with negative budget status. Variations in the pattern of total sexual partners by religion have a similar pattern for both sexes. Among the males for example, 54.2 per cent of Christians have had more than five sexual partners in their lifetime compared to only 23.5 per cent of Muslims. Between the female groups, 41.7 per cent of Christians were characterized by above-median total sexual partnerships compared with 23.1 per cent of Muslims.
<table>
<thead>
<tr>
<th></th>
<th>Males</th>
<th></th>
<th>Females</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>minimum (1)</td>
<td>average (2-4)</td>
<td>large (5+)</td>
<td>minimum (1)</td>
</tr>
<tr>
<td>Age</td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>less than 30 yrs</td>
<td>1</td>
<td>5.5</td>
<td>8</td>
<td>44.9</td>
</tr>
<tr>
<td>30 - 39 yrs</td>
<td>3</td>
<td>11.5</td>
<td>10</td>
<td>38.5</td>
</tr>
<tr>
<td>40 + yrs</td>
<td>2</td>
<td>66.6</td>
<td>1</td>
<td>33.3</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Creole</td>
<td>1</td>
<td>11.1</td>
<td>4</td>
<td>44.4</td>
</tr>
<tr>
<td>Mende</td>
<td>1</td>
<td>14.3</td>
<td>1</td>
<td>14.3</td>
</tr>
<tr>
<td>Temne</td>
<td>1</td>
<td>8.3</td>
<td>7</td>
<td>58.3</td>
</tr>
<tr>
<td>Others</td>
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<td>6</td>
<td>37.5</td>
</tr>
<tr>
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</tr>
<tr>
<td>Budget status</td>
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<tr>
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<td></td>
<td></td>
</tr>
<tr>
<td>surplus budget</td>
<td>4</td>
<td>12.5</td>
<td>10</td>
<td>31.2</td>
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<tr>
<td>Religion</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Christianity</td>
<td>2</td>
<td>8.3</td>
<td>9</td>
<td>37.5</td>
</tr>
<tr>
<td>Islam</td>
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<td>11.7</td>
<td>11</td>
<td>64.7</td>
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Table 6: Number of sexual partnerships in the last year: never-married respondents by selected socio-economic characteristics in Freetown

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<thead>
<tr>
<th></th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>minimum (1) average (2-4)</td>
<td>large (5+)</td>
</tr>
<tr>
<td></td>
<td>N   %</td>
<td>N   %</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>less than 30 yrs</td>
<td>2   11.1</td>
<td>13  72.2</td>
</tr>
<tr>
<td>30 - 39 yrs</td>
<td>4   16.0</td>
<td>19  76.0</td>
</tr>
<tr>
<td>40 + yrs</td>
<td>1   33.3</td>
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</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Creole</td>
<td>1   12.5</td>
<td>6   75.0</td>
</tr>
<tr>
<td>Mende</td>
<td>1   14.3</td>
<td>4   57.1</td>
</tr>
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<td>Temne</td>
<td>2   16.7</td>
<td>10  83.3</td>
</tr>
<tr>
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<td>12  75.0</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
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<tr>
<td>none</td>
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<td>3   75.0</td>
</tr>
<tr>
<td>primary-secondary</td>
<td>3   8.8</td>
<td>26  76.5</td>
</tr>
<tr>
<td>post-secondary</td>
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<td>3   60.0</td>
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<tr>
<td>Religion</td>
<td></td>
<td></td>
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<tr>
<td>Christianity</td>
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<td>16  69.6</td>
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<tr>
<td>Islam</td>
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<td>14  82.3</td>
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Table 7: Sexual partnership in the past month\(^a\) of never-married respondents by selected socio-economic characteristics in Freetown

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<tr>
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<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>minimum (1)</td>
<td>average (2-4)</td>
</tr>
<tr>
<td></td>
<td>N  %</td>
<td>N  %</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>less than 30 yrs</td>
<td>3  16.7</td>
<td>6  33.3</td>
</tr>
<tr>
<td>30 - 39 yrs</td>
<td>6  22.2</td>
<td>9  33.3</td>
</tr>
<tr>
<td>40 + yrs</td>
<td>2  66.6</td>
<td>1  33.3</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Creole</td>
<td>2  25.0</td>
<td>3  37.5</td>
</tr>
<tr>
<td>Mende</td>
<td>2  16.7</td>
<td>5  41.7</td>
</tr>
<tr>
<td>Temne</td>
<td>2  22.2</td>
<td>1  11.1</td>
</tr>
</tbody>
</table>

\(^a\) Drop from last year.
<table>
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<th>Others</th>
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<th>6</th>
<th>37.5</th>
<th>7</th>
<th>43.7</th>
<th>18.7</th>
<th>1</th>
<th>5.5</th>
<th>11</th>
<th>61.1</th>
<th>6</th>
<th>33.3</th>
<th>5.5</th>
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</thead>
<tbody>
<tr>
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<td>2</td>
<td>50.0</td>
<td>3</td>
<td>75.0</td>
<td>1</td>
<td>25.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td>primary-secondary</td>
<td>5</td>
<td>14.3</td>
<td>11</td>
<td>31.4</td>
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<td>11.8</td>
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<td>11.4</td>
<td>18</td>
<td>51.4</td>
<td>13</td>
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</tr>
<tr>
<td></td>
<td>post-secondary</td>
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<td>75.0</td>
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<td>60.0</td>
<td>4</td>
<td>40.0</td>
<td>6</td>
<td>60.0</td>
<td>40.0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
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<td>2</td>
<td>16.7</td>
<td>7</td>
<td>58.3</td>
<td>18.2</td>
<td>6</td>
<td>27.3</td>
<td>13</td>
<td>59.1</td>
<td>3</td>
<td>13.6</td>
</tr>
<tr>
<td></td>
<td>surplus budget</td>
<td>6</td>
<td>18.2</td>
<td>13</td>
<td>39.4</td>
<td>14</td>
<td>42.4</td>
<td>15.6</td>
<td>2</td>
<td>9.1</td>
<td>14</td>
<td>63.6</td>
<td>6</td>
<td>27.3</td>
</tr>
<tr>
<td>Religion</td>
<td>christianity</td>
<td>5</td>
<td>20.8</td>
<td>7</td>
<td>29.2</td>
<td>12</td>
<td>50.0</td>
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<td>7</td>
<td>19.4</td>
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<td>50.0</td>
<td>11</td>
<td>30.5</td>
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<td></td>
<td>islam</td>
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<td>16.7</td>
<td>7</td>
<td>38.9</td>
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<td>11.8</td>
<td>1</td>
<td>7.7</td>
<td>9</td>
<td>69.2</td>
<td>3</td>
<td>23.1</td>
</tr>
</tbody>
</table>

*The three categories here differ from the earlier two as there is a column on inactivity: those who had sexual partners in the last-year analysis but did not have one in the last month. The other two categories are based on different numbers of sexual partnership. For example, the ‘large’ category in the last-year analysis refers to 5 sexual partners or more, while in the monthly analysis it refers to 2 partners or more. The other two groups have none and 1 sexual partners respectively.*
Table 8: Age cohort and extramarital sexual activity in Freetown

<table>
<thead>
<tr>
<th>Levels of extramarital partnership</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>under 30</td>
<td>30-39 years</td>
</tr>
<tr>
<td>Minimum (1)</td>
<td>10 38.5</td>
<td>30 28.1</td>
</tr>
<tr>
<td>Average (2-3)</td>
<td>8 30.8</td>
<td>10 31.3</td>
</tr>
<tr>
<td>High (4+)</td>
<td>8 30.8</td>
<td>13 40.6</td>
</tr>
<tr>
<td>Total</td>
<td>26 100</td>
<td>53 100</td>
</tr>
</tbody>
</table>
Non-marital sexual partnership pattern in the past year

The pattern of sexual partnerships in the last year (Table 6) shows some deviation from what was observed for total lifetime sexual partnerships. Among the male age categories for example, the over-30 years group shows a reduction in the tendency for above-median sexual interaction. Only eight per cent from this group had five or more sexual partners.

The younger male group also has a reduction in the percentage of those with large sexual partnership, from 50 per cent for total sexual partnerships to only 16.7 per cent for sexual partnerships in the last year. The younger male age-group still retained the inclination for more sexual partnerships than the older male group.

Among the female respondents a more striking variation is observed. Virtually all female respondents by whatever classification have dropped out of large sexual partnership categories, so most of the variations observed in respect of sexual partnership occur between the moderate and the minimum sexual partnership groups. Variation by age group is minimal, except for the under-30 age group of which 4.8 per cent had five or more partners in the last year, a pattern which resembles that of males under 30. Generally, about one-third of each unmarried female group restricted themselves to one sexual partner within the last year. There is, however, a tendency for all the female age groups to concentrate in the median sexual partnership region.

Variations by ethnicity seem to reflect the pattern observed for total sexual partnerships. For example, the Temne unmarried males still showed the least tendency for above-median sexual activity. They had no respondents with many sexual partners in the past year, compared with 38.6 per cent of Mende males with five or more sexual partners, which is the most among the four ethnic groups. The Temne also had the modal percentage in the minimum partnership region, with 16.7 per cent males who had restricted themselves to only one sexual partner within the last year. The Creoles also show a moderate tendency which is exactly the same as the ‘others’ ethnic group. Both groups had 12.5, 75 and 12.5 per cent categories of respondents respectively within the minimum, the median and the above-median sexual activity groups. However, the pattern among the females is rather different, with 7.7 per cent of Creole respondents having had at least five sexual partners within the last year.

The Mende women had the largest percentage (75%) of respondents with two to four sexual partners in the past year. The variations introduced by education further show the greater tendency of the primary-secondary male group to large sexual partnership compared with the two other male groups, as observed in the total sexual partnership analysis, which shows that all male respondents with five or more sexual partnerships in the past year have either primary or secondary education.

Those with post-secondary education seem to have maintained a conservative attitude toward multiplicity of sexual partnerships relatively to other male education groups. They have the modal percentage of 40 per cent of male respondents with minimum sexual partners as well as the lowest percentage even in the median sexual partnership range.

---

7 The tendency to above-median sexual activity may in fact characterize the Mende female group rather than the Creole. The one case (7.7%) of above-median partnership may be due to sampling error, rather than the 75 per cent of Mende females with two to four sexual partners, which is the modal percentage among all the ethnic groups.
The same pattern was perhaps reflected by female respondents; for example, the primary-secondary group has the only case with large sexual partnership. It also has 65.7 per cent of respondents whose sexual partners range between two and four as against 25.6 per cent of the no-education group, and 70 per cent of the post-secondary group. Higher education status among the never-married females seems to be associated with large sexual partnership.

On the other hand, this pattern is absent among males and when sexual partnership among men is analysed, their educational status did not differentiate significantly among their partnership indications as may be observed in the female educational groups. The sexual partnership analysis by budget status reveals an interesting pattern which may appear contradictory to normal expectation. This applies particularly to the female budget groups among whom no respondents with low-budget status had up to five sexual partners within the last year, compared with 4.5 per cent of the surplus-income group who had had many sexual partners over the same period.

This pattern on the contrary seems to offer a clue concerning some issues of female sexual promiscuity and how the economic motive in sexual relationships tends to operate among women. Above-median sexual activity for economic gain may not necessarily be associated with sexual multi-partnership. It may involve a minimum level of sexual partnerships but with the element of concentration or focus in sexual interaction. The pattern in the male group is also consistent as none of the low-budget men seem to have the economic capacity to indulge in large sexual partnership in comparison with the surplus budget group. While 15.6 per cent of the surplus-budget men had had not less than five sexual partners in the last year, no deficit-budget men seem to have done so. However, the fact that many within the deficit budget group (90.9%) have had between two and four partners within the last year shows that their sexual activity has not been low.

The variations introduced by religion show that never-married Muslim males are more concentrated with the average number of sexual partners than their Christian counterparts: 17.4 per cent of Christian males have had at least five sexual partners compared with 5.9 per cent of Muslim males. Among the female respondents, the same pattern is repeated, with 46.1 per cent of Muslim respondents having restricted themselves to only one sexual partner within the last year. They have been less characteristic even of the moderate partnership range than their Christian counterparts: 53.6 per cent of Muslim females had had between two and four sexual partners, which is about 15.3 per cent lower than their Christian counterparts.

Non-marital sexuality within the last month

The pattern of sexual partnership within the last month shows some reduction in the size of each group actively involved in sexual relationship; the degree of reductions however varies among the gender groups as illustrated in Table 7. Generally, among the female respondents, 17.4 per cent had sexual partners in the last year but have been without sexual partners over the last month, while 16.5 per cent of never-married males were in this group.

The observed variations in the pattern of partnership distribution for each sex independent of the other did not seriously differentiate the various socio-economic groups from one another. Thus among male respondents, the two age groups are both characterized

---

8 This argument seems to distinguish the economically-induced sexual behaviour of a purely commercial sex worker from that of a female concubine or a young woman and her sugar daddy. The former may, and indeed often does involve multipartnership, with or without sexual focus, while sexual focus seems to appropriately model the sexual interaction within the latter group.
by a two or more modal sexual partnership category, except that the actual proportion shows
Table 9: Temporal pattern of extramarital sexual relationship

<table>
<thead>
<tr>
<th>Variables</th>
<th>% drop</th>
<th>% year-month</th>
<th>% last year (emar1)</th>
<th>% last month (emar2)</th>
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<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intimacy level</td>
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<td></td>
<td></td>
</tr>
<tr>
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<td>19 61.3 12</td>
<td>12 38.7 19</td>
<td></td>
</tr>
<tr>
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<td>31.6</td>
<td>48 63.2 28</td>
<td>24 31.6 52</td>
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</tr>
<tr>
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<td>37.6</td>
<td>23 53.3 20</td>
<td>11 25.6 32</td>
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<tr>
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</tr>
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<td>35 60.3 23</td>
<td>23 39.7 35</td>
<td></td>
</tr>
<tr>
<td>women, shorter</td>
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<tr>
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<td>15 26.8 41</td>
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<td>7 30.4 16</td>
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<td>14 19.4 58</td>
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<td>33 70.2 14</td>
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<tr>
<td>female Muslim</td>
<td>28.9</td>
<td>26 57.8 19</td>
<td>13 28.9 32</td>
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<td>Spousal age difference</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>minimum age diff (both sexes)</td>
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<td>51 60.0 34</td>
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<td>wives with much lower age</td>
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</tr>
<tr>
<td>wives with much higher age</td>
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<td>7 60.0 4</td>
<td>1 10.0 9</td>
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<td>26 55.3 21</td>
<td>14 29.8 33</td>
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</tr>
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<td>11 20.4 43</td>
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<tr>
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<td>32.0</td>
<td>31 62.0 19</td>
<td>15 30.0 35</td>
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</tr>
<tr>
<td>Freetown</td>
<td>18.6</td>
<td>51 50.0 51</td>
<td>32 31.4 70</td>
<td></td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Creole</td>
<td>15.8</td>
<td>18 47.4 20</td>
<td>12 31.6 26</td>
<td></td>
</tr>
<tr>
<td>Mende</td>
<td>50.0</td>
<td>34 68.0 16</td>
<td>9 18.0 41</td>
<td></td>
</tr>
<tr>
<td>Temne</td>
<td>27.8</td>
<td>22 61.1 14</td>
<td>12 33.3 24</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Others</td>
<td>19.5</td>
<td>41</td>
<td>50.0</td>
</tr>
<tr>
<td>----------------</td>
<td>---------</td>
<td>------</td>
<td>----</td>
<td>------</td>
</tr>
<tr>
<td>Premarital sexual activity level</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>male, low</td>
<td></td>
<td>23.7</td>
<td>22</td>
<td>57.9</td>
</tr>
<tr>
<td>male, high</td>
<td></td>
<td>35.5</td>
<td>43</td>
<td>69.4</td>
</tr>
<tr>
<td>female, low</td>
<td></td>
<td>19.6</td>
<td>26</td>
<td>46.4</td>
</tr>
<tr>
<td>female, high</td>
<td></td>
<td>36.3</td>
<td>14</td>
<td>63.6</td>
</tr>
</tbody>
</table>
that the younger male group has six per cent more respondents with above-median sexual activity than the 30-39-years age group. Among the female groups, greater proportions of the lower age groups have kept below three sexual partners in the last month. The larger percentage of the older age group with two or more sexual partners is perhaps caused by its relatively low sample size.

The ethnicity variable differentiates on the one hand between the Creole males with 66.6 per cent large sexual partnership and the three other groups whose above-median sexual activity varied generally between 37.5 per cent and 41.7 per cent. Among the female groups, those with large sexual partnership varied from 33.3 per cent for the 'others' group to 20 per cent for the Temne group.

Much of the variation introduced by educational variables seems to differentiate gender groups from the no-education and the primary-secondary groups. For example, no respondents in the post-secondary category, either males or females, had more than two sexual partners within the last month; similarly, the primary-secondary groups are characterized by a larger percentage with two or more sexual partners, closely followed by the no-education group.

The pattern of sexual partnership by religion did not deviate from the previous pattern which shows the stronger inclination of Christian males for above-median partnership: 50 per cent of Christian males have had at least two partners compared to 44.4 per cent of the Muslim males. The gap is slightly smaller in the female groups, among whom the Christians with two or more sexual partners exceeded the Muslims by 7.4 per cent. However, the percentage that dropped out of active sexual partnership was greater among the Christians than among the Muslims.

Extramarital sexual activity

Analysis on extramarital relationships was obtained from a combination of questions. These are whether respondents have ever had an extramarital relationship since their first marriage, the number of sexual partners since first marriage and the number of sexual partners in the last year and within the last month.

This perspective is informed primarily by two considerations. The first has to do with the realization that the practice of extramarital sex among respondents has a temporal dimension. That is, some of the respondents who had engaged in extramarital sexual relationships might have done so in the distant past, which is outside the temporal span considered dangerous, particularly for HIV infection. Secondly, the variations observed in the temporal pattern of AIDS awareness by respondents also suggest that any likely change in sexual behaviour due to such knowledge would likewise exhibit temporal variations.

Three aspects of the extramarital relationship have been examined. One is the variation in the incidence of extramarital relationship generally between the two sexes. The second is the pattern of variation in extramarital sexual activity with selected socio-demographic classificatory parameters by sex. The third aspect is the phenomenon of withdrawal from extramarital sexual activity against the observed differences in the temporal pattern of AIDS awareness as well as the incidence of a previous sexually transmitted disease. The particular STD referred to here is gonorrhoea, chosen because 32 per cent of all respondents said they had had gonorrhoea at some time. The relative variations introduced to extramarital sex by socio-economic variables are compared, vis-à-vis sexual morbidity factors.
Gender patterns of extramarital sex

The incidence of extramarital sex seems rather higher in Freetown than in some comparable cities. From the response to the question on extramarital relationships at least 73.8 per cent of males and 69.7 per cent of females had had extramarital relationships since their first marriage. Further analysis shows that the range of extramarital sexual relationships lies between one and 19 sexual partners for both sexes. The mean number of extramarital partners for men was a little over four partners compared to 2.54 partners for women. Among the males 29.1 per cent had only one extramarital partner compared to 37.7 per cent of females. Although both the mean and the median number of extramarital partners for males exceeded those for females — 4.3 and 3.0 respectively for men against 2.5 and 2.0 partners for females — the women’s modal partnership level of two exceeded that of men. Further desegregation of extramarital partnership is examined in Table 8 to see if there are variations in the number of extramarital partnerships among age cohorts by sex. It was assumed that the number of years spent in marriage might introduce variations to extramarital sexual activity.

The patterns of sexual partnership among the under-30-year-old males appear more evenly distributed than those of the older cohort. The under-30 cohort also has the largest proportion of respondents with only one extramarital partner since marriage. This pattern differs from the other male age cohorts, especially from the 30-39 years age group among whom 40.6 per cent of respondents had at least four sexual partners since first marriage. Number of extramarital sexual partnerships among the 40-year-old males is somewhere between the two younger cohorts, with a modal percentage of 2-3 sexual partners.

Female respondents on the other hand tend to contrast with the observed pattern among the males especially when the percentages of the three cohorts in the large sexual partnership range are compared. The youngest female age cohort in particular contrasts with the equivalent male group: for example, close to one-third of the under-30-year-old men had at least four sexual partners since marriage, but only 8.7 per cent of women under 30 had done so. The female pattern shows a positive variation between the magnitude of extramarital partnership and the number of years spent in marriage while this pattern seems reversed among the married male cohort.

The temporal sequence in extramarital relationships

A relatively high incidence of extramarital relationships has been observed, evidently involving both male and female respondents. However, within the cohort analysis which focuses primarily on the vulnerability of respondents to AIDS, the time when such extramarital relationships occurred becomes relevant as the incidence of the AIDS scourge only became very prominent in the 1980s.

The temporal pattern of extramarital relationships is examined further to ascertain what socio-demographic peculiarities seem to indicate the likelihood of extramarital relationships and the relative consistencies of such explanations as the level of extramarital sexual activity.

---

9 The extramarital relationship level in Lagos, for example, involved 58.9 per cent of married men and 17.4 per cent of married women.

10 The respondent age cohort has been employed as a surrogate for the number of years spent in marriage, on the assumption that on the average, older respondents are likely to have spent more of years in marital unions than younger ones. This assumption was necessary as the data on year of marriage or number of years in marriage were not collected.
changes over time. A series of socio-economic variables were considered on the basis of
published and unpublished works\textsuperscript{11}. Some of these factors are designed to reveal divergences in the socio-economic and demographic traits of a married couple while a factor like intimacy is a psychological factor which may influence the chances of a married respondent engaging in extramarital sex.

The age difference and the educational gap between the couple were considered in the analysis, as were other variables which relate primarily to each respondent\textsuperscript{12} exclusively, such as budget status, duration of stay in Freetown, incidence of premarital sexual activity, type of marital union (monogamous or polygynous), religion, childhood environment and ethnicity.

We first intended to analyse each sex separately, or at least to design each variable in a manner that would separate the two sexes. This idea was dropped as it tended to create too many categories, which diminished the reliability of our analysis; through an initial logistic analysis some variables were excluded as they had the tendency to reduce the number of respondents included in the analysis as well as to create many redundant matrices which ultimately reduces the reliability of the analysis. So not all the variables hypothesized were included in the logistic regression analysis. The analysis in Table 9 shows the classification of those who had had extramarital relationships within the last year as well as the last month. The table compares the extent of extramarital relationship in the last month with that in the last year, and assesses the variation in extramarital sexual activity between the last year and the last month.

A comparison of the level of extramarital relationship between those who have ever had such a relationship and those who did so within the last year shows only a negligible reduction. Extramarital relationships within the last year involved 62.2 per cent of male and 48.5 per cent of female respondents. This shows a much more significant reduction for female respondents among whom 21.2 per cent of those who had ever had an extramarital relationship had discontinued in the last year. Among male respondents, only 11.2 per cent had discontinued extramarital relationships within the last year. However, the extent of extramarital dropout increased for both sexes within the last month.

Among the married females there was a reduction of 54.2 per cent on the level of extramarital sex between the last year and the last month, and among males, 46 per cent. A comparative analysis of the variation in the patterns of extramarital relationships within the last year as well as the last month shows that in most cases there are minimal differences in the level of extramarital sex among the variable subcategories. This tendency is reflected also by the pattern of dropout in extramarital relationships among the variable subgroups. Among the four intimacy groups, the level of dropout varied from 22.6 per cent for men with low intimacy and 37.9 per cent for women with low intimacy. This tendency is reflected also by the pattern of dropout in extramarital relationships among the variable subgroups. Among the four intimacy groups, the level of dropout varied from 22.6 per cent for men with low intimacy and 37.9 per cent for women with low intimacy.

The pattern variations among the other variable subcategories are similar to what is observed in the intimacy analysis, so a logistic regression analysis was used to further assess the effect of each variable within a multi-variable arrangement. Through a selection process which involved variable combination and recombination a few variables were entered into the analysis. The sets of variables which entered the two analyses differed significantly.

\textsuperscript{11} Isiugo-Abanihe (1994) and Babatola (1995) were relevant. Much of the relationship between some of the selected variables and the propensity for extramarital relations was also explored in the latter study.

\textsuperscript{12} Not all variables could be computed to show contrasts between partners since data were collected on a few variables on each respondent’s partner.
As shown in Tables 10 and 11 the common variables to the two analyses are education status, spousal age difference, ethnicity, and childhood environment. The results for both periods show that groups are not statistically differentiated in their likelihood to have had extramarital relationships within either the last year or the last month, supporting the validity of the earlier result above. But there were still some relative differences among the subgroups. The analysis for the last year, for example, shows that all other groups, both male and female, under the duration factor have a lower likelihood of extramarital relationships than men who had stayed a short time in Freetown. The low level of differentiation among subgroups generally in the analysis may be due to the relatively small sample size. Perhaps a clearer insight would be obtained with larger sample analysis.

Table 10
Logistic results of extramarital relationship in the last year

<table>
<thead>
<tr>
<th>Variables</th>
<th>Co-efficient</th>
<th>Odds ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>none</td>
<td>0.00</td>
<td>1.000</td>
</tr>
<tr>
<td>primary</td>
<td>-0.3236</td>
<td>0.7235</td>
</tr>
<tr>
<td>secondary</td>
<td>0.4534</td>
<td>1.5737</td>
</tr>
<tr>
<td>post secondary</td>
<td>0.4597</td>
<td>1.5836</td>
</tr>
<tr>
<td>Spouse age difference</td>
<td></td>
<td></td>
</tr>
<tr>
<td>minimum age diff (both sexes)</td>
<td>0.00</td>
<td>1.000</td>
</tr>
<tr>
<td>wives with much lower age</td>
<td>-0.3381</td>
<td>0.7131</td>
</tr>
<tr>
<td>wives with much higher age</td>
<td>0.5927</td>
<td>1.8089</td>
</tr>
<tr>
<td>husbands with wide age advantage</td>
<td>-1.1442</td>
<td>0.3185</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Creole</td>
<td>0.00</td>
<td>1.000</td>
</tr>
<tr>
<td>Mende</td>
<td>0.8456</td>
<td>2.3294</td>
</tr>
<tr>
<td>Temne</td>
<td>0.5952</td>
<td>1.8134</td>
</tr>
<tr>
<td>Others</td>
<td>-0.1047</td>
<td>0.9006</td>
</tr>
<tr>
<td>Environment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>village</td>
<td>0.00</td>
<td>1.000</td>
</tr>
<tr>
<td>town</td>
<td>0.1464</td>
<td>1.5911</td>
</tr>
<tr>
<td>Freetown</td>
<td>-0.5258</td>
<td>0.5911</td>
</tr>
<tr>
<td>Duration</td>
<td></td>
<td></td>
</tr>
<tr>
<td>men, short</td>
<td>0.00</td>
<td>1.000</td>
</tr>
<tr>
<td>men, long</td>
<td>-0.3925</td>
<td>0.6753</td>
</tr>
<tr>
<td>women, short</td>
<td>-0.7074</td>
<td>0.4929</td>
</tr>
<tr>
<td>women, long</td>
<td>-0.3856</td>
<td>0.6794</td>
</tr>
<tr>
<td>Budget status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>men, low budget</td>
<td>0.00</td>
<td>1.000</td>
</tr>
<tr>
<td>men, surplus budget</td>
<td>1.0378</td>
<td>2.823</td>
</tr>
<tr>
<td>women, low budget</td>
<td>-0.4924</td>
<td>0.6112</td>
</tr>
</tbody>
</table>

\[^a^]\text{dropped automatically from the analysis because of redundant matrices}

Educational analysis shows that those without education had less likelihood of extramarital relationship with the last month, than the other education groups, except for the primary education group, which had less likelihood than the non-education group. Both the secondary and the post-secondary respondents had the highest and somewhat comparable
Table 11
Logistic results of extramarital relationships in the last month

<table>
<thead>
<tr>
<th>Variables</th>
<th>Co-efficient</th>
<th>Odds ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>none</td>
<td>0.0</td>
<td>1.00</td>
</tr>
<tr>
<td>primary</td>
<td>-0.378</td>
<td>0.688</td>
</tr>
<tr>
<td>secondary</td>
<td>0.4660</td>
<td>1.5936</td>
</tr>
<tr>
<td>post-secondary</td>
<td>0.8740</td>
<td>2.3964</td>
</tr>
<tr>
<td>Spousal age difference</td>
<td></td>
<td></td>
</tr>
<tr>
<td>minimum age diff.</td>
<td>0.0</td>
<td>1.00</td>
</tr>
<tr>
<td>wives, lower age gap</td>
<td>0.3269</td>
<td>1.3867</td>
</tr>
<tr>
<td>wives, higher age gap</td>
<td>-1.0344</td>
<td>0.3555</td>
</tr>
<tr>
<td>Husbands, wider age advantage</td>
<td>-6.2192</td>
<td>0.8032</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Creole</td>
<td>0.0</td>
<td>1.00</td>
</tr>
<tr>
<td>Mende</td>
<td>-0.5594</td>
<td>0.5715</td>
</tr>
<tr>
<td>Tenne</td>
<td>-0.0913</td>
<td>0.9128</td>
</tr>
<tr>
<td>Others</td>
<td>0.0250</td>
<td>1.0253</td>
</tr>
<tr>
<td>Environment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>village</td>
<td>0.0</td>
<td>1.0</td>
</tr>
<tr>
<td>town</td>
<td>0.7171</td>
<td>2.048</td>
</tr>
<tr>
<td>Freetown</td>
<td>0.6174</td>
<td>1.854</td>
</tr>
<tr>
<td>Intimacy level</td>
<td></td>
<td></td>
</tr>
<tr>
<td>men, low</td>
<td>0.0</td>
<td>1.0</td>
</tr>
<tr>
<td>men, high</td>
<td>-0.4409</td>
<td>0.6435</td>
</tr>
<tr>
<td>women, low</td>
<td>-0.4925</td>
<td>0.6111</td>
</tr>
<tr>
<td>women, high</td>
<td>-0.8489</td>
<td>0.4279</td>
</tr>
<tr>
<td>Religion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>male Christian</td>
<td>0.00</td>
<td>1.00</td>
</tr>
<tr>
<td>male Muslim</td>
<td>0.1925</td>
<td>1.212</td>
</tr>
<tr>
<td>female Christian</td>
<td>-1.1102</td>
<td>0.3269</td>
</tr>
<tr>
<td>female Muslim</td>
<td>a</td>
<td></td>
</tr>
</tbody>
</table>

*dropped automatically from the analysis because of redundant matrices*

likelihood of extramarital relationship. Age differences showed that wives with wider age advantage had more likelihood of having extramarital relationships than those who are in the same age range as their spouses. The ethnic variables show that Creoles were less likely to have had extramarital relationships over the last year than either the Mende or the Tenne. The orientation however changes when comparison is made with the respondents in the 'other' groups.

Those born within Freetown showed less likelihood of extramarital relationships than those born in a village. This pattern contrasts significantly with what was observed in Lagos where urbanity of childhood environment correlated with higher likelihood of extramarital sex. The budget status analysis shows that men with surplus budget were very likely to have had extramarital relations within the last year, about three times more likely than low budget-status men. The pattern shown in Table 11 is somewhat like that of Table 10 as it affects the relative differentiation of the various subgroups. Among the variables examined, only education, environment and to some extent spousal age difference seem to differentiate in a comparatively large measure the incidence of extramarital relationships within the last month.

The intimacy factor shows a rather poor differentiation in extramarital behaviour in this respect, although the pattern shows that men with low intimacy have a greater likelihood of
extramarital relationships over the past month. The two female intimacy groups had less likelihood of extramarital relationships over the same time than the low-intimacy men. Education differentiation showed that respondents with post-secondary education are about twice as likely to have had extramarital relationships as those without education. The secondary education group also exceeded the non-education group in their likelihood of extramarital sexual activity, but the primary education respondents had less likelihood.

The religion analysis shows that the Muslim males have a higher likelihood of extramarital relationships than their Christian counterparts while the female Muslims were less likely. Age difference patterns show that wives who are much younger than their husbands are the only group with a higher likelihood of extramarital relationships compared to spouses with minimal age difference with their partners. The two other groups, that is, those with higher age advantage and the husbands with wide age gap, show a lesser likelihood. The environment factors are in line with the results under the last-year analysis: respondents born in towns outside Freetown have a greater likelihood of extramarital relationships than those born either in Freetown or in the villages.

The pattern of extramarital relationship by ethnicity however shows the Creoles as having the greatest likelihood of extramarital relationships within the past month with the exception of the ‘other’ ethnic groups. The pattern above for the two periods tends to show less differentiation among the various subgroups in general. It shows perhaps that the propensity for extramarital relationships has become common regardless of socio-economic variations. Since much extramarital sexual activity was not explained exhaustively by these socio-economic variables, further analysis is carried out to explore the relevance of morbidity factors as conceptualized in the differential awareness patterns of AIDS and the incidence of gonorrhoea among the population. The next section analyses the relationship between extramarital dropouts and the incidence of gonorrhoea infection as well as the temporal differences in the AIDS awareness pattern.

**Morbidity factors and discontinuance of extramarital relationships**

Table 12 illustrates the incidence of extramarital relations discontinuance and how this relates to some morbidity variables. The emergent pattern is rather diffuse. Analysis of discontinuance within the last year shows that only 20 per cent of male respondents who had had gonorrhoea had no extramarital relationship within the same period. This value is lower than the 40 per cent of males who had never had gonorrhoea, yet did not engage in such a relationship. Among the female respondents the same pattern is observable. It does not seem that having had gonorrhoea in the past had as much influence on the pattern of discontinuance as some other factors may have. A comparative analysis of the temporal pattern of AIDS awareness shows that among males, 33.3 per cent of pre-1990 ‘knowers’ discontinued extramarital relationships in 1989 or thereafter, while among those who heard of AIDS in 1990, 21.2 per cent stopped extramarital relationships a year before their awareness. There is some relationship between early knowledge and higher degree of withdrawal from extramarital relationships, but the margin between the early knowers and the late knowers seems not to be large.

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13 The discontinuance percentage was obtained by identifying those who had had extramarital relationships before, but who did not do so within the last year: they had stopped having extramarital relationships.
Table 12
Extramarital relations discontinuance

<table>
<thead>
<tr>
<th>Time awareness pattern of AIDS</th>
<th>Male</th>
<th>Female</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early knowers (pre-1990)</td>
<td>33.3</td>
<td>29.0</td>
<td>58.9</td>
<td>61.3</td>
</tr>
<tr>
<td>Late knowers (post-1989)</td>
<td>21.2</td>
<td>37.5</td>
<td>60.1</td>
<td>75.0</td>
</tr>
<tr>
<td>Recency of gonorrhoea experience</td>
<td>25.0</td>
<td>33.3</td>
<td>37.5</td>
<td>16.7</td>
</tr>
<tr>
<td>past (pre-1986)</td>
<td>17.2</td>
<td>16.7</td>
<td>82.7</td>
<td>50.0</td>
</tr>
</tbody>
</table>

A contrary pattern is observed among the females, among whom the magnitude of discontinuance of ‘late knowers’ exceeded that of the ‘early knowers’ by 8.5 per cent. Analysis of recency of gonorrhoea experience shows that for both sexes, those with recent gonorrhoea experience had a greater percentage of discontinuance. About eight per cent more of men recently infected discontinued extramarital relationships in the last year than men infected with gonorrhoea before 1986. The difference between the percentage of dropout of non-infected and previously infected respondents was however not large enough to conclude that it was the incidence of previous gonorrhoea experience that caused the difference.

The pattern among female respondents shows greater differentiation, 33.3 per cent of those recently infected dropped out of extramarital relationships compared to 16.7 per cent of those infected before 1986. The pattern of extramarital dropouts within the last month seems to contrast significantly with that of the last year. Among the three morbidity variables, only a previous experience of gonorrhoea among men tends to differentiate extramarital sexual activity over the period. The other two variables, early and late knowledge of AIDS, and the recency of gonorrhoea experience did not give much weight to the morbidity variables’ having had greater influence on extramarital sex discontinuance. The pattern observed above perhaps calls for better communication, information and educational strategies to ensure a healthier pattern of sexual behaviour.

Focus in sexual partnership

The importance of focus in sexual relationships has been highlighted elsewhere (Andersen 1992; Orubuloye, Caldwell and Caldwell 1992a). It has been observed that prolonged sexual relationship with a partner enhances the possibility of contracting HIV if one partner is infected. If intensive sexual intercourse is combined with multiple sexual partnerships, the risk of AIDS infection is heightened. Table 13 shows an analysis of focus in the sexual interaction of the respondents.

The pattern of multi-partnership sexual focus takes into account the marital status as well as the kind of marriage of the respondents. At the level of sexual intercourse with the first partner, at least 99.6 per cent of unmarried females and 77.8 per cent of unmarried males
were involved\textsuperscript{14}. At that level, the unmarried female respondents had a greater concentration of focus in their sexual intercourse. The gap between their mean and median values shows greater divergences in the sexual intercourse frequency among its members than among the unmarried males.

The percentage of unmarried males who networked to the second level was higher than that of the unmarried females, 68.9 per cent for males and 61.2 per cent for females.

Table 13
Marital status and pattern of sexual networking

\begin{tabular}{|c|c|c|c|c|}
\hline
\textbf{Marital status} & \textbf{Unmarried males} & \textbf{Unmarried females} & \textbf{Married monogamous males} & \textbf{Married polygynous males} & \textbf{Married females} \\
\hline
\textbf{Levels of sexual partnership} & level 1 & level 2 & level 3 & level 4 & level 1 & level 2 & level 3 & level 4 & level 1 & level 2 & level 3 & level 4 \\
\hline
Unmarried males & 35 (77.8) & 31 (68.9) & 12 (26.7) & 8 (17.8) & \textbf{mean} 25.7 & 21.4 & 10.2 & 17.5 \\
& & & & & \textbf{median} 20.0 & 12.0 & 4.5 & 4.5 \\
Unmarried females & 39 (79.6) & 30 (61.2) & 9 (18.4) & 2 (4.1) & \textbf{mean} 34.3 & 40.9 & 56.5 & 71.0 \\
& & & & & \textbf{median} 20.0 & 30.0 & 50 & 71.0 \\
Married monogamous males & 36 (40.9) & 16 (18.2) & 6 (6.8) & \textbf{mean} 30.3 & 30.5 & 20.3 \\
& & & & & \textbf{median} 15.5 & 12.5 & 14.0 \\
Married polygynous males & 4 (44.4) & 4 (44.4) & 4 (44.4) & \textbf{mean} 30.2 \\
& & & & & \textbf{median} 15.0 \\
Married females & 29 (29.3) & 8 (8.1) & 3 (3.0) & \textbf{mean} 43.8 & 57.0 & 35.0 \\
& & & & & \textbf{median} 40.0 & 62.0 & 8.0 \\
\hline
\end{tabular}

Note: The mean and the median values refer to the frequency of sexual intercourse by the reference group at that particular sexual partnership level

However, the phenomenon of sexual focus is far stronger among the female group than among unmarried males. On the average, the unmarried male had an intercourse frequency of 221 times with his partner at the second partnership level compared to 41 times for the unmarried female. This intense degree of focus compares with the focus reported by the married women at the same level of sexual partnership.

The level of coital frequency of unmarried males compared with unmarried females seems to characterize the difference in coital frequency of married males and unmarried females. What seems to differentiate multi-partner sexual activity between males and females at this level is that greater percentages of males of whatever categories are involved.

The third sexual partnership level shows a modal involvement of the married males with two wives; 44 per cent of males with two wives had an extra sexual partner in addition to their two wives. They were followed by the unmarried males among whom 26.7 per cent had

\textsuperscript{14} The actual percentages were higher, but the current figures were based on those who provided answers to the questions on the frequency of sexual intercourse with their sexual partners, up to the fourth person within the last year. The married groups were generally omitted from the analysis at the first sexual partnership up to the level that is the same as the number of their wives.
at least three sexual partners within the last year. About 18 per cent of both never-married
Table 14: Proximate levels of prostitution among males and females

<table>
<thead>
<tr>
<th>Partnership levels</th>
<th>Single males</th>
<th>Married males</th>
<th>Single females</th>
<th>Married females</th>
</tr>
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<tr>
<td></td>
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<tr>
<td></td>
<td>level of</td>
<td>level of</td>
<td>level of</td>
<td>level of</td>
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<tr>
<td></td>
<td>reported sex</td>
<td>reported sex</td>
<td>reported sex</td>
<td>reported sex</td>
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<tr>
<td></td>
<td>with</td>
<td>with</td>
<td>with</td>
<td>with</td>
</tr>
<tr>
<td></td>
<td>prostitutes</td>
<td>prostitutes</td>
<td>prostitutes</td>
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<td></td>
<td>level</td>
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<td>level</td>
<td>level</td>
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<td>of</td>
<td>of</td>
<td>of</td>
<td>of</td>
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<tr>
<td></td>
<td>reported</td>
<td>reported</td>
<td>reported</td>
<td>reported</td>
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<td></td>
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<td>involving</td>
<td>involving</td>
<td>involving</td>
</tr>
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<td></td>
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<td>rewards</td>
<td>rewards</td>
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<td>rewards</td>
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<tr>
<td>level 1</td>
<td>2</td>
<td>4.7</td>
<td>10</td>
<td>23.3</td>
</tr>
<tr>
<td>level 2</td>
<td>5</td>
<td>15.6</td>
<td>12</td>
<td>37.5</td>
</tr>
<tr>
<td>level 3</td>
<td>2</td>
<td>14.3</td>
<td>4</td>
<td>28.6</td>
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<tr>
<td>level 4</td>
<td>2</td>
<td>22.2</td>
<td>3</td>
<td>33.3</td>
</tr>
</tbody>
</table>
females and monogamous males were involved in sexual partnerships at the third partnership level.

The analysis of focus at this level shows that the female groups have much sexual concentration at this level. Some element of sexual focus is also noticed in the sexual interaction of the married male groups, both polygynists and monogamists at the third partnership level. On the other hand, the unmarried males were less characterized by serious sexual focus at this level.

At least 17.8 per cent of single men said they had had fourth partners within the last year and about 4.1 per cent of single females did so. No respondent with two or more wives had a fourth partner; however, three per cent of married females networked to the fourth partnership level. The sexual intercourse pattern at this level still showed the largest focus almost characterizing the single females, followed by the married females, while the single males maintained their tendency for the lowest average of coital frequency even at the fourth partnership level.

Variations in the categories of sexual partnership among male groups

The role of sexual intercourse is not limited to the question of its concentration or diffusion, it also involves the identity of the sexual partner (Orubuloye, Caldwell and Caldwell 1992 a,b). It is generally believed that sexual intercourse with a prostitute may expose the individual to greater vulnerability to sexual diseases. Evidence from medical science, for example, shows that sexual intercourse with a prostitute subjects her customer to contact with sexually-related disease which the prostitute may have contracted from at least her last seven sexual partners.

It has been observed generally that respondents are often reluctant to identify their sexual partners as prostitutes, hence low percentage values of prostitution have often appeared in different studies. However, the methodological advances made so far in sexual networking analysis involve the use of other surrogates to estimate the proximate level of prostitution and, by extension, of the level of effects on the general sexual health of society.

Table 14 attempts to estimate the approximate level of prostitution among the population at the four levels of reported sexual partnership, for the two male categories. It compares for each level the professed level of prostitution-partnership and the incidence of monetary reward for sexual relationship. It combines the analysis with that of the level of contraceptive use across the four sexual partnership levels.

The emergent pattern from Table 14 confirms the tendency observed elsewhere to underreport the incidence of prostitute patronage. Among single males at the first partnership level, only 4.7 per cent said they had engaged a prostitute, understating the proximate percentage of about 23.3 per cent who paid money for sex. The pattern of monetary reward for sexual intercourse seems to indicate that the level of prostitute partnership may not be lower than 20 per cent for single males; the lowest level of financially rewarded sexual relationship was at the third partnership level where 28.6 per cent had engaged partners whom they rewarded financially.

Among the married males, the highest level of prostitute partnership admitted was 2.9 per cent at the third sexual partnership level. This is also relatively low if compared to the percentage of money-rewarded sexual relationships. At level one, 2.3 per cent said they had engaged prostitutes while 20.8 per cent said they had paid for their sexual relationship. Such wide deviations characterized the four partnership levels. The extent of financially rewarded sex culminates at the fourth sexual partners level, where 57.1 per cent of married males claimed to have paid money for sex.

The incidence of contraception, however, seems to fare better but only particularly so with single males, the lowest level of contraception being at the first partnership level with
33.3 per cent claiming to have contracepted, while 57.1 per cent represents the peak for them at the third partnership level. Among the married males, the rate of contraception was lower, varying from 29.6 per cent at the second partnership level to 47.6 per cent at the third partnership level.

However, the pattern of contraception reported by the women far exceeded the men's level. It is difficult to assess such a high level of reported contraception; it tends to contradict the observed pattern of premarital maternity observed in the earlier part of this work, except however that such sexual behaviour has gained acceptance of late.

**Conclusion**

This study has examined the pattern of sexual networking in Freetown, against the backdrop of the AIDS epidemic. It was based on the initial set of data collected at the initial period when the various aspects of research on sexual networking at least in West Africa were being articulated. The results obtained in Freetown seem to conform in certain respects with what has been found elsewhere in West Africa. However, some differences are observable.

One of the primary aspects of the Freetown findings is the high incidence of never-married respondents who claimed to have become fathers and mothers. The present result indeed also showed the phenomenon of a large percentage of deficit-budget respondents particularly among the females, however, the budget-status differentials did not seem to have differentiated the tendency for large sexual partnership. This perhaps may have to do with the unique differences in the way the economic factors operate between purely commercial sex and para-commercial sex. Contrary to some ordered correlations between extramarital relationships and some social, demographic and psycho-emotional variables identified elsewhere, extramarital relationships in Freetown seems to be highly undiscriminated by many factors.

There seems to be a probability of indiscriminate participation, especially given the percentage of women who still had extramarital relationships within the last month of the survey. Another issue that raises much concern is the relatively low level of response of extramarital sexual activity to AIDS awareness as well as to the incidence of previous sexually transmitted diseases. The observed pattern seems to show that the information received was not compelling or dissuading enough or that respondents are generally unperturbed by the threat of AIDS.

Indeed, from the percentages of those who opined that there is one form of solution to the problem of AIDS, the need is clear for better information and education programs for a significant proportion of the populace. A strong element of sexual focus also characterizes the population especially the female respondents, while the men seem to have a rather high level of sexual relations with prostitutes.

Although the reported level of contraception seems satisfactory, it rather doubtful that the reported level of non-marital parenthood could have occurred with this level of contraception, unless widespread contraceptive use is a new phenomenon; or perhaps the ex-nuptial births are evidence of contraceptive failure. An analysis of contraceptive use and failure seems necessary, and perhaps given the advances in the methodology of approaches to sexual networking, further investigation of Freetown sexual behaviour with a larger sample may produce useful information.

**References**


Sexual networking, STDs, and HIV/AIDS transmission among Nigerian police officers

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Department of Psychology, Ondo State University, Ado-Ekiti

Abstract

This study examines the sexual behaviour of Nigerian police officers, the number of their sexual partners, relation with commercial sex workers, prevalence of STDs and the use of condoms among them. Three hundred and fifty-eight police officers, randomly sampled from Ondo State Police Command, Akure, responded to an interview guide. Results show that Nigerian police officers belong to the high-risk group and run the risk of being infected by HIV/AIDS. Whilst premarital and extramarital sexual relations were very common among the officers, they also maintained a high level of multiple sexual partners. Most of the police officers’ extramarital sexual partners were single girls, mainly students. A number of the police officers also engaged in sexual relations with commercial sex workers in hotels and brothels, particularly when on transfer to new stations. The prevalence of STDs was 23.8 per cent and gonorrhoea was the most reported type of STD. Most of the officers contracted STDs from their woman friends and commercial sex workers. They sought and received treatment from modern doctors. A large proportion of the infected police officers informed their partners, while few of the married ones told their wives. The officers were knowledgeable about the use of condoms and had used condoms in sexual relations.

Sexually transmitted diseases (STD) are not new in Nigeria, but what may be new is research interest in this area of human health. For instance, the word atosi means gonorrhoea but we do not know the equivalent English word for kusinu-kusode; this does not mean the absence of this disease among the Yoruba, but the most recognized type of STD among them is gonorrhoea.

Among the Ondo for instance, all other STDs are uncommon. There are two types of gonorrhoea recognized by traditional healers: atosi eleje (blood-type gonorrhoea), and atosi onikan (milk-type gonorrhoea). The study of the prevalence of STDs in Nigeria began about two decades ago. Osoba (1981) reported the prevalence of gonorrhoea in the general population to be ten per cent and of syphilis about five per cent. Orubuloye, Caldwell and Caldwell (1994) assert that HIV infection has been identified in the last three years, and the number of infected individuals is about one per cent of the general population of Nigeria. HIV prevalence among Nigerian commercial sex workers was found to be 14 per cent in 1990 (Mann, Taratola and Netter 1992); by 1992, this prevalence among commercial sex workers in Lagos was estimated at 20 per cent. Though no reason was given for this sharp

* The author is grateful to the SAREC/OSUA Behavioural Research Centre Ondo State University, Ado-Ekiti for funding this research and for providing the validated research instrument for the study.
increase in prevalence within a period of two years, the Minister of Health noted it with great concern. It is an indication that some measures have to be taken to arrest this ugly situation.

To initiate preventive measures, one of the important research efforts is to identify the major transmitters of STDs, the mode of distribution of the disease in the population and how society behaves toward people who have contracted STDs. An in-depth investigation of the sexual behaviour of the potential transmitters of STDs may serve as a good starting point.

Previous studies had identified some high-risk occupational groups as major transmitters because of the prominent roles they play in the spread of STDs. Truck drivers and itinerant market women were identified as high-risk by Tierney (1990) and Orubuloye, Caldwell and Caldwell (1993). Students had also been identified as a high-risk group in the spread of STDs (Nzyuko 1991).

There is, though, no known study identifying police as a high risk occupational group. Personal observation from the author’s research interaction with police officers and speculations from the general public suggest that they are potential transmitters of STDs.

This observation was based on several points: first, there is frequent unexpected change of location among Nigerian police officers. It is not always convenient or possible for the police officers to move their family with them to their new locations. This frequent transfer encourages police officers toward extramarital affairs and multiple sexual partners. In this process, STD if contracted, may continue to spread from one location to another as the police officers move. This is more so when such police officers are in stations where adequate medical facilities are not available or within the reach of the officers. Secondly, the nature of the duties of police officers has been reported to place great strain on their marriage (Straton 1975). Most of the police officers are reported to be dissatisfied with their marital life, and this may encourage extramarital sexual affairs. The shifting nature of police work may in part account for the reported dissatisfaction with marital life. In a study of the family relations of Nigerian married nurses (Akinnawo and Ibudeh 1992) many of the nurses said they were not satisfied with their marriage because the shifting nature of their jobs does not allow them to give the necessary attention to their family members and their spouses. Thirdly, police work had been identified as one of the most occupationally stressful professions (Lester 1982). Love-making, especially through extramarital sexual relations, may be one of the coping mechanisms. A preliminary study of the occupational stress in the Nigerian Police Force revealed that many of the police officers use love-making as a coping mechanism to survive the stress in their job (Akinnawo 1993).

It is apparent from these observations that the nature of the job of police officers encourages and sustains extramarital and multiple-sexual-partners relationships. But there is no known study of the sexual behaviour of Nigerian police officers and the likely health effects of their sexual behaviour.

The present study is an attempt to investigate the sexual behaviour of Nigerian police officers in this era of AIDS. Specifically, the study investigated their sexual behaviour, sexual partners, relation with commercial sex workers, prevalence of STDs and knowledge and use of condoms.

The study is a preventive approach to the study of STDs, particularly AIDS, a torchlight to intervention programs, and a contribution to the behavioural management of STDs not only among Nigerian police officers but also among other high-risk groups.

**Methodology**

Three hundred and fifty-eight Nigerian police officers responded to a structured interview guide. Female officers, and male police officers who had not spent more than one year in the service, were excluded from the study.
The questionnaire contained items intended to elicit information on the characteristics of the subjects, their sexual experiences, their sexual partners, their relationship with commercial sex workers, the prevalence and their feelings about STDs, and their knowledge and use of condoms. The study was carried out in Ondo State Police Command. The survey covers almost all the police stations and posts in the state.

The interviews were conducted, through the help of the State Police Public Relations Office, by the author and some trained research assistants, who were also police officers (Inspectors). The involvement of the police officers in the interview made the job easier for the investigator, especially after the approval of the State Police Commissioner and with the co-operation of the State Police Public Relations Officer. Four hundred police officers were selected from whom 358 were successfully interviewed. The findings are reported here.

Table 1
Characteristics of the police officers

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>%</th>
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<tbody>
<tr>
<td><strong>Age</strong></td>
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</tr>
<tr>
<td>18-20</td>
<td>38</td>
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<tr>
<td>21-30</td>
<td>172</td>
<td>48.0</td>
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<tr>
<td>31-40</td>
<td>105</td>
<td>29.3</td>
</tr>
<tr>
<td>41-50</td>
<td>35</td>
<td>9.8</td>
</tr>
<tr>
<td>Above 50</td>
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</tr>
<tr>
<td><strong>Level of education</strong></td>
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<td></td>
</tr>
<tr>
<td>Modern school</td>
<td>37</td>
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</tr>
<tr>
<td>Secondary (WASC/GCE)</td>
<td>50</td>
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</tr>
<tr>
<td>H.SC/OND/TTC</td>
<td>192</td>
<td>53.6</td>
</tr>
<tr>
<td>NCE and above</td>
<td>35</td>
<td>9.8</td>
</tr>
<tr>
<td>No response</td>
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<td>3.1</td>
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<td><strong>Religion</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Christianity</td>
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</tr>
<tr>
<td>Islam</td>
<td>56</td>
<td>15.6</td>
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<tr>
<td>Traditional</td>
<td>5</td>
<td>1.4</td>
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<tr>
<td>Others</td>
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<td>0.6</td>
</tr>
<tr>
<td>None</td>
<td>10</td>
<td>2.8</td>
</tr>
<tr>
<td>No response</td>
<td>8</td>
<td>2.2</td>
</tr>
<tr>
<td><strong>State of origin</strong></td>
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<td></td>
</tr>
<tr>
<td>Eastern States</td>
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<tr>
<td>Western States</td>
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<td>Mid Western States</td>
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<tr>
<td>Northern States</td>
<td>48</td>
<td>13.4</td>
</tr>
<tr>
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<tr>
<td>Single</td>
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<tr>
<td>Married</td>
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<td>0.3</td>
</tr>
<tr>
<td><strong>Age at first marriage</strong></td>
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<td></td>
</tr>
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<td>9.5</td>
</tr>
<tr>
<td>21-25</td>
<td>79</td>
<td>22.1</td>
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<tr>
<td>26-30</td>
<td>86</td>
<td>24.0</td>
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<tr>
<td>31-35</td>
<td>10</td>
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</tr>
<tr>
<td>No response</td>
<td>5</td>
<td>1.4</td>
</tr>
<tr>
<td>Not applicable</td>
<td>144</td>
<td>40.2</td>
</tr>
<tr>
<td><strong>Number of wives</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>168</td>
<td>47.0</td>
</tr>
<tr>
<td>2</td>
<td>29</td>
<td>8.1</td>
</tr>
</tbody>
</table>
The data

The characteristics of the 358 police officers interviewed are shown in Table 1. The mean age of the police officers was 31 years.

Most of the police officers had secondary school education, one-quarter of them had less, and one-fifth enlisted in the force with academic qualifications above secondary education.

Most of the subjects were Christians, Yoruba and from the South-western States. The ethnic and religious distribution is due to the recent policy that allows some categories of police officers to move to their state of origin or the nearest state to their home. This exercise was part of the strategies to reduce corruption and enhance the efficiency of the force. The fact that Christianity is the dominant religion in the southwestern part of Nigeria explains why most of the police officers who participated in the study were Christians.

About 60 per cent of the officers were married. The mean age at first marriage was 25 years, while the range is from 18 to 35 years. Nearly 50 per cent were married between 21 and 30 years of age and only 10 per cent were married before the age of 21 years. Out of the 213 police officers reported married, 79 per cent had one wife compared with 48 per cent who reported that their father had only one wife.

The majority of the married officers had between one and four children while most of them reported that their fathers had more than four children. Nearly 50 per cent of the police officers reported their fathers’ occupation as farming, and trading as the major occupations of mothers. These occupations correspond with the traditional occupations of males and females in the Southwestern region.

Table 2

Sexual experience of the police officers

<table>
<thead>
<tr>
<th>Frequency</th>
<th>%</th>
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<tr>
<td>Physiological status at first sexual experience</td>
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<tr>
<td>Early adolescence</td>
<td>23</td>
</tr>
<tr>
<td>Mid-adolescence 15-16</td>
<td>73</td>
</tr>
<tr>
<td>Late adolescence 17-20</td>
<td>162</td>
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<tr>
<td>Early adulthood 21-35</td>
<td>53</td>
</tr>
<tr>
<td>Cannot remember</td>
<td>30</td>
</tr>
<tr>
<td>Not applicable/no response</td>
<td>17</td>
</tr>
<tr>
<td>First sexual partner</td>
<td></td>
</tr>
<tr>
<td>Playmate</td>
<td>24</td>
</tr>
<tr>
<td>Girl-friend</td>
<td>253</td>
</tr>
<tr>
<td>Wife</td>
<td>37</td>
</tr>
<tr>
<td>Prostitute</td>
<td>7</td>
</tr>
<tr>
<td>Others (neighbours, househelp etc)</td>
<td>16</td>
</tr>
<tr>
<td>Not applicable/no response</td>
<td>21</td>
</tr>
<tr>
<td>Circumstances that led to the relation</td>
<td></td>
</tr>
<tr>
<td>Playing together</td>
<td>19</td>
</tr>
<tr>
<td>Party</td>
<td>25</td>
</tr>
<tr>
<td>Persuasion</td>
<td>18</td>
</tr>
<tr>
<td>Affection/love</td>
<td>191</td>
</tr>
<tr>
<td>Forced/rape</td>
<td>4</td>
</tr>
<tr>
<td>Starting marital life</td>
<td>20</td>
</tr>
</tbody>
</table>
The majority of the officers were recruited into the police force between the ages of 17 and 25. While 131 or 37 per cent were recruited between 17 and 20 years old, and 183 or 51 per cent between 21 and 25 years old, only 43 or 12 per cent were recruited into the force at older ages. More than 80 per cent of the officers were recruited into the force as constables. At the time of this survey, the sample consisted of 100 constables, 68 corporals, 76 sergeants, 51 inspectors, 33 Assistant Superintendents of Police, Deputy Commissioner and Commissioner of Police.

There is frequent movement of the police officers. Only 24 per cent of the police officers had remained in their original station since joining the force, 13 per cent had been transferred three times, seven per cent had been transferred four times, 15 per cent had been moved between five and ten times, and six per cent had been transferred more than ten times.

The majority of the police officers experienced great difficulties in moving their families with them from one station to another. The difficulties centre around the problem of accommodation, education of children and employment for their spouses. The frequency at which the officers are moved from one station to another, and the difficulties of moving their families with them immediately, encourage extramarital sexual relations and multiple sexual partners among them.

**Sexual behaviour**

Nearly all the police officers (96.4%) had experienced sexual relations at the time of the investigation (Table 2). By age 20, 72 per cent had had their first sexual experience. It is significant to note that 27 per cent of them had had their first sexual encounter before reaching the age of 17 years. The mean age of first sexual experience is around 18. This corresponds with what obtains in the general population. While 70 per cent of the police officers reported having enjoyed their first sexual experience, about 26 per cent of them reported not having enjoyed it because of inexperience, fear of being caught, pain or anxiety.

**Sexual partners**

One hundred and sixty-one or 76 per cent of the married police officers reported the number of their sexual partners before marriage. The majority of them (72%) reported more than one sexual partner before marriage, while 44 per cent reported more than three sexual partners. The mean number of their sexual partners before marriage was estimated at six. The pattern is similar to what has been observed among the general population in the region (Orubuloye et al. 1994).

Most of the police officers currently had more than one sexual partner: the mean number of their current sexual partners was four, including wives or fiancées and other women outside marriage. The mean number of sexual partners apart from the wives was 3.2. The police officers were not able to give accurate accounts of their lifetime partners, so the information was excluded from the analysis.

Premarital or extramarital sexual affairs take place between the officers and mostly their woman friends and commercial sex workers.

The ages of the officers' extramarital sexual partners ranged from 12 to 50 years with a mode of 20 years and a mean of 21.3. These extramarital sexual partners were mainly single girls, married and divorced women.
The occupations of these women who have extramarital affairs with the officers cut across all professions: farmers, traders, artisans, civil servants, students and apprentices. Most of them are, however, students or apprentices and traders. The majority of the officers met their married sexual partners before the women got married while some of the officers entered into relations with their sexual partners as married women. Frequency of sexual relations with extramarital partners ranged from daily to monthly and the mode is weekly while some of them had sexual relations at random.

The study reveals that extramarital sexual relations is an open affair. Some of the officers reported that their wives and relations had knowledge of their extramarital sexual partners.

About 35 per cent of the officers reported that their wives knew about their extramarital partners, 62 per cent of them confirmed that their relatives, especially their brothers, sisters, and parents knew their extramarital sexual partners. The responses about the police officers’ sexual partners are summarized in Table 3.

### Table 3
**Sexual experience before and after marriage**

<table>
<thead>
<tr>
<th>Number of sexual partners before marriage</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>45</td>
<td>12.5</td>
</tr>
<tr>
<td>2</td>
<td>31</td>
<td>8.7</td>
</tr>
<tr>
<td>3</td>
<td>14</td>
<td>3.7</td>
</tr>
<tr>
<td>More than 3</td>
<td>71</td>
<td>19.8</td>
</tr>
<tr>
<td>Cannot estimate</td>
<td>28</td>
<td>7.8</td>
</tr>
<tr>
<td>No response/not applicable</td>
<td>168</td>
<td>47.4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Current number of sexual partners</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>118</td>
<td>33.0</td>
</tr>
<tr>
<td>2</td>
<td>67</td>
<td>18.7</td>
</tr>
<tr>
<td>3</td>
<td>26</td>
<td>7.3</td>
</tr>
<tr>
<td>More than 3</td>
<td>103</td>
<td>28.8</td>
</tr>
<tr>
<td>No response</td>
<td>32</td>
<td>8.9</td>
</tr>
<tr>
<td>Not applicable</td>
<td>12</td>
<td>3.3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of sexual partners besides wives</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>75</td>
<td>20.9</td>
</tr>
<tr>
<td>2</td>
<td>35</td>
<td>9.8</td>
</tr>
<tr>
<td>3</td>
<td>20</td>
<td>5.5</td>
</tr>
<tr>
<td>More than 3</td>
<td>104</td>
<td>29.1</td>
</tr>
<tr>
<td>Not applicable</td>
<td>106</td>
<td>29.6</td>
</tr>
<tr>
<td>No response</td>
<td>18</td>
<td>5.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physiological status of extra-marital partners</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early adolescence</td>
<td>6</td>
<td>1.7</td>
</tr>
<tr>
<td>Mid-adolescence</td>
<td>30</td>
<td>8.4</td>
</tr>
<tr>
<td>Late adolescence</td>
<td>86</td>
<td>24.0</td>
</tr>
<tr>
<td>Young adults (21-25 years old)</td>
<td>93</td>
<td>26.0</td>
</tr>
<tr>
<td>Adults above 26 years old</td>
<td>34</td>
<td>9.5</td>
</tr>
<tr>
<td>Not applicable/no response</td>
<td>109</td>
<td>30.4</td>
</tr>
<tr>
<td>Total</td>
<td>358</td>
<td>100.0</td>
</tr>
</tbody>
</table>

**Relations with commercial sex workers**

Many of the police officers reported sexual affairs with prostitutes in hotels or brothels near their place of work, especially on arrival in new stations. The circumstances that led police
officers to patronize commercial sex workers include sexual urge, spouse absence, the nature of their duties, because their wives were pregnant or breastfeeding, and affection.

**Knowledge of STDs**

About 24 per cent of the police officers reported having contracted STDs, including gonorrhoea, syphilis and others not specified. The level and pattern of STDs correspond with what obtains in the general population. The experienced symptoms include inability to urinate, milky discharge, itching, irritating discharge, and a combination of two or more of the symptoms (Table 4). Most of the police officers contacted STDs from their girl friends and sex workers.

<table>
<thead>
<tr>
<th>Table 4</th>
<th>Experience with sexually transmitted diseases</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Frequency</strong></td>
<td><strong>%</strong></td>
</tr>
<tr>
<td>Ever treated for STD</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>85</td>
</tr>
<tr>
<td>No</td>
<td>228</td>
</tr>
<tr>
<td>No response</td>
<td>45</td>
</tr>
<tr>
<td>Type of STD treated</td>
<td></td>
</tr>
<tr>
<td>Gonorrhoea</td>
<td>63</td>
</tr>
<tr>
<td>Syphilis</td>
<td>11</td>
</tr>
<tr>
<td>Others</td>
<td>11</td>
</tr>
<tr>
<td>Not applicable</td>
<td>273</td>
</tr>
<tr>
<td>Experienced symptom</td>
<td></td>
</tr>
<tr>
<td>Burning sensation</td>
<td>4</td>
</tr>
<tr>
<td>Milky discharge</td>
<td>18</td>
</tr>
<tr>
<td>Inability to urinate</td>
<td>33</td>
</tr>
<tr>
<td>Swollen gland</td>
<td>8</td>
</tr>
<tr>
<td>Irritating discharge</td>
<td>1</td>
</tr>
<tr>
<td>Combination of 2 or more of above symptoms</td>
<td>16</td>
</tr>
<tr>
<td>Not applicable</td>
<td>273</td>
</tr>
<tr>
<td></td>
<td>358</td>
</tr>
</tbody>
</table>

Most of the officers did not keep their experience to themselves, they informed their significant others, especially their friends, doctors and relatives, and a few of them informed their wives. Most of the officers sought treatment and were actually treated. They were treated by modern doctors, traditional healers, pharmacists or dispensers, through self-medication and by spiritual healers. The majority of the infected police officers informed those who infected them. Some of the officers, however, did not inform their partners because they were not able to identify them or because they felt ashamed and they did not want to hurt them. Most of the infected police officers reported that their partners received treatment from hospitals, herbal homes or chemists, after they informed them, while some of the infected officers did not know whether their partners received any treatment.

The majority of the infected police officers reported that their wives have the right to refuse to have sexual relations with them during the period of their infection. In general, 70
per cent of the police officers reported that wives have the right to refuse to have sexual relations with an infected husband.

Knowledge and use of condoms

More than 80 per cent of the police officers reported that they have seen condoms before. However, only 39 per cent of them reported that they actually used them in sexual relations. They used condoms during sexual relations with sex workers, women friends, strangers and their wives during the postpartum period. The major reasons for using condoms include protection against STDs and protection against unwanted pregnancies. Fifty-eight per cent of the police officers planned to use condoms during future extramarital sexual relations while a few (1.1%) were not sure whether they would use condoms during such relations and said that the prevailing circumstances would determine their actions. About 18 per cent reported that they would not use condoms during their future extramarital sexual relations.

Police officers who planned to use condoms would do so to avoid being infected with STDs and to protect their partners against unwanted pregnancies. The officers who reported that they would not use condoms under any circumstance would not do so because they disliked condoms, because they trust their extramarital partners, and because their religion forbids the use of condoms.

Conclusion and discussion

Police Officers belong to the group generally referred to as high-risk groups. They experienced high levels of premarital and extramarital sexual relations and maintained multiple sexual partners outside marriage. Their way of life could be likened to that of truck drivers.

Most of the police officers' extramarital sexual partners were single girls, particularly students, apprentices and sex workers.

The prevalence of STDs among the police officers was 23.8 per cent and gonorrhoea was the commonest. Most of the officers who had contracted STDs were infected by their girlfriends and sex workers. A majority of the infected police officers sought and received treatment by modern doctors and informed their partners; some of them did not inform their partners for personal and cultural reasons.

Nigerian police officers seemed to be knowledgeable about the use of condoms. A significant proportion had used condoms during extramarital relations to protect themselves against STDs and to prevent unwanted pregnancies.

Frequent transfer of police officers has become an inevitable hazard to the officers and their families. Quite often adequate preparations are not made for the officers on transfer to enable them to have their families with them immediately. Hence many married officers are separated from their spouses for a considerable length of time. Many resort to taking another wife in the new station or simply engage in extramarital sexual relations.

The high levels of STDs and extramarital sexual relations reported by the officers pose a serious danger to the officers, their spouses and the community with which they have close interaction. There is urgent need for the education of the officers on the consequences of their way of life. The police college, public health authorities and the doctors need to teach the officers about STDs and HIV/AIDS.

The campaign against AIDS and promotion of condom use, which is currently under way along the major highways in Nigeria, should urgently be extended to the barracks as part of the intervention program on AIDS. A combination of efforts between the National AIDS control program and the various family planning organizations will minimize STDs, unwanted pregnancies and HIV/AIDS among this highly mobile group.
References


Sexual networking, STDs and HIV/AIDS in four urban gaols in Nigeria

I.O. Orubuloye, O.P. Omoniyi and W.A. Shokunbi

a Ondo State University, Ado-Ekiti, Nigeria
b University College Hospital, Ibadan, Nigeria

Truck drivers, female hawkers and prostitutes are generally regarded as high-risk groups because they have a high rate of partner change, run abnormally high risks of being infected with sexually transmitted diseases (STDs) including HIV/AIDS, and are capable of transmitting them to the general population who live around them (Orubuloye, Caldwell and Caldwell 1993; Orubuloye 1995). Recent experience has shown that the prison population runs a high risk of being engulfed by AIDS. By late 1992, HIV-positive prisoners had been detected in at least one of the prisons in Nigeria and there was beginning to be concern for the safety of the prison population. Therefore a study of the prison population was planned as part of a larger continuing research program of the Ondo State University, Ado-Ekiti, Nigeria, on Sexual Networking, STDs and HIV/AIDS Transmission, supported by a grant from the Swedish Agency for Research Cooperation with Developing Countries (SAREC).

The aim of the prison study was to investigate the attitudes and activities that are likely to facilitate the spread of sexually transmitted diseases, HIV and AIDS; and to develop an intervention program for the prison population and any population that may be in a similar situation.

The prison study

The prison study was undertaken in the last quarter of 1992 and the sample was taken from four gaols in two major cities and two towns in Southwestern Nigeria. Since we made an undertaking not to reveal the identities of the gaols, the locations where the samples were taken therefore will be identified only by the letters A,B,C,D.

A total of 518 prisoners who were willing to take part in the study were interviewed in the four gaols. The respondents are distributed as follows:

- Prison A: 203
- Prison B: 145
- Prison C: 130
- Prison D: 40

The subjects posed were discussed at length but the respondents also answered a questionnaire which was completed by the interviewers, usually in English or Yoruba. The co-operation of the prison authorities was obtained to gain access to the prisoners. The prison authorities and the prisoners were assured that research was urgently needed for the improvement of the welfare and health conditions of the inmates and that no attempt would be made to record their names or identify them after the interview.

The research team consisted of both social scientists and doctors. The latter took blood samples. The doctors noticed that a high proportion of the prisoners were suffering from scabies and other minor but uncomfortable complaints; they obtained modest funding from
the research program to procure adequate medication, largely because they felt the need to help and not in order to effect co-operation. The task was made easier because the doctors in the team were already offering voluntary free health services to the prisoners on humanitarian grounds long before the study was undertaken.

The questionnaire was designed to cover the socio-economic characteristics of the prisoners, circumstances surrounding imprisonment and an account of their sexual behaviour before and during imprisonment. Information was also sought on knowledge and experience of sexually transmitted diseases and AIDS.

Table 1
Characteristics of the prisoners

<table>
<thead>
<tr>
<th></th>
<th>A (N=230)</th>
<th>B (N=145)</th>
<th>C (N=130)</th>
<th>D (N=40)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 20 years</td>
<td>16.7</td>
<td>9.0</td>
<td>10.8</td>
<td>-</td>
</tr>
<tr>
<td>20-29</td>
<td>49.3</td>
<td>45.5</td>
<td>53.0</td>
<td>27.5</td>
</tr>
<tr>
<td>30-39</td>
<td>21.7</td>
<td>32.4</td>
<td>23.8</td>
<td>50.0</td>
</tr>
<tr>
<td>40 and above</td>
<td>12.3</td>
<td>13.1</td>
<td>12.4</td>
<td>22.5</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No formal schooling</td>
<td>13.3</td>
<td>20.1</td>
<td>19.2</td>
<td>5.0</td>
</tr>
<tr>
<td>Primary only</td>
<td>38.9</td>
<td>42.7</td>
<td>30.6</td>
<td>30.0</td>
</tr>
<tr>
<td>Secondary not completed</td>
<td>25.1</td>
<td>13.1</td>
<td>13.8</td>
<td>15.0</td>
</tr>
<tr>
<td>Secondary and above</td>
<td>26.7</td>
<td>22.7</td>
<td>30.7</td>
<td>50.0</td>
</tr>
<tr>
<td>No response</td>
<td>-</td>
<td>1.4</td>
<td>5.7</td>
<td>-</td>
</tr>
<tr>
<td>Religion</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Christianity</td>
<td>81.7</td>
<td>43.4</td>
<td>56.2</td>
<td>72.5</td>
</tr>
<tr>
<td>Islam</td>
<td>15.3</td>
<td>55.9</td>
<td>41.5</td>
<td>27.3</td>
</tr>
<tr>
<td>Traditional</td>
<td>2.5</td>
<td>-</td>
<td>0.8</td>
<td>-</td>
</tr>
<tr>
<td>Others</td>
<td>0.5</td>
<td>0.7</td>
<td>1.5</td>
<td>-</td>
</tr>
<tr>
<td>Occupation (before gaol)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Farming</td>
<td>2.8</td>
<td>11.5</td>
<td>2.5</td>
<td>13.8</td>
</tr>
<tr>
<td>Trading/business</td>
<td>22.1</td>
<td>11.5</td>
<td>25.0</td>
<td>8.4</td>
</tr>
<tr>
<td>Artisan</td>
<td>26.2</td>
<td>37.7</td>
<td>17.5</td>
<td>55.2</td>
</tr>
<tr>
<td>Civil servant</td>
<td>4.9</td>
<td>3.8</td>
<td>10.0</td>
<td>3.4</td>
</tr>
<tr>
<td>Professional</td>
<td>22.8</td>
<td>18.5</td>
<td>30.0</td>
<td>10.8</td>
</tr>
<tr>
<td>Unemployed</td>
<td>15.2</td>
<td>13.1</td>
<td>2.5</td>
<td>5.9</td>
</tr>
<tr>
<td>No response</td>
<td>6.0</td>
<td>3.9</td>
<td>12.5</td>
<td>2.5</td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>46.8</td>
<td>44.8</td>
<td>48.5</td>
<td>30.0</td>
</tr>
<tr>
<td>Married</td>
<td>53.2</td>
<td>52.4</td>
<td>50.7</td>
<td>67.5</td>
</tr>
<tr>
<td>Divorced/separated</td>
<td>-</td>
<td>1.4</td>
<td>0.8</td>
<td>2.5</td>
</tr>
<tr>
<td>No response</td>
<td>-</td>
<td>1.4</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
The characteristics of the prisoners

Table 1 shows selected characteristics of the prisoners. All the prisoners interviewed were males. A small number of females in the four gaols were contacted but they did not show any interest in the survey, primarily because they were shy, so they were excluded. The majority of the prisoners are in the age group 20-39 years, more than one-half being 20-24 except in one gaol where the majority were 30-39. Most of the prisoners had some formal education although some did not complete primary or secondary school. The level of education reflects that of the general population of the southwest region with a long tradition of formal education.

Christianity is the dominant religion of the prisoners in three of the gaols, while slightly more than one-half reported their religion as Islam in the fourth gaol. The distribution reflects the pattern of the dominant religions in the areas where the gaols are located. One-third of the respondents in two of the gaols reported themselves as Catholics, while traditional religion was hardly reported in any gaols. The majority of the respondents described themselves as traders or artisans before they were sent to gaol; the proportion in white collar occupations is small. More than one-half of the prisoners in three of the gaols and two-thirds in the fourth gaol were married. In all the gaols about one-tenth had contracted more than one marriage, about the same proportion were polygynously married. Between 48 per cent and 70 per cent of them had at least one child at the time of the investigation; of these, between 19 and 25 per cent had more than four children.

Sexual behaviour

The prisoners in all the four gaols were sexually active; nearly all had had sexual experience before imprisonment. The mean age of first sexual experience is about 18 years, and the majority had had their first sexual experience before reaching the age of 20 years. Between two and ten per cent had their first sexual encounter before the age of ten years (Table 2). Except in one of the gaols, between one half and two-thirds reported at least one current sexual partner. Since nearly all the prisoners in the gaols were males, and, since males and females are physically separated in the prisons, it is probable that some kind of homosexual intercourse was occurring; in order to avoid trouble or hurt we did not press the matter further. However, some of the prison officers believed that the congestion in the prison cells could facilitate such practices.

The responses to the question on number of lifetime sexual partners indicate that the prisoners had a large variety of sexual partners before they were sent to gaol. Between 35 and
59 per cent had more than one lifetime sexual partner, while about 22 and 40 per cent could not easily remember or estimate the number of their lifetime sexual partners.

### Table 2
**Age at first sexual experience**

<table>
<thead>
<tr>
<th></th>
<th>A (N=230)</th>
<th>B (N=145)</th>
<th>C (N=130)</th>
<th>D (N=40)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 10 years</td>
<td>8.4</td>
<td>2.1</td>
<td>2.3</td>
<td>2.5</td>
</tr>
<tr>
<td>10-14</td>
<td>18.2</td>
<td>17.2</td>
<td>15.3</td>
<td>15.0</td>
</tr>
<tr>
<td>15-19</td>
<td>48.3</td>
<td>42.9</td>
<td>48.5</td>
<td>40.0</td>
</tr>
<tr>
<td>20-24</td>
<td>11.4</td>
<td>23.5</td>
<td>17.7</td>
<td>20.0</td>
</tr>
<tr>
<td>25 and above</td>
<td>6.5</td>
<td>7.6</td>
<td>5.5</td>
<td>15.0</td>
</tr>
<tr>
<td>Other response</td>
<td>7.2</td>
<td>6.7</td>
<td>10.7</td>
<td>7.5</td>
</tr>
</tbody>
</table>

Between 28 and 39 per cent of the prisoners had had sexual relations with prostitutes, usually in hotels, bars and brothels (Table 3). The majority of the prisoners reported that they had sexual relations with prostitutes on several occasions. Altogether, the sexual life of the prisoners is similar to that of the general population and other high-risk groups in the society (Orubuloye, Caldwell and Caldwell 1991, 1993).

### Table 3
**Sex with prostitutes**

<table>
<thead>
<tr>
<th></th>
<th>A (N=230)</th>
<th>B (N=145)</th>
<th>C (N=130)</th>
<th>D (N=40)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you ever had sex with commercial sex workers?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>27.6</td>
<td>37.9</td>
<td>38.5</td>
<td>37.5</td>
</tr>
<tr>
<td>No</td>
<td>65.0</td>
<td>54.5</td>
<td>57.7</td>
<td>52.5</td>
</tr>
<tr>
<td>No response</td>
<td>7.4</td>
<td>7.6</td>
<td>3.8</td>
<td>10.0</td>
</tr>
<tr>
<td>If yes, where?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hotel/bar/brothel</td>
<td>21.7</td>
<td>37.2</td>
<td>26.2</td>
<td>32.5</td>
</tr>
<tr>
<td>In a house</td>
<td>1.0</td>
<td>-</td>
<td>2.3</td>
<td>-</td>
</tr>
<tr>
<td>On a trip</td>
<td>4.4</td>
<td>0.7</td>
<td>10.0</td>
<td>5.0</td>
</tr>
<tr>
<td>Not applicable</td>
<td>72.4</td>
<td>61.4</td>
<td>59.2</td>
<td>62.5</td>
</tr>
<tr>
<td>No response</td>
<td>0.5</td>
<td>0.7</td>
<td>2.3</td>
<td>-</td>
</tr>
<tr>
<td>How many times?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Once</td>
<td>4.5</td>
<td>8.2</td>
<td>8.4</td>
<td>5.0</td>
</tr>
<tr>
<td>More than once</td>
<td>5.5</td>
<td>16.0</td>
<td>14.0</td>
<td>15.0</td>
</tr>
<tr>
<td>Too many to remember</td>
<td>17.6</td>
<td>13.8</td>
<td>16.5</td>
<td>17.5</td>
</tr>
<tr>
<td>NA/no response</td>
<td>72.4</td>
<td>62.0</td>
<td>61.1</td>
<td>62.5</td>
</tr>
</tbody>
</table>
Sexually transmitted diseases, HIV/AIDS

The level of sexually transmitted disease is high: between 28 and 39 per cent reported that they had been infected (Table 4). Nearly all reported gonorrhoea as the major STD, while fewer than three per cent reported syphilis. The majority reported that they caught the disease from their girl friends and prostitutes, while about two per cent in one of the gaols said they had caught it from fellow-prisoners. Nearly all reported the symptoms and discomforts which they experienced as inability to urinate, discharge and itching.

Table 4
Sexually transmitted diseases

<table>
<thead>
<tr>
<th></th>
<th>A (N=230)</th>
<th>B (N=145)</th>
<th>C (N=130)</th>
<th>D (N=40)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you ever contracted a STD?</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Yes</td>
<td>36.0</td>
<td>39.3</td>
<td>33.8</td>
<td>27.5</td>
</tr>
<tr>
<td>No</td>
<td>64.0</td>
<td>57.9</td>
<td>65.4</td>
<td>72.5</td>
</tr>
<tr>
<td>No response</td>
<td>-</td>
<td>2.8</td>
<td>0.8</td>
<td>-</td>
</tr>
<tr>
<td>If yes, what type?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gonorrhoea</td>
<td>35.5</td>
<td>36.6</td>
<td>29.2</td>
<td>25.0</td>
</tr>
<tr>
<td>Syphilis</td>
<td>-</td>
<td>1.4</td>
<td>3.1</td>
<td>2.5</td>
</tr>
<tr>
<td>Other</td>
<td>0.5</td>
<td>2.1</td>
<td>0.8</td>
<td>-</td>
</tr>
<tr>
<td>Don't know</td>
<td>-</td>
<td>0.7</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Not applicable</td>
<td>64.0</td>
<td>59.2</td>
<td>66.9</td>
<td>72.5</td>
</tr>
<tr>
<td>Who infected you?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Girl/woman friend</td>
<td>25.7</td>
<td>22.0</td>
<td>20.0</td>
<td>10.0</td>
</tr>
<tr>
<td>Sex workers</td>
<td>8.9</td>
<td>11.0</td>
<td>10.8</td>
<td>17.5</td>
</tr>
<tr>
<td>Wife</td>
<td>0.5</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Others</td>
<td>-</td>
<td>-</td>
<td>1.5</td>
<td>-</td>
</tr>
<tr>
<td>Not applicable/NR</td>
<td>64.9</td>
<td>67.0</td>
<td>67.7</td>
<td>72.5</td>
</tr>
<tr>
<td>Did you receive any treatment?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>33.0</td>
<td>36.6</td>
<td>31.5</td>
<td>27.5</td>
</tr>
<tr>
<td>No</td>
<td>2.0</td>
<td>3.4</td>
<td>0.8</td>
<td>-</td>
</tr>
<tr>
<td>Not applicable/NR</td>
<td>65.0</td>
<td>60.0</td>
<td>67.7</td>
<td>72.5</td>
</tr>
<tr>
<td>Where did you receive treatment?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Modern hospital</td>
<td>23.2</td>
<td>16.6</td>
<td>14.6</td>
<td>15.0</td>
</tr>
<tr>
<td>Chemist/dispensary</td>
<td>1.5</td>
<td>4.8</td>
<td>6.2</td>
<td>7.5</td>
</tr>
<tr>
<td>Self medication</td>
<td>2.5</td>
<td>5.5</td>
<td>5.4</td>
<td>5.0</td>
</tr>
<tr>
<td>Not applicable/NR</td>
<td>72.8</td>
<td>73.1</td>
<td>73.8</td>
<td>72.5</td>
</tr>
</tbody>
</table>

The majority of prisoners infected with sexually transmitted diseases sought and received treatment from chemists and modern doctors, while a few were treated by traditional doctors and spiritual healers. While a few reported that their partners sought and received treatment from modern doctors, traditional and spiritual healers, the majority were not interested in what happened to their partners.
On the question of whether the prisoners knew anyone ever treated for sexually transmitted diseases, between 43 and 68 per cent reported that they knew of such persons. The majority of these persons were males, friends or workmates of the prisoners, both single and married, and between the ages of 20 and 34 years.

Knowledge of AIDS is widespread: between 65 and 77 per cent of the prisoners had heard of it. Most of the information came from the radio, television and newspapers and magazines in that order. Between two and three per cent knew persons, mainly male friends or workmates, who had been treated for AIDS. The majority of the affected persons were single. Clinical evidence has shown that five out of the 100 cases of blood samples taken in one of the gaols are suspected of being HIV-positive. One hundred and forty five male prisoners out of a total number of 600 inmates in that prison were interviewed. This shows that five per cent of the blood samples taken or 3.5 per cent of the respondents or 0.01 per cent of all the inmates of one of the four gaols were likely to be HIV-positive. This is a very serious matter because 68 per cent of the respondents in the same prison reported at least one current sexual partner. Similarly, about 40 per cent of the respondents in the same prison reported that they had previously contracted sexually transmitted diseases. About three per cent of the respondents in this prison reported that they had used a needle to inject drugs.

A closer look at the background of the five cases shows that they were between 25 and 34 years of age, sexually active, serving long prison terms and convicted for murder or armed robbery. Although blood samples were not taken in three out of the four gaols, Nigerian prisons may well soon be engulfed in STDs and HIV/AIDS.

Conclusion

It is now evident that prisoners belong to the sexually active group. A large proportion had experienced both a high level of partner change and infection with sexually transmitted disease before they were sentenced to prison. They run an abnormally high risk of being infected with HIV/AIDS, and are capable of transmitting it to other inmates in the prisons and to the general population when they are eventually out of gaol.

Three other factors are worthy of note: the congestion in the prison cells which results in an outbreak of scabies in one of the prisons and suspicion that homosexual intercourse was going on in the cells; the sharing of needles and injection of substances believed to be dangerous drugs; and the evidence of HIV-positive cases. Given the nature of the prisons and prison life, it is an explosive situation which requires intervention programs that will focus on eradication of STDs and other infectious diseases in the prison. This will be a pragmatic approach towards minimizing the risk of HIV/AIDS transmission. In addition, screening for HIV of all prison inmates and removal of HIV-positive prisoners will also help to contain the spread of the epidemics.

Finally, there is an urgent need to improve the living conditions of the prisoners. Overcrowding, and poor sanitary and nutritional conditions for which the Nigerian prisons are notorious, could aid the spread of STDs and AIDS.

References

Street youth in Accra city: sexual networking in a high-risk environment and its implications for the spread of HIV/AIDS

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AIDS Control Programme Ministry of Health, Ghana, Accra

Efforts to find a solution to the AIDS pandemic so far have been characterized by the use of shortcuts that bring quick results. This has resulted in stereotyping certain categories of people as high-risk behaviour groups and thereby concentrating attention on them: homosexuals and intravenous drug users in the industrialized countries and female prostitutes in developing countries, mainly in Africa. In the process certain groups have become marginalized and hence cut off from both mainstream heterosexual and targeted homosexual AIDS prevention campaigns. Incidentally, some of such marginalized groups have become the bridge along which the Human Immunodeficiency Virus (HIV) escapes from the so-called high-risk groups to the general population.

In the United States for example, there was the initial rhetoric concerning AIDS with the use of terms such as ‘gay plague’. As such the potential for harm to women seemed vague and was virtually neglected. The result was that by 1986 AIDS was the leading cause of death among women 25-34 years in New York (Wofsy 1987). Since 1983 the proportion of female AIDS cases in the United States infected through sexual contact has increased from 14 per cent to 26 per cent, indicating an increase in heterosexual transmission (Guinan and Hardy 1987; Kaplan 1987). Another study shows that in 1986 approximately 70 per cent of the heterosexual cases of AIDS had primary partners who were intravenous drug users, and 18 per cent of primary partners of female cases were bisexual men (Curran et al. 1988).

In Africa deviant groups like homosexuals and intravenous drug users are not considered important groups for the spread of HIV/AIDS and hence no attention has been given to them. But non-conventional sex, homosexual or heterosexual, is not new and existed even in prehistoric times (Kinsey, Pomeroy and Martin 1948). The lack of focus on homosexuality and bisexuality in Africa is explained by the ‘nature of the overt conventional response to the phenomenon by Africans in general, which is often fright, confusion and denial of such forms of sexuality’ (Aina 1991:81). Writing about the Azande of Sudan, Evans-Pritchard (1974) mentioned adolescent and situational bisexuality when discussing the phenomenon he called ‘marriage with boys’. This relationship gave men who were not yet capable of legal access to women the chance to release tension by having orgasm between the thighs of the boys. Also mentioned in Aina’s (1991) study is ritual bisexuality which he explained as a whole class of sexual relations related to the gaining of mystical powers and witchcraft. The main one involved sexual intercourse with someone who is socially undesirable such as a destitute or a seriously disabled person.
The rationale behind this is that, through this interaction, the normal dominant partner draws from his less fortunate partner the predestined store or essence of good fortune and fate that all human beings are supposed to possess spiritually (Aina 1991:83).

The other activity, believed to be practised by the Yoruba and Hausa of Nigeria, involved anal intercourse by which the dominant partner is believed to ‘augment and/or charge like a battery his own store of such quality or essence, thereby contributing to his increased success in whatever endeavours he undertakes’ (Aina 1991:83).

The evidence for the practice in Africa aside, the pattern of these supposed traditional forms of bisexuality and homosexuality needs pointing out. It involved dominant males, possibly wealthy, and less fortunate partners, mainly boys. This pattern has continued into the present time with increased intensity due to urbanization and modernization-Westernization. Recent studies have observed that male prostitutes can be found in virtually all large African cities and tourist centres around the five-star and other hotels catering mainly to an expatriate clientele and the local rich. Often they double as pimps procuring female prostitutes for heterosexual relations (Aina 1991). Again the element of unequal relationships could be discerned: an affluent Western tourist and a poor African youth ready to do anything for what amounts to a mere pittance in external money. Similar observations have been made in other developing countries in Southeast Asia (Sittitrai 1988; Sittitrai et al. 1989; Muangman et al. 1988, on Thailand), and in Brazil (Parker 1989).

Two observations can be made. In terms of gender, the literature on female prostitutes in developing countries is much larger than that on male prostitutes. Regionally, research on bisexuality and homosexuality seems to have received a little more attention in Southeast Asia and Brazil than in Africa, and the few studies in the latter tend to be more speculative than empirical. The establishment of the practices in these other developing societies only reminds African researchers that they can no longer behave like ostriches and continue to bury their heads in sand in the face of the danger posed by AIDS.

One other effect of earlier researchers’ focus on high-risk behaviour groups is the fear and prejudice that have characterized AIDS globally. Some recent researchers, however, have called for the redirection of attention from the behaviour of individuals and groups towards institutions and environments within which they operate, thereby allowing the conditions within which the behaviour occurs to be studied (Muir 1991). Writing on AIDS in Uganda, Barnett and Blaikie (1992) emphasized that focusing on individual behaviour alone can provide a clear target for scapegoating since it identifies those who are most vulnerable to infection and who, therefore, are ‘dangerous’ to the rest of the society. They observed that, because of civil disruption, war, smuggling and unequal access to economic resources, ‘the question has become less one of certain sexual behaviour being risky, but all sexual behaviour being risky because the environment is one of high risk’ (Barnett and Blaikie 1992:68).

In line with the WHO classification of global epidemiological patterns, which is basically conceived in relation to types of behaviour, research on AIDS in Africa has been dominated by efforts to identify people’s high-risk sexual behaviour. In the process prostitutes have been singled out for much emphasis (Mann 1988; Yeboah-Afari 1988; Nagelkerk et al. 1990; Ahmed et al. 1991; Nzila et al. 1991), and long-distance truck drivers similarly (Carswell et al. 1989; Nzyuko 1991; Orubuloye, Caldwell and Caldwell 1992). Also targeted for research is an amorphous sexually active population. Uganda is about the only country in Africa where adolescents have been specifically targeted for study beyond the usual knowledge, attitude and practice (KAP) research. But most of the studies have been on students (Kisekka 1976; Ankrah and Rwabukwali 1987), and others focused on regular adolescents as part of the general population (Konde-Lule 1992). Intervention programs in the whole of the continent
have followed a similar pattern with attention turned to the general population or the youth as if all people have equal access to information.

Adolescents and young adults are generally believed to be at increased risk of becoming infected with HIV because they are in a stage of cognitive, physical and emotional development and experimentation with sex and drugs. Peer pressure is very important at this stage and health problems are primarily due to STDs (see King et al. 1988). Street-involved youth are particularly vulnerable because they may engage in higher-risk behaviour and because they are alienated from social-service providers and school systems. That puts them outside the AIDS information networks while they of themselves lack the social supports to change their behaviour. Although the problem of street children in Ghana has not reached the proportion found in some Western countries (Caswell and Green 1988) or even in Brazil (Parker 1989; Larmer and Margolis 1993), there is evidence that they exist and the number is growing. This group is in part the product of the educational and economic reforms that have taken place under the country’s structural adjustment program and there is evidence that it is growing numerically.

For example, with the phasing out of the former elementary school system, no provision was made for the upgrading of the holders of the former Middle School Leaving Certificate. Institutions such as the four-year Teacher Training Colleges which were absorbing some of these young people have all been phased out. In addition, the new Junior Secondary School system does not make provision for those who fail the Basic Education Certificate Examination to repeat the examination; neither are there facilities for those who do not get entry to the Senior Secondary School (SSS) to upgrade themselves. Yet, for 1993, out of 138,000 candidates who qualified for admission to the SSS, only 60,000 could be offered places. Most of the unfortunate ones will find their way to the cities to join the growing army of unemployed youth.

**AIDS in Ghana**

AIDS cases were first seen in Ghana in 1986 and in that year the AIDS Control Programme was set up to educate the public about the dangers posed by the disease and to keep track of the progress of the disease. In January 1992 a total of 6,009 HIV-positive cases had been reported in the country, of whom 4,075 (about 68 per cent) were females. The number of AIDS cases in the same period was 3,290 and nearly 74 per cent were females. By July 1993, the number of detected HIV-positive cases had almost doubled to 11,940 and that of AIDS cases had more than tripled to 10,285. The current figures indicate that the proportion of female HIV-positive cases has increased slightly to 71 per cent and that of AIDS cases has fallen by five per cent.

As elsewhere in Africa, the figures must be interpreted with caution. The fluctuations in the number of cases reported could be affected by two factors. One is the availability of reagents for testing for the AIDS virus. There can be a lull in reported cases when there are no reagents, which is possible in an African situation. The figures will show a sudden jump from the time testing resumes. The other factor could be a general improvement in recording HIV/AIDS cases. It must be pointed out that in Ghana HIV tests are mainly performed in the symptomatic stage of the disease. Most HIV/AIDS cases are observed when people report sick, as very few people go for voluntary screening. A few cases are also observed during blood donation. Screening at antenatal clinics has also become almost universal in Ghana as well as at STD clinics. This may explain the slight increase in the proportion of female HIV cases while their proportion in the AIDS cases is falling.

The age distribution of HIV/AIDS cases in Ghana reflects the general pattern observed globally. Nearly 90 per cent fall within the most economically active age group of 15-49. The
1992 figures showed that about 74 per cent of reported AIDS cases were aged between 20 and 39. About three per cent were aged 15-19 years. Given the generally long incubation period of AIDS it is probable that a substantial proportion of seropositive persons in Ghana contracted the virus in their teens. As elsewhere in Africa, the mode of transmission of HIV in Ghana is mainly through heterosexual relations. This study, therefore, describes the socio-economic characteristics of street-involved youth in Accra, their attitude and knowledge about human sexuality, and their sexual behaviour and perceptions about sexually transmitted diseases (STDs) including AIDS. A section examines sexual networking within the environment of the youth and those involved in the network. The possible escape routes for HIV from this environment to the general population are highlighted and recommendations for averting a potential danger of spread are offered.

The study

The study was prompted by the need to establish an AIDS intervention program that specifically targets ‘street children’. The initial problem was how to operationalize the concept of ‘street children’. Muir has conceded that

street youths can be difficult to quantify, for they range on a continuum from those who live at home but spend a great deal of time ‘hanging out’, to those who actually live on the street (often in abandoned buildings and underground parking lots) and whose financial and personal support comes from street life. Street youths can be as varied as the general population (Muir 1991:139).

Young people trying to sell their petty goods to people in passing vehicles along some of the major streets in Accra are now a common sight. But they may not be necessarily homeless; some may even be continuing pupils and students who sell full-time during vacation or part-time when school is in session. Some may still live at home but spend most of their time on the street, possibly working for their parents. The idea therefore was to target street-involved youth which it was hoped would include all the categories mentioned above.

The fieldwork

The data for the study came from two main sources: a questionnaire survey and focus-group discussions. The fieldwork was conducted between 11 and 27 August 1992 in the centre of Accra. Two areas, the Kantamanto and Agbobloshie markets and the transport stations adjoining them, were selected as the survey areas. A staff of four interviewers and one supervisor carried out the fieldwork. The Accra Metropolitan Assembly had organized the street-involved youth into groups to facilitate their mobilization for voluntary work such as clean-up exercises, and possibly for taxation. Each group had a leader and an area within which it operated. The co-ordinator of all the groups was used as the ‘insider’ contact man who also was one of the interviewers. Before every day’s operations the contact man organized the group in which interviewing would be conducted. Five groups were identified and in each all willing persons 10 to 24 years old were interviewed until there were 50 respondents per group.

After the interviewing, four homogeneous groups of eight individuals each, selected on the basis of age and sex, were engaged in focus-group discussions.

The setting
The area selected for the study is the hub of brisk commercial activities which attract a teeming number of people during the day. Set within the study area is an undeveloped piece of land, part of which is used for the dumping of refuse. A few makeshift structures add to the general atmosphere of substandard conditions. The sheds serve as the places of rest for most of the youth during the day. Although the peddling and smoking of marijuana is illegal in Ghana, these activities are done openly in and around these sheds. The peddlars and smokers seem to find safety in numbers which are quite large at certain periods of the day: between five and seven o’clock in the morning when the smokers ‘charge up’ for the day’s task, around noon to one in the afternoon when they go for ‘refuelling’, and from six to seven in the evening when they retire from the day’s activities. There is no regular pattern of activities for the rest of the day as they cope with their survival strategies. In the night, the frontage of shops and sheds in the markets offers shelter and the tables serve as beds for many.

Even in these circumstances everything is highly monetized. The youth pay money for the use of a makeshift bath house, to visit the toilet and even to sleep on the verandahs. A condition of the survival of the fittest prevails in the environment, the stronger ones exploiting the situation to their advantage. Some of the strong ones hire out mats for use on the verandah at night at the cost of 100 cedis (about US 20 cents) a night. Those who want a screened verandah for intimate relationships pay something extra. There is such an intense pressure on the street-involved youth to always have money, that all values, decency and pride have been cast aside. The need to get money in order to survive compels them to go into socially unacceptable means of earning incomes: the boys into the sale of marijuana, petty stealing and swindling. Some of the girls are forced into ‘survival sex’. The legitimate activities for earning a living include porterage and cleaning. A few sell petty items in the street.

Most of the youth do not have fixed daily schedules. The porters, for example, can spend the whole night around the fire expecting a cargo truck to arrive. Almost all of them are compelled to wake up early, sometimes as early as four in the morning, before owners of stores and sheds come to work. The early part of the day is thus spent roaming about before sunrise. This unavoidable situation makes them fall foul of the law quite often as they usually encounter police on patrol. The participants in the focus-group discussions were bitter about the criminal activities of some law enforcement officers. The girls complained bitterly about the activities of a task force set up by the Metropolitan Assembly to clear the streets of peddlars. Some of the girls, in fact, changed over from petty trading into commercial sex when their wares were seized by the task force. Items seized were never returned to their owners. Some of the girls arrested were handed over to the wives or mistresses of the members of the task force to serve them for a period. The sex trade receives the bulk of the displaced girls because, as they put it, ‘there is no harassment involved’.

According to the porters, night raids by the police have become a regular affair. Those caught in such raids are made to empty their pockets and the contents, often including money, are never returned to their owners. They are then put in a van and abandoned at another end of the city. When they are taken to the police station they are released only after paying huge sums of money. The boys, however, conceded that they often get involved in some illegal activities which put the police and the People's Militia on their trails. Almost all the porters smoke marijuana as well as get involved in illegal gambling. The life of the street-involved youth in Accra is thus one of continuous struggle for survival in an atmosphere of fear, intimidation, violence and vulnerability. Their environment, therefore, makes them susceptible to infection and their limited resources reduce their capacity to seek adequate medical help.

**Characteristics of the sample**
Table 1 shows the basic characteristics of the survey population. The total sample size was 250 of whom 70 per cent were males. The median age for both sexes was 20.1 years with males slightly older than females (20.2 years and 19.6 years respectively). A substantial majority (84%) described themselves as working. Males were likely to be porters (47.4%) while the largest proportion of the females (33.3%) were in the sex trade. The majority (91.2%) had at least primary school education (six years). Males were more likely than females to have had some post-primary education (62.9% versus 6.7%). About 64 per cent professed to be Christians and some 18 per cent described themselves as Muslims. Almost 11 per cent said they had no religion.

Nearly two-thirds migrated to Accra from other parts of the country, most of them as primary migrants. About 53 per cent spent their childhood years in Accra or another city in Ghana and another 20 per cent lived in medium-sized towns. In fact, only six per cent spent their childhood years in a rural environment. It could thus be said that almost all the respondents have been shaped by urban conditions for the best part of their lives.

### Table 1
**Basic characteristics of sample population**

<table>
<thead>
<tr>
<th>Age and sex distribution (%)</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>10-14</td>
<td>9.1</td>
<td>6.6</td>
</tr>
<tr>
<td>15-19</td>
<td>38.3</td>
<td>46.7</td>
</tr>
<tr>
<td>20-24</td>
<td>52.6</td>
<td>46.7</td>
</tr>
<tr>
<td>Median age</td>
<td>20.2 years</td>
<td>19.6 years</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Level of education (%)</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>No education</td>
<td>7.4</td>
<td>12.0</td>
</tr>
<tr>
<td>Primary</td>
<td>29.7</td>
<td>81.3</td>
</tr>
<tr>
<td>Post primary</td>
<td>62.9</td>
<td>6.7</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Occupational distribution (%)</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>No work</td>
<td>14.9</td>
<td>18.7</td>
</tr>
<tr>
<td>Mechanic</td>
<td>7.4</td>
<td>-</td>
</tr>
<tr>
<td>Porter/labourer</td>
<td>47.4</td>
<td>6.7</td>
</tr>
<tr>
<td>Petty trading</td>
<td>27.4</td>
<td>29.3</td>
</tr>
<tr>
<td>Prostitution</td>
<td>-</td>
<td>33.3</td>
</tr>
<tr>
<td>Dressmaking/barber</td>
<td>2.7</td>
<td>12.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Religious affiliation (%)</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Christianity</td>
<td>60.0</td>
<td>72.0</td>
</tr>
<tr>
<td>Islam</td>
<td>20.6</td>
<td>13.3</td>
</tr>
<tr>
<td>Traditional</td>
<td>6.9</td>
<td>8.0</td>
</tr>
<tr>
<td>No religion</td>
<td>12.5</td>
<td>6.7</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td>N</td>
<td>175</td>
<td>75</td>
</tr>
</tbody>
</table>

**Residential and feeding arrangements**

About 51 per cent of both sexes sleep away from their homes (Table 2). Females were more likely than males to sleep at home (53% versus 47%). Most of them (37%) slept in the market (males 39%; females 32%). About ten per cent sleep at bus stops. A few females said they sleep in hotels (1.3%).

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Almost all of them (98.8%) spend most of the day away from home (see Table 2). They are mostly found in the market (70%) and the transport station (14.4%). Just six per cent spend some time at workshops.

Food does not seem to be a problem to the study group. The majority of them (82%) said they eat three times a day and another 17 per cent eat twice a day. Only nine per cent take their regular meals at home and another four per cent take some meals at home. The majority take all their meals away from home. There seems to be no organized eating habit with just a quarter of them saying that they take their meals from organized food stalls. The members of the group mainly cater for themselves. About 14 per cent said parents provide some of their meals and another four per cent mentioned siblings as the providers of some of their meals.

Table 2
Residential arrangements (%)

<table>
<thead>
<tr>
<th></th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Where do you sleep at night?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>At home</td>
<td>47.4</td>
<td>53.3</td>
</tr>
<tr>
<td>Market</td>
<td>40.0</td>
<td>36.0</td>
</tr>
<tr>
<td>Bus stop</td>
<td>10.9</td>
<td>8.0</td>
</tr>
<tr>
<td>Restaurant</td>
<td>1.7</td>
<td>1.3</td>
</tr>
<tr>
<td>Hotel</td>
<td>0</td>
<td>1.3</td>
</tr>
<tr>
<td>Where do you spend most of the time in the day?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>At home</td>
<td>0.6</td>
<td>2.7</td>
</tr>
<tr>
<td>Transport station</td>
<td>17.7</td>
<td>6.7</td>
</tr>
<tr>
<td>Workshop</td>
<td>7.4</td>
<td>2.7</td>
</tr>
<tr>
<td>Street</td>
<td>7.4</td>
<td>10.6</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td>N</td>
<td>175</td>
<td>75</td>
</tr>
</tbody>
</table>

Family background and extent of parental influence

From the respondents’ accounts, the educational background of their parents was reasonably high by Ghanaian standards (Table 3). Only 16.8 per cent of fathers had not had any formal education, compared with 42.4 per cent of mothers. Most of the parents have primary education (43.2% for fathers and 36.8% for mothers). Fathers were more likely than mothers to have post-primary education (20% against 4%). Surprisingly, a significantly large proportion did not know the educational background of their parents (20% for fathers and 16.8% for mothers); this reveals that an appreciable proportion of the group were not familiar with their parents.

Table 3
Level of parents' education (%)

<table>
<thead>
<tr>
<th></th>
<th>Fathers</th>
<th>Mothers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No school</td>
<td>16.8</td>
<td>42.4</td>
</tr>
<tr>
<td>Primary</td>
<td>43.2</td>
<td>36.8</td>
</tr>
<tr>
<td>Post-primary</td>
<td>20.0</td>
<td>4.0</td>
</tr>
<tr>
<td>Don’t know</td>
<td>20.0</td>
<td>16.8</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td>N</td>
<td>250</td>
<td>250</td>
</tr>
</tbody>
</table>
The majority (58%) came from single-parent homes. At the time of the survey 41 per cent lived alone and another 20 per cent lived with other siblings. Only eight per cent stayed with both parents; a further nine per cent of respondents stayed with their mothers only and three per cent with fathers only. Most of them did not benefit from the joint upbringing by both parents in their childhood years. Only 41 per cent spent most of their childhood years with both parents. The majority either stayed with mothers only (31%), grandmothers (9%) or fathers only (7%). By their own judgement only 31 per cent thought that both parents had been responsible for their upbringing. The largest proportion (35%) said mothers had been responsible for their upbringing and another 12 per cent gave the credit to grandmothers. Only eight per cent mentioned fathers.

When asked whether they talk with their parents 44 per cent answered in the affirmative. Another 26 per cent said they talk to mothers only and just eight per cent talk to fathers only. About 21 per cent said they do not talk to their parents at all. Giving reasons why they do not talk with parents, 81 per cent said they did not live together, three per cent said they did not know the whereabouts of their parents, and two per cent said the parents were annoyed with them.

Reduced parental influence is revealed in another perspective. Both sexes were more likely to report to siblings in case of trouble (24%), than to mothers (23%) or fathers (13%). Almost 13 per cent consult friends when in trouble. Similarly, they were more likely to take their important decisions alone (37%) or with friends (18%), than with siblings (14%), and parents (4%). Interestingly, males were more likely than females to consult mothers on important decisions (14% versus 1%), whilst females were more likely than males to consult fathers (9% versus 5%).

Knowledge and attitude about human sexuality

People’s attitudes towards sex tend to affect their sexual behaviour. A battery of questions were put to the respondents to test this. To the question ‘Can one stay away from sex?’, 58 per cent responded in the affirmative. About 39 per cent said it was not possible and three per cent did not know. Giving reasons for the inability to stay away from sex 35.2 per cent of those who answered in the negative said ‘it can’t be avoided’, 28.6 per cent said ‘it is natural’ and 15.2 per cent said ‘it is important’. These responses are consistent with the general belief among the participants of the focus group discussions that normal human beings can never stay away from sex. They saw sex as a biological need that must be met. About two per cent said it cannot be avoided for economic reasons (see Table 4). When the question ‘How often must one have sex?’ was put only 14.4 per cent did not respond and 8.4 per cent said they did not know. That means that even some of those who said one can stay away from sex gave their views about the frequency of sexual contact. About eight per cent thought sexual contact should be every day, 44 per cent said it should be two to three times a week and 19 per cent said once a week (see Table 5).

<table>
<thead>
<tr>
<th>Reasons why one cannot stay away from sex (%)</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>It’s important</td>
<td>16.4</td>
<td>12.5</td>
</tr>
<tr>
<td>It’s natural</td>
<td>31.5</td>
<td>21.9</td>
</tr>
<tr>
<td>Can’t be avoided</td>
<td>37.0</td>
<td>37.5</td>
</tr>
<tr>
<td>Economic necessity</td>
<td>1.4</td>
<td>3.1</td>
</tr>
<tr>
<td>Not stated</td>
<td>13.7</td>
<td>25.0</td>
</tr>
</tbody>
</table>
Only 15 of the males (9%) and eight of the females (11%) knew any sexual taboos: almost all the taboos related to females. They included the avoidance of sex before a girl is taken through puberty rites or female circumcision, and the avoidance of sex during menstruation. Although the last is still observed by many people but not necessarily as a taboo, the first two have lost their significance mainly as a result of modernization and the influence of Christianity.

Both males and females had similar opinions about the earliest age a person must have sexual relations. The mean recommended age for first sexual intercourse for males was given by males as 17.1 years and by females as 18.9 years: while that for females was 17.2 years recommended by males and 16.6 years by females. There is, however, a difference between the ideal and reality. Both sexes mentioned that their closest friends had their first sexual experience earlier than when they thought it should be. The mean ages at first sexual experience of their closest friends were 15.9 years for males and 14.9 years for females. For both sexes, the earliest age at first sexual experience reported (seven years), was among those who grew up in a medium-sized town. For those who grew up in the rural areas the earliest ages reported were 13 years for males and 15 years for females.

### Table 5

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Every day</td>
<td>6.3</td>
<td>13.3</td>
</tr>
<tr>
<td>2-3 times a week</td>
<td>45.7</td>
<td>38.7</td>
</tr>
<tr>
<td>Once a week</td>
<td>20.6</td>
<td>16.0</td>
</tr>
<tr>
<td>1-2 times a month</td>
<td>6.9</td>
<td>4.0</td>
</tr>
<tr>
<td>Don’t know</td>
<td>6.3</td>
<td>13.3</td>
</tr>
<tr>
<td>Not stated</td>
<td>14.2</td>
<td>14.7</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td>N</td>
<td>175</td>
<td>175</td>
</tr>
</tbody>
</table>
those with no education, primary and post-primary education respectively. However, the pattern is better observed among the males than the females. For example, there was virtually no difference between the proportion among the females with no education and those with post-primary education (44% and 40% respectively).
Table 6
Age at first sexual experience of respondents (%)

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Below 10 years</td>
<td>2.9</td>
<td>1.3</td>
</tr>
<tr>
<td>10-14 years</td>
<td>17.1</td>
<td>21.4</td>
</tr>
<tr>
<td>15-19 years</td>
<td>48.0</td>
<td>60.0</td>
</tr>
<tr>
<td>20-24 years</td>
<td>9.2</td>
<td>12.0</td>
</tr>
<tr>
<td>No sex</td>
<td>21.7</td>
<td>4.0</td>
</tr>
<tr>
<td>Not stated</td>
<td>1.1</td>
<td>1.3</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td>N</td>
<td>175</td>
<td>75</td>
</tr>
</tbody>
</table>

The observation brings to light the fact that sex education is not given much attention in Ghanaian schools and much of what people know about sex is learnt away from school. In fact most of both sexes (62%) received information about sex from friends (peer group members). A very small proportion (9%) received some information from mothers and a similar proportion through eavesdropping (Appendix A). Expectedly, females were more likely than males to receive some sex information from mothers (12% versus 7%). Much of the information passed on was pregnancy-related (54%). A quarter of both sexes mentioned disease-related issues as the topic taught in the education. Females were more likely than males to discuss pregnancy-related issues instead of diseases (65% pregnancy, 43% disease) and the reverse is true in the case of males (30% disease, 18% pregnancy).

Sexual behaviour

Seventeen per cent of the respondents had never had sexual relations. Females were more likely than males to have become sexually active (95% versus 78%), but reported significantly fewer sexual partners than males.

Although many had begun sexual relations, fewer said they had sexual intercourse in the last year, and fewer still in the last three months (see Table 7).

Among those who had ever had sexual intercourse, the number of partners reported was significantly higher for males (Table 8). Cultural restrictions may explain the differences in reporting. Traditionally a woman is expected to remain the sexual partner of one man either within or outside marriage. Therefore, a woman may be more likely to report one partner at a time.

Table 7
Percentage sexually active by sex

<table>
<thead>
<tr>
<th></th>
<th>Males</th>
<th>Females</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ever</td>
<td>78.3</td>
<td>94.7</td>
<td>83.2</td>
</tr>
<tr>
<td>In the last year</td>
<td>76.6</td>
<td>94.7</td>
<td>82.0</td>
</tr>
<tr>
<td>In the last 3 months</td>
<td>70.3</td>
<td>90.7</td>
<td>76.4</td>
</tr>
</tbody>
</table>
Table 8
Mean number of sexual partners by sex

<table>
<thead>
<tr>
<th></th>
<th>Males</th>
<th>Females</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life timea</td>
<td>5.9</td>
<td>4.3</td>
<td>5.4</td>
</tr>
<tr>
<td>In the last yearb</td>
<td>3.2</td>
<td>2.3</td>
<td>2.9</td>
</tr>
<tr>
<td>In the last 3 monthsc</td>
<td>2.4</td>
<td>2.3</td>
<td>2.4</td>
</tr>
</tbody>
</table>

aAmong those who ever had sex
bAmong those active in last year
cAmong those active in last 3 months

However, the proportions of the sexes who reported ‘Too many to count’ sexual partners are quite revealing (see Appendix D). In the last three months 2.7 per cent of females reported too many partners to count as against none of the males. The proportions in the last year and over a lifetime stood at eight per cent versus 3.4 per cent and 21.3 per cent versus 17.8 per cent respectively. The females who reported too many sexual partners were certainly in commercial sex. For them sex was for survival. This comes out clearly in Table 9. Giving reasons for having sexual relations a majority of the males (54.3%) said it was for pleasure as against only 36 per cent of the females. Rather, commercial consideration was mentioned by 24 per cent of females as against only 1.1 per cent of males.

Table 9
Reasons for having sexual relations (%)

<table>
<thead>
<tr>
<th></th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>For pleasure</td>
<td>54.3</td>
<td>36.0</td>
</tr>
<tr>
<td>For money</td>
<td>1.1</td>
<td>24.0</td>
</tr>
<tr>
<td>Want a child</td>
<td>16.0</td>
<td>18.7</td>
</tr>
<tr>
<td>Want to marry</td>
<td>2.9</td>
<td>6.7</td>
</tr>
<tr>
<td>Friends do it</td>
<td>1.1</td>
<td>1.3</td>
</tr>
<tr>
<td>Test fertility</td>
<td>0.6</td>
<td>2.7</td>
</tr>
<tr>
<td>No reason</td>
<td>0.6</td>
<td>4.0</td>
</tr>
<tr>
<td>Not stated</td>
<td>1.7</td>
<td>1.3</td>
</tr>
<tr>
<td>No sex</td>
<td>21.7</td>
<td>5.3</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Another form of the sexual activity of the respondents is revealed in Table 10. The majority of the respondents (64.8%) said they had sex either daily or between one and three times a week (80% for females and 58.3% for males). Again the figures bring out the difference between sex for pleasure and sex for survival. For some of the girls sex must be a daily affair if they are to survive. Details of their sexual activities are discussed below. About 42 per cent of both sexes said they had intercourse with their sexual partners at home, which is significantly lower than the proportion who reported sleeping at home at night (49%). A lot of sexual activities take place in the open: 28 per cent in the market and another seven per cent ‘any place’. Some boys said they sometimes sleep with more than one girl at a time on the same ‘bed’.

*Supplement to Health Transition Review Volume 5, 1995*
Table 10
How often do you meet your sexual partners? (%)

<table>
<thead>
<tr>
<th></th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily</td>
<td>16.0</td>
<td>36.0</td>
</tr>
<tr>
<td>1-3 times a week</td>
<td>42.3</td>
<td>44.0</td>
</tr>
<tr>
<td>1-2 times a month</td>
<td>5.7</td>
<td>9.3</td>
</tr>
<tr>
<td>Occasionally</td>
<td>9.2</td>
<td>4.0</td>
</tr>
<tr>
<td>Not stated</td>
<td>5.1</td>
<td>1.3</td>
</tr>
<tr>
<td>No sex</td>
<td>21.7</td>
<td>5.3</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Generally the males were not frightened by the possibility of their sexual activities resulting in pregnancy. The girls were to some extent, but, like the young men, they did not do anything to prevent pregnancy. Abortion appeared to be very common in the group and members were more likely to have an abortion than to allow a pregnancy to continue. The girls were particularly against the use of foaming tablets saying that they cause abrasions which in turn cause heavy discharges.

**Sexual networking**

Sexual networking in the environment of the street-involved youth has as its participants the members of the group themselves on one hand, and on the other, members of the general resident population in Accra and others from outside Accra whose activities bring them into the environment regularly. Figure 1 illustrates the sexual networking in the environment of the street-involved youth. A lot of sexual activities take place among the youth themselves. Most of them have partners from within the group which forms part of the survival strategies of the girls. From these ‘quasi-regular’ partners the girls get about 500 cedis (around US$1.00) a day as food money. This compels the girl to satisfy the boy’s sexual demands every time. In the night some of the girls leave their partners to go to solicit clients in town. There was evidence of partner swapping within the group. For example during the focus-group discussions several boys pointed to a particular girl from whom they thought they had once contracted venereal disease.

The forces sustaining the relationships among the youth easily become apparent. On the one hand are boys who see sex as a form of pleasure. On the other are vulnerable girls who need money to survive but do not have the requisite qualifications to enable them to secure a respectable means of livelihood. In addition, they need protection in a potentially violent environment and a place to rest in the day time; these are controlled by the boys. The relationships are, therefore, not very stable and have within them elements of recklessness.

Another sexual relationship involves the porters and some of the resident traders and hawkers. A relationship with a porter enables a trader to get allocation of goods for sale without going through the struggle which usually follows the arrival of a cargo truck. Some of the trucks arrive before dawn and a trader has to be around if she wants some allocation of items to sell. This is where the relationship with a porter counts. Since the porters do the offloading they can easily make allocations to their favourites. To the porters the relationship is easy access to something they regard as pleasurable and the prestige of being intimate with a respectable woman. To the traders it is pure business and a way of maximizing profit without much trouble.
Some of the porters have casual relationships with some of the female itinerant traders. The cost of offloading goods from trucks is borne by the owners of the goods. The porters befriend the traders either by offloading their goods free of charge or by lending them money to pay the truck drivers until their goods are bought. A close relationship with a porter may also make it possible for an itinerant trader to get a place to rest while waiting for her goods to be bought.

The long-distance truck drivers who bring goods to the study area also have sexual relationships with some of the itinerant traders. Most of the items brought to Accra are perishable and getting transport at the right time and regularly is an important aspect of the business of the traders. A relationship with a truck driver ensures this.

A number of the female members of the street-involved youth practise commercial sex. They can be found at the street corners and around hotels where they solicit clients. As prostitutes they are also easily accessible to some of the truck drivers.

The foregoing illustrates the complex sexual networking that goes on in what appears to be a simple environment. Four routes along which HIV/AIDS can travel from the high-risk environment to the general population and vice versa can be observed.

Route 1 is from the female prostitutes. Males in the general population can contract the disease from them and in turn pass it on to their wives and regular partners. The reverse is also possible.

Route 2 is along the same direction but from the males, through the female resident traders and hawkers to the general resident male population.

Route 3 is from the female itinerant traders to their male partners in other localities outside Accra.

Finally, route 4 is from the truck drivers to their female partners in other localities outside Accra.

Sabatier (1987) has explained that when the AIDS virus is introduced into a society it tends towards the path of least resistance. This is often the path trodden by the poorest, most disadvantaged, least powerful, or most stigmatized (Muir 1991). Almost all the adjectives describe most, if not all, the groups identified above. In fact, during the focus-group discussions participants strongly condemned the negative messages the general population constantly directs at them which make them view themselves as inadequate, powerless and unworthy (cf. Turner, Miller and Moses 1989).

Other studies have observed that ultimately the ‘basic reproductive rate’ of AIDS, that is, the number of other people that the typical HIV-infected person goes on to infect, will determine the severity of the spread of the disease (Lewis, Watters and Case 1989:37). If the rate is less than one, then the spread of AIDS will be restricted mainly to the core group. If the rate is more than one, the AIDS epidemic is likely to spread alarmingly, affecting increasing numbers of the general population. As elsewhere, the basic reproductive rate among the group is not known. However, the steady progress of the disease in the country so far leaves no doubt that AIDS is firmly established in Ghana. The number of possible escape routes in the environment indicate that if the disease is introduced into it (if this has not already occurred), the effect will be tremendous. Much will, however, depend upon how much the youth know about STDs in general and AIDS in particular, and the extent of the presence of other co-factors, especially venereal diseases.

Knowledge of STDs/AIDS

Awareness of STDs is high, with 98 per cent of both sexes having heard of the diseases. About 22 per cent reported having been treated for STDs before, the male proportion being almost twice that of females (26% and 15% respectively). It must be emphasized that venereal diseases are highly stigmatized in Ghana and sufferers are likely to keep the
information to themselves. There is, therefore, reason to believe that the figure is
Figure 1: Illustration of sexual networking in the environment of the study group

![Diagram showing sexual networking]

**KEY**
- Route 1: Originates with girls
- Route 2: Originates with youths
- Route 3: Originates with female itinerant traders
- Route 4: Originates with male truck drivers

**Irregular relationship**
- Regular sexual relationship
- External relationship
- Casual sexual relationship
- Mixed sexual relationship

- Male
- Female

The high-risk environment

**Groups**
- Irregular youth
- Female itinerant traders
- Male long distance truck drivers
- Female residents and hawkers
- Male partners in other localities
- Female partners in other localities
- General resident population
  - Clients of prostitutes
  - Wives
  - Regular partners
conservative for the proportion reporting ever having an STD. Evidence to this effect came up during the focus-group discussions: at one of the all-female sessions participants made a passionate appeal to us to get them examined through special arrangements. Following that, an arrangement was made to get two males and two females examined and treated in an STD clinic in Accra. The plan was to assess how much it would cost to operate a larger-scale clinic specifically for the street-involved youth. The initial test showed that all the four had STDs and the girls had multiple infection of two to four different types of venereal disease. The level of knowledge of the early symptoms of STDs was also quite appreciable. Without being prompted 67 per cent of respondents mentioned discharge and 66 per cent mentioned pain in the lower abdomen or genital organs as some of the symptoms.

Table 11 shows the respondents' knowledge of the mode of transmission of STDs. It shows that most know they are transmitted by sexual contact and male and female responses are quite similar. However, the level of misconceptions is disturbing and females are more likely than males to hold them. For example, 50.7 per cent of females and 36.6 per cent of males attributed the transmission of STDs to witchcraft, and 14.7 per cent of females and 6.3 per cent of males attributed it to act of God or supernatural causes. Self-medication is the chief method used to treat STDs in the group. The usual prescription was penicillin in either akpeteshie (a local gin) or palm wine. There was so much unsatisfactory treatment that some boys had developed chronic pain in their penis. During the survey one male in the group was rushed to hospital in serious pain from retention of urine for three days. In addition to the misconceptions they had about ordinary STDs, the young people did not regard them as serious ailments. Some confessed that they still had intercourse when they knew they had an STD, just for enjoyment.

Table 11
Knowledge of respondents on the transmission of venereal diseases a (%)

<table>
<thead>
<tr>
<th></th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Through sexual contact</td>
<td>88</td>
<td>93</td>
</tr>
<tr>
<td>Through sex with prostitutes</td>
<td>93</td>
<td>87</td>
</tr>
<tr>
<td>Act of God/supernatural</td>
<td>6</td>
<td>15</td>
</tr>
<tr>
<td>Witchcraft</td>
<td>37</td>
<td>51</td>
</tr>
<tr>
<td>Through blood transfusion</td>
<td>64</td>
<td>65</td>
</tr>
<tr>
<td>Through kissing</td>
<td>31</td>
<td>27</td>
</tr>
</tbody>
</table>

a Multiple answers

Similarly, awareness of AIDS was very high (98%) and about a fifth had seen an AIDS patient. Table 12 shows their knowledge of the mode of transmission of AIDS. Most people knew about the transmission routes. However, as with STDs, certain misconceptions were still held, including that AIDS was caused by kissing, by witchcraft and by act of God or supernatural causes. Again females were more likely than males to express those misconceptions.
Table 12
Knowledge on the transmission of HIV/AIDS (percentage distribution)\(^a\)

<table>
<thead>
<tr>
<th></th>
<th>Males</th>
<th>Females</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Through sexual contact</td>
<td>92</td>
<td>97</td>
<td>94</td>
</tr>
<tr>
<td>Through sex with prostitutes</td>
<td>91</td>
<td>93</td>
<td>92</td>
</tr>
<tr>
<td>Act of God/supernatural</td>
<td>9</td>
<td>19</td>
<td>12</td>
</tr>
<tr>
<td>Witchcraft</td>
<td>34</td>
<td>48</td>
<td>38</td>
</tr>
<tr>
<td>Through blood transfusion</td>
<td>76</td>
<td>91</td>
<td>80</td>
</tr>
<tr>
<td>Through kissing</td>
<td>54</td>
<td>47</td>
<td>52</td>
</tr>
</tbody>
</table>

\(^a\) Multiple answers

**Risk-reduction behaviour**

Nearly 90 per cent of the youth knew of condoms but only 34 per cent had ever used them. Only six per cent always used condoms in the last three months and another 19 per cent used them occasionally. For those who use condoms the main reason was to prevent venereal disease. About four per cent mentioned AIDS specifically. Another 40 per cent said they used condoms to prevent pregnancy. The main reason for not using the condom was that they ‘just didn't like it’ (33%). Another eleven per cent felt that condoms do not give any protection. About five per cent did not use condoms because ‘they had faith in their partners’ and a few others said they wanted babies (3%).

On whether there had been any change in their sexual behaviour since hearing of AIDS only nine per cent said they practise abstinence and another ten per cent said they insist on the use of condoms. What most of the respondents regarded as changed behaviour included ‘no sex until partner was well known’ (45%), ‘reduction in the number of sexual partners’ (42%), and ‘avoidance of sex with prostitutes’ (33%) (see Appendix C).

**Discussion**

Current records show that AIDS has become established in Ghana. Knowledge of the disease is almost universal not only because of the continuous education but also because significant numbers of people are falling ill and AIDS-related deaths are becoming widespread in many communities. As is the general situation in Africa, poverty seems to play a part in the spread of STDs including HIV/AIDS in Ghana. Communities and individuals struggling to survive, with inadequate facilities and low incomes, are often more at risk. Patterns of infection reflect inequality between the sexes. Women's lower social and economic status often makes them less able to protect themselves against the risk of infection resulting in a 3:1 female to male ratio among AIDS sufferers. However, in both sexes HIV/AIDS patients are predominantly young, within the age group 20-39 years.

Accordingly, most AIDS intervention programs have been tailored along these observed lines. In addition to the general programs aimed at the so-called sexually active population, some group-specific studies have been initiated. One example is a continuing condom promotion study among prostitutes in Accra being undertaken by the AIDS Control Programme. Two categories of prostitutes are involved in the study, resident and non-resident prostitutes. The former have fixed residential addresses where they receive clients. The latter have no fixed addresses and solicit for clients from the streets and hotels. A nagging problem faced by the study is the inability to retain participants, particularly from the second category of prostitutes, for follow-up and monitoring. The experience in the fieldwork for the current...
study was different. All participants were co-operative and some of the females voluntarily asked for advice and assistance for medical examination and treatment of venereal diseases. In addition, they agreed to participate in focus-group discussions on condition that they would be supplied with condoms.

Another example was the United States Agency for International Development (USAID)-sponsored KAP study on youth and young adults aged 15 to 30 years. This was a two-stage study — before and after — meant to evaluate a media campaign aimed at the study population. After ten months of media campaign the evaluation showed that while there had been a significant increase in the level of awareness among the young people, sexual behaviour, such as the number of sexual partners and condom use, had remained virtually unchanged (see McCombie and Anarfi 1991, 1992). In this study it was assumed that all young people had equal access to information. Only young people found at home were included in the study. However, the current study has revealed that there are a number of young people in Ghana who have no fixed accommodation and spend most of their time on the streets.

It has been conceded that education about AIDS prevention may be difficult with adolescents and young adults because of ‘their emerging independence, rebellion, their sense of invincibility, distrust of adults or governments, and present-time orientation, and because of peer pressure’ (Muir 1991:143). However, the absence of a known vaccine or cure for AIDS leaves us with education and information as the only means of averting the spread of the disease. This study has confirmed the general observation that young people are more sexually active than many adults may realize, and as a group, they value sexual experience more than they do chastity (King et al. 1988). Sexual behaviour among the study population could be described as dangerous, with some involved in sex for survival and an appreciable proportion contracting STDs every now and then. Their life was one of high stress (in seeking food, shelter, and protection), with little money, unemployment, and a lack of medical services. Although awareness of AIDS was almost universal among the group, the preventive messages were largely ignored in the drama of meeting their more immediate needs, such as where to sleep and how to obtain food, or for those who were on drugs, when to get the next dose.

Their centre of activity, and the kind of work most of them were doing for a living, brought them into contact with other people with whom they had sexual relationships: truck drivers, resident women traders and hawkers, and itinerant women traders. The environment, therefore, offers a very good opportunity for involving concurrently some of the known AIDS-related high-risk and vulnerable groups in an intervention program. The network of sexual relationships which reaches beyond the environment of the young people to the general population in Accra and beyond, will be very useful as routes for the dissemination of AIDS prevention messages.

Recommendations

Given that most of the behaviour of the street-involved youth helps them cope and survive in their adverse environment, AIDS intervention programs must be innovative and follow an integrated approach. In addition to mass awareness campaigns, an office must be set up preferably at the centre of activity of the youth to cater specifically for their needs. This will make certain medical and educational facilities more accessible to this category of people who feel cut off from the main society. The young people should be able to visit the office for advice and counselling or even treatment without the fear of being tagged. Social marketing could be put to good use in such an office.
The treatment of sexually transmitted diseases should be made a priority. There was evidence that those who contracted STDs were not able to treat them properly. Untreated STDs are known to facilitate the spread of HIV. Such treatment must be subsidized.

Effort must be made to improve the social and economic conditions of the youth and reduce their dependence on practices such as the peddling and abuse of drugs and prostitution. Those who require training in certain skills must be given the opportunity to upgrade themselves.

Lessons could be taken from similar programs elsewhere to improve the effectiveness of the AIDS education. The education must be specifically designed to help individuals build decision-making, communication, and assertiveness skills. A study by Kipke, Boyer and Hein (1989) in Canada observed that increased knowledge improved behavioural skills and enabled individuals to refuse certain behaviour and to negotiate lower-risk sexual activity.

Other studies have observed that educational programs which make use of ‘insiders’ as role models have proved particularly successful (see Batjes and Pickens 1988; Conant et al. 1989). The program must, therefore, have components of peer support and peer education. Above all, the integrated approach requires that the program must be run by a team of dedicated experts with varied backgrounds. They should include a social scientist, a medical practitioner, a psychologist, a counsellor and a social worker to offer career guidance. However, for many of the young people environmental factors like dysfunctional families will need to be addressed before HIV prevention can be most effective.
Appendices

Appendix A: Respondents’ sources of sex education

<table>
<thead>
<tr>
<th>Source</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Friend (peer)</td>
<td>59.1</td>
<td>64.7</td>
</tr>
<tr>
<td>Mother</td>
<td>6.8</td>
<td>11.8</td>
</tr>
<tr>
<td>Eavesdropping</td>
<td>11.4</td>
<td>5.9</td>
</tr>
<tr>
<td>Media</td>
<td>6.8</td>
<td>8.8</td>
</tr>
<tr>
<td>School/teacher</td>
<td>9.1</td>
<td>2.9</td>
</tr>
<tr>
<td>Older siblings</td>
<td>4.5</td>
<td>2.9</td>
</tr>
<tr>
<td>Health worker</td>
<td>2.3</td>
<td>2.9</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td>N a</td>
<td>44</td>
<td>34</td>
</tr>
</tbody>
</table>

a Only represents those who have ever had some sex education.

Appendix B: Reported content of sex education

<table>
<thead>
<tr>
<th>Topic</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnancy -related</td>
<td>43.2</td>
<td>64.7</td>
</tr>
<tr>
<td>Disease-related</td>
<td>29.5</td>
<td>17.7</td>
</tr>
<tr>
<td>Can’t remember</td>
<td>20.5</td>
<td>11.7</td>
</tr>
<tr>
<td>Not stated</td>
<td>6.8</td>
<td>5.9</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td>N a</td>
<td>44</td>
<td>34</td>
</tr>
</tbody>
</table>

a Only represents those who have ever had some sex education.

Appendix C: Modified sexual behaviour since hearing of AIDS (% of those who reported modified behaviour)a

<table>
<thead>
<tr>
<th>Behaviour</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>No sex until partner well known</td>
<td>44</td>
<td>47</td>
</tr>
<tr>
<td>Reduced number of partners</td>
<td>40</td>
<td>45</td>
</tr>
<tr>
<td>Avoids anal sex</td>
<td>23</td>
<td>35</td>
</tr>
<tr>
<td>Insists on use of condom</td>
<td>8</td>
<td>13</td>
</tr>
<tr>
<td>Avoids oral sex</td>
<td>18</td>
<td>32</td>
</tr>
<tr>
<td>Practises abstinence</td>
<td>10</td>
<td>8</td>
</tr>
<tr>
<td>Asks about partner’s behaviour</td>
<td>25</td>
<td>28</td>
</tr>
<tr>
<td>Avoids sex with prostitutes</td>
<td>32</td>
<td>36</td>
</tr>
</tbody>
</table>

a Multiple response
### Appendix D Number of sexual partners over certain periods (%)

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In the last three months</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>8.0</td>
<td>4.0</td>
</tr>
<tr>
<td>1</td>
<td>25.2</td>
<td>36.0</td>
</tr>
<tr>
<td>2-5</td>
<td>28.0</td>
<td>34.7</td>
</tr>
<tr>
<td>6+</td>
<td>3.4</td>
<td>5.3</td>
</tr>
<tr>
<td>Too many to count</td>
<td>0</td>
<td>2.7</td>
</tr>
<tr>
<td>Can’t tell</td>
<td>13.7</td>
<td>12.0</td>
</tr>
<tr>
<td>No sex</td>
<td>21.7</td>
<td>5.3</td>
</tr>
<tr>
<td><strong>In the last year</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>1.7</td>
<td>0</td>
</tr>
<tr>
<td>1</td>
<td>22.9</td>
<td>29.3</td>
</tr>
<tr>
<td>2-5</td>
<td>28.6</td>
<td>33.3</td>
</tr>
<tr>
<td>6+</td>
<td>8.0</td>
<td>5.3</td>
</tr>
<tr>
<td>Too many to count</td>
<td>3.4</td>
<td>8.0</td>
</tr>
<tr>
<td>Can’t tell</td>
<td>13.7</td>
<td>18.7</td>
</tr>
<tr>
<td>No sex</td>
<td>21.7</td>
<td>5.3</td>
</tr>
<tr>
<td><strong>In lifetime</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>6.3</td>
<td>6.7</td>
</tr>
<tr>
<td>2-5</td>
<td>26.2</td>
<td>37.3</td>
</tr>
<tr>
<td>6+</td>
<td>15.4</td>
<td>4.0</td>
</tr>
<tr>
<td>Too many to count</td>
<td>17.8</td>
<td>21.3</td>
</tr>
<tr>
<td>Can’t tell</td>
<td>12.6</td>
<td>25.3</td>
</tr>
<tr>
<td>No sex</td>
<td>21.7</td>
<td>5.3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td><strong>N</strong></td>
<td>175</td>
<td>75</td>
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</table>

### References


*Supplement to Health Transition Review Volume 5, 1995*


Sexual behaviour in the face of risk: the case of bar girls in Malawi’s major cities

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**Abstract**

The first case of AIDS in Malawi was diagnosed in 1985. The close association of AIDS with sexual promiscuity led the Ministry of Health to mount a campaign to create awareness of the dangers of promiscuous sex. Surveys so far carried out indicate that about 80 per cent of bar girls carried the HIV virus. This study sought to investigate why young women became bar girls, how much they knew about AIDS, and why they persisted in what is regarded as a high-risk occupation. The study revealed that economic necessity was a major consideration in engaging and persisting in commercial sex. Poverty then may be a major factor in the rapid spread of AIDS in Malawi.

The first case of AIDS in Malawi was diagnosed in 1985. Since then it has become apparent that the causative HIV virus is widespread in all areas of the country. A Ministry of Health estimate in 1992 put the prevalence rate at ten per cent of the adult population (UNICEF/Malawi Government 1993:169).

It is now known that AIDS in sub-Saharan Africa is transmitted primarily through heterosexual intercourse with an infected partner. Since HIV infection is primarily transmitted through sexual intercourse, persons who have multiple sexual partners stand a greater chance of catching the virus than those who restrict their sexual contact to one partner. Commercial sex therefore exposes women employed in it as well as their male clients to increased risk of sexually transmitted diseases including AIDS (Orubuloye, Caldwell and Caldwell 1994a:101). Screening of 500 bar girls in Blantyre, the country’s commercial city, showed that 80 per cent were HIV-positive (UNICEF/Malawi Government 1993:169).

This paper discusses the reasons why young women enter what is regarded as a high-risk occupation and persist in it, in spite of the massive campaign by the Ministry of Health against promiscuous sex, and the evidence that there is currently no vaccine or cure for AIDS. It draws heavily on the results of a study of prostitution (Kishindo 1992) which covered the country’s three cities and one municipality: Blantyre, Lilongwe and Mzuzu cities and the Municipality of Zomba.

**The anti-AIDS campaign**

It is widely accepted that pending the development of an effective vaccine or cure for AIDS, behavioural change is the only means of stemming the spread of the disease (Cleland et al.

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1. In Malawi bar girls and prostitutes are synonymous because although the former are officially employed to serve drinks to patrons, they also engage in commercial sex with the connivance of the bar owner.

2. Former capital of the country; now university town.
The Ministry of Health set up the National AIDS Control Programme in 1988 to co-ordinate efforts against the disease. Since then the program has mounted an information campaign using various media to educate the population on such issues as symptoms of AIDS, mode of transmission and preventive measures. The radio has played a very important role in reaching the country’s largely illiterate population (National Statistical Office 1994:114). A 1992 national survey of AIDS awareness found that general knowledge of AIDS was almost universal among males (98%) and females (95%). Among both males and females, sexual intercourse was the most frequently reported mode of HIV transmission (93% and 86% respectively), followed by needles and blades, and blood transfusion (National Statistical Office 1994:111).

Bars and bar girls

An estimated eleven per cent of Malawi’s population are urban-resident. These urban residents are engaged in formal employment in industry, government departments, and the informal sector; the government is the largest employer of labour in the formal sector. As small-holder agricultural production becomes an increasingly unprofitable occupation because of recurrent drought, shrinking holdings due to a high rate of population growth estimated at 3.2 per cent annually, and ever-rising farm input prices, rural-urban migration has been increasing rapidly over the last few years. The new immigrants, often with little or no formal education, find menial jobs in the informal sectors of the country’s towns and cities. An increasing number of those migrating to the towns and cities are young women.

The bar is a very important after-hours and weekend meeting place for urban residents; the more popular bars provide music and snacks as well as the usual liquor. The regular bar patrons tend to be in the 30-50 age group, and in wage or salaried employment, or business. They tend to come to the bar unaccompanied by wives or girl-friends: the explanation they offer is that wives or girl-friends may not be very comfortable with the crude language which is often used in those places, and the likelihood of violence breaking out among drunken patrons. Observation, however, reveals that some patrons visit bars primarily for female company and sex. International hauliers from Tanzania are a conspicuous presence in the bars of the northern city of Mzuzu, where they stop over on their southward journey to the southern city of Blantyre. They are also conspicuous in Blantyre’s bars, where Zimbabwean hauliers are also regulars. These international hauliers are the centre of attraction for bar girls and ‘free-lance’ prostitutes because they seem to have a lot of money to spend.

Although bar girls are officially employed to serve drinks and clean the bars, in reality this is only a cover for what they really are: prostitutes. These bar girls engage in commercial sex with the full knowledge of the bar owner, to whom the availability of sex for sale is one more means of attracting patrons to the bar. None of the 84 bars sampled for the study had fewer than four bar girls.

A typical bar has behind it single-room accommodation for the bar girls. The bar owners do not normally charge rent for the rooms, a fact which is used to justify the very low wages that they pay the bar girls. Many bar owners view their relationship with their bar girls as a business partnership: the girls attract patrons to the bar and increase the volume of business;

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3 Those that are not attached to a particular bar, but move from one bar to another, and sometimes solicit in the streets.
in return, the bar owner provides premises and cover for the bar girls to operate their business. The rooms behind the bar serve as venues for sexual encounters with clients.

Although bar girls may have their own favourite clients, the nature of their job is such that they have to have sexual intercourse with whoever is able to pay the ruling rate; if they are too selective they run the risk of having a limited clientele and hence reduced potential earnings. It is however not uncommon for bar girls to have clients with whom they develop a personal attachment. The special client gives the bar girl cash and other gifts, and he does not have to pay for each sexual encounter. It is this relationship that may ultimately develop into a marriage between a client and a former bar girl.

A total of 540 bar girls in Blantyre, Lilongwe, Mzuzu and the Municipality of Zomba were interviewed for the study. None of them was currently married, although 55 (10.2%) have been married at one time or another; and 64 (11.9%) reported having living children. They tended to have predominantly rural backgrounds: only 16 (2.9%) reported they were born and brought up in the city. These 16 reported fathers in wage or salaried employment and business, while the rest reported fathers who were subsistence farmers, small-scale businessmen, craftsmen or artisans. The bar girls tended to be heterogeneous in their ethnic backgrounds although one particular ethnic group may be predominant depending on what ethnic group is in the majority in the locality: thus in Blantyre and Zomba in the south, bar girls of Yao origin predominated; in Lilongwe in the centre, Chewa bar girls were predominant; while in Mzuzu, Tonga and Tumbuka girls formed the majority. The average age of the bar girls was 19 years, with an average of three years experience in the occupation.

An important feature of a bar girl’s life is her geographical mobility: when a bar girl is no longer able to attract clients in one locality because she is a known STD carrier, or more popular girls have come onto the scene, or because she does not want to be found out by relatives who might disapprove of her occupation, she moves to a new locality where she hopes to re-establish herself. A bar girl will also move from one unpopular bar to a more popular one within the same area where the likelihood of attracting clients is greater. The geographical mobility of infected bar girls contributes to the spread of HIV.

Educational attainment

The highest level of education attained by bar girls was a Primary School Leaving Certificate (PSLC), obtained after eight years of primary school. The lowest level attained was Standard 5, that is five years of primary school. This means that all the girls had some formal education and were literate and numerate to varying degrees. This is worth noting in a country where the literacy rate for women is estimated at only 36 per cent (Malawi Government 1991:10). It is possible, although this could not be verified with the bar owners, that a measure of literacy and numeracy is a requirement for recruitment.

The reasons for failure to continue to higher levels of education were varied, although the lack of school fees was the most frequently cited reason (see also World Bank 1990:40). Table 1 gives the frequencies for the various reasons.

Lack of school fees was the single most important obstacle to proceeding to the next level in the school cycle. Although the primary school fees of K3.50 per year for junior classes and K4.50 per year for senior classes at the time of the study may not seem much money to people in wage or salaried employment, for many families in Malawi who have to

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4 Prostitution is illegal in Malawi, but law enforcement officials turn a blind eye to the activities of the bar girls, perhaps because technically they are not soliciting. The police seem to be more interested in those who solicit in the streets.

5 At the time of the study 1MK = US 22 cents.
A prevalent attitude in Malawi, especially in the rural areas, is that girls do not need to go to school since their material needs will be taken care of by the men who will marry them. According to this view what a girl really needs is training in the ‘wifely skills’ of cooking, washing, pounding the maize and farm work. The roles of wife and mother, which according to this view are the proper roles of women in society, do not require academic certificates for their efficient performance. It is therefore not unusual for parents to dissuade their daughters from going beyond a certain level of education. Parents who do not want their female children to have formal education, or to proceed beyond a certain level, conveniently use the ‘lack of fees’ argument. It is not uncommon for a family not to afford school fees for a daughter, but be able to afford them for a son. The reasoning here is that the son as head of household is expected to provide for his wife’s and children’s material needs and a good education will ensure wage or salaried employment. The daughter on the other hand will get married to someone else’s son. The girls who are forced to leave school under these circumstances have to find means of economic support which may be in the form of menial jobs, or early marriage.

However, among some ethnic groups such as the Yao in the south and Tonga in the north, early marriage for females is the norm, and that in itself may force the girl to drop out of school to get married. Of the 26 who had indicated they dropped out of school because they had to get married 16 (61.5%) were from Blantyre, which is a predominantly Yao area, the rest were from Mzuzu (4) and Lilongwe (6). The average age at marriage was 14.5 years. At the time of the study these bar girls were divorced from their husbands, having been married only a few years.

A girl may also be compelled to leave school because her labour is needed at home. From a very early age a daughter makes a significant contribution to household labour: she helps look after younger siblings, thus freeing the mother to do other things; helps cook the food; fetches water and helps with agricultural tasks. This is believed to provide practical training for the females’ culturally defined future roles as wives and mothers. A girl is a real

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6 The United Democratic Front government which ousted the Malawi Congress Party from power in the first multiparty Presidential and General Election in 30 years on 17 May 1994 put in place free primary education in September 1994.
asset to her mother, especially in a family of many boys. All the 66 cases who had to withdraw from school in order to help with household work reported that their major responsibility was to look after young siblings when their parents went to the farms or to sell items in the market and generally to manage the household during the mother’s absence.

Under Ministry of Education rules in existence till 1993 when they were changed, a girl who got pregnant while registered as a student in any government or government-assisted school was expelled from school, and could not be readmitted after delivery. She could however re-enrol in a private school. For those girls whose parents could not afford to send them to private schools, early pregnancy marked the end of a school career.

A Malawian pupil who reached the highest class in the primary school cycle (Standard 8) met the biggest obstacle in his or her academic career: the Primary School Leaving Certificate (PSLC) examination. This examination serves as the basis for selection into government and government-assisted secondary schools where places are extremely limited: fewer than ten per cent of those who sit the examination are selected every year. Those parents who can afford to send their children to private secondary schools; but many pupils repeat in the hope of improving their grades so as to gain entry into secondary school (UNICEF/Malawi Government 1993:145). Chances of getting selected at the second or third attempt are however not guaranteed. Ultimately one simply gives up. This was the experience of the 123 girls in the sample.

But not everyone finds school exciting and wants to proceed. In the eleven (2%) cases where the girls left because they found school boring, it was found that they enrolled in school at higher ages than the official age of six: their average age on enrolment in Standard 1 was 9.5 years. They therefore found themselves among classmates three or four years younger than they were, so it is likely they found some of the class activities designed for younger pupils such as reading aloud, and writing on the ground, childish and uninteresting; and by the time they got into Standard 5 or Standard 6 they had developed interests outside the classroom which made it difficult for them to like school.

Reasons for becoming a bar girl

All the 540 bar girls involved in the study were aware that working as bar girls would involve having sexual intercourse with multiple partners, and knew the risks such behaviour entailed. Three reasons were given by the respondents for becoming bar girls: 501 (92.8%) reported they became bar girls primarily to earn money to support themselves; 29 (5.4%) hoped to meet a man with a regular income to marry them; and ten (1.9%) wanted somewhere to live and companionship after being disowned by parents for behaviour regarded as shameful, which included hemp smoking, pregnancy and abortion. None of the bar girls in the sample, even those who had become bar girls primarily for financial security, regarded their job as a lifetime occupation: they all expected ultimately to settle down to married life (cf. Orubuloye et al. 1994a:108).

With PSLC and lower the only jobs that were open to the girls were menial, such as cleaners, child minders, and housemaids. These jobs commanded only the statutory minimum wage which at the time of the study was K1.75 per day or K52.20 per month in the cities and the municipality. The statutory minimum wage is rarely enforced unless the worker actually complains to the Department of Labour, and very few workers know that they have a right to complain, or that there is such a thing as a minimum statutory wage. It is very easy for employers to pay these workers a wage below the statutory minimum.

Among the bar girls in the sample the average monthly wage earned was K33.50, less than the statutory minimum wage; the bar girl was expected to make up the shortfall by engaging in commercial sex. But even the meagre wages that were due to the bar girls for doing their official duties were often not paid, thus compelling them to live almost entirely on
the proceeds of commercial sex. Since the agreements between the bar girls and bar owners were usually verbal it was not always easy for Department of Labour officers to compel the bar owners to pay the bar girls what was due to them. The bar girls were also reluctant to report bar owners because such action would invite eviction from the premises and loss of a base for their operations.

Compared to normal employment, and taking into account the bar girls’ level of formal education, commercial sex is very profitable. The rate of remuneration per encounter varied from one city to another, with K21.50 (about US$4.75) as the average rate. The average number of clients per bar girl was eleven per week. At the rate of K21.50, and assuming there was only one sexual act at each encounter, a bar girl’s earnings would be K236.50 per month. At prevailing salary scales this was more than what a beginning graduate in the civil service earned. These earnings were often sent home to build houses, support children and other relatives, or pay for farm inputs. Only 130 (24.1%) of the bar girls reported their parents or other relatives were aware of the kind of work they were involved in: the majority of parents, therefore, assumed the money they received came from a respectable job.

The average weekly or monthly income however masks large differentials in the bar girls’ earnings. How much business a bar girl is able to attract depends on such factors as age, beauty, cleanliness and reputation for sexual performance. A bar girl rated high on these aspects is likely to be more sought after than one who is rated lower. At month-ends the more popular girls may have as many as five clients in one evening (cf. *Daily Times* 1995). These popular bar girls are often resented by their less popular colleagues, and fights, accusations and counter-accusations of witchcraft are not uncommon. Given the large number of clients with whom a bar girl has sexual intercourse she clearly is a focus of infection (cf. Orubuloye, Caldwell and Caldwell 1994b:34).

**Awareness of AIDS**

All the bar girls in the sample were aware that AIDS is primarily transmitted through sexual intercourse, that it has no cure, and that people in their occupation can avoid catching the disease and prevent its spread by using condoms during sexual intercourse. The radio was predominantly the initial source of the information which was later reinforced in health talks given to them by community health personnel at hospitals where they attended routine medical examinations. However at the time of the study only 126 (23.3%) of the bar girls had ever used a condom during sexual intercourse although these were available free from the hospitals. The reasons given for this situation are listed below:

1. Clients’ negative attitude: clients claimed that the condom reduced sexual excitement and made sexual intercourse unexciting and mechanical. Sexual intercourse with a condom was often likened to eating a sweet that is still covered in its wrapper.

2. Bar girls’ own misconceptions about the condom: a widespread view among women was that a condom can slip off a client and lodge itself in the woman’s uterus, causing sterility. It was also believed to cause vaginal itching.

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7 Malawi public health laws require that people who handle food served to the public undergo regular medical examinations. It is under these laws, I was informed, that bar girls are examined for STDs. At the time of the study, bar girls were expected to report for these examinations once a month. An infected person is barred from handling food; and if an infected person knowingly passes on an infection he or she is liable to prosecution and imprisonment (see e.g. *Nation* 1995). It would appear that this law is rarely enforced because public health officials believe it is not really their responsibility, and police believe they have more pressing issues to attend to. However, news spreads and STD-infected girls lose their clients and are forced to leave.
3. The belief that the particular individual was not in imminent danger of catching an STD, including AIDS (see Kishindo 1990).

According to the bar girls the clients’ refusal to use condoms was the greatest obstacle to their more widespread use among bar girls. Twenty four (4.4%) of the bar girls reported that on a number of occasions when they suggested the use of condoms to their clients they were abandoned for someone willing to have sexual intercourse without the condom. This represented loss of potential earnings. Twelve (2.2%) of the bar girls reported that they have been offered several times the normal rate for unprotected sex by clients, mostly international hauliers and tourists. All the bar girls indicated that they would not refuse unprotected sexual intercourse if the price was right. Generally the bar girls did not demand the use of condoms in their sexual encounter: where condoms were used, it tended to be at the instigation of the client. All the bar girls who had used condoms reported reduced sensation during the sexual act.

All the bar girls were aware that there was as yet no vaccine or cure for AIDS. However, they generally did not, as individuals, believe they were in any greater danger than anyone else. Their own persistence in a high-risk occupation tended to be rationalized in terms of predestination: one’s manner of death is preordained, and no human act can change it (Kishindo 1990:22). A few believed that since the incubation period of the disease may be as long as ten years, a cure would be found before they developed full-blown AIDS.

Conclusion

This paper has shown that young women who become bar girls in Malawi’s cities do so out of economic necessity. A person with only a PSLC or less commands only a statutory minimum wage in the formal sector, and even less in the informal sector, where they may get employment in menial jobs. It is easy to exploit this kind of worker, who often is not aware of the law stating the minimum wage, or where to lodge disputes over pay. Serving in a bar does not require any high academic qualification, and therefore is one of the few jobs available to girls with low education. When service as a bar girl is combined with commercial sex, there is a good chance for a girl to improve her financial security, which is not possible in those jobs which command only statutory minimum wages. But commercial sex creates an unequal power relationship between the client and the service provided. The client determines the timing, nature and frequency of the sexual act. The average bar girl who is often in desperate need of money for her immediate survival avoids making demands which might drive away her clients, such as the use of condoms, if the clients are not disposed to protected sexual intercourse. Thus the bar girl is exposed to STDs of various types. An HIV-positive bar girl may in a single month infect more than 100 men, who would in turn infect their own wives, girl-friends and other sexual partners. It may be argued then that bar girls and other prostitutes form the foci of AIDS infection in the country’s urban centres from which, given the close ties that Malawian urban dwellers have with their villages, the disease may have found its way to the villages.

As long as poverty remains at present levels and the female, for whatever reason, cannot get a good job or profitable self-employment, commercial sex will remain an attractive option. And in the context of current male attitudes where penetrative, unprotected sex is regarded as the only ‘normal sex’, the high rate of AIDS infection in the Malawi population will continue.

References


A note on suspect practices during the AIDS epidemic: vaginal drying and scarification in southwest Nigeria

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Abstract

Vaginal drying and scarification have been reported as possible risk factors. Published research on the former has been confined to East and Middle Africa. This paper reports on research in West Africa employing a survey of 1,976 females in southwest Nigeria, where they reported on their own vaginal drying, the scarification of their sons, and their participation in blood oaths. It was concluded that vaginal drying is not a risk-factor for AIDS in southwest Nigeria, and probably more broadly in West Africa, that scarification may be in the few cases when group scarification is practised, and that the practice of blood oaths probably puts those involved in danger.

The severity of the sub-Saharan Africa AIDS epidemic has led to a search in the region for cultural practices that might facilitate the transmission of HIV either through rendering the vaginal wall thinner or damaged or by breaking the body's skin in such a way as to make the exchange of blood more likely.

Research on vaginal drying has mostly been reported for East, Southern and Middle Africa, while there has been only limited reporting of scarification and similar practices. This note adds to the information available by reporting on Southwest Nigeria.

The Southwest Nigerian study

The opportunity was taken to add questions to a large study in Southwest Nigeria on related matters pertinent to AIDS: male sexual behaviour (Orubuloye, Caldwell and Caldwell 1995a,b), and male and female circumcision (Caldwell, Orubuloye and Caldwell 1995c). The questions reported here were asked only of female respondents.

A sample survey, with some in-depth questions, was conducted in 1994-95 in three predominantly Yoruba states of Southwest Nigeria, Ondo State, Oyo State and Lagos State. In each, one urban area was sampled, Ado Ekiti, Ibadan and Badagry respectively. Because of the very limited rural population in Lagos State, rural surveys were only carried out in Ondo State, where the Ekiti West and Ekiti Southwest Local Government Areas were sampled and in Oyo State where Egbeda Local Government Area was chosen. A total of

* In Canberra, the authors were assisted by Wendy Cosford, Pat Goodall, Jacob Oni and Ron D'Souza; in Nigeria, by Toyin Sadiq and Kemi Oguntimehin
1,749 males and 1,976 females were interviewed, although only the latter are reported upon here.

The towns and rural areas chosen were selected so as to examine change. Both the towns and the local government areas chosen have an unusually high level of educational institutions even for this advanced part of the country. The female respondents were 88 per cent Yoruba with an average age around 35 years. Just over half had experienced some secondary education and most of these women worked in the non-traditional sector of the economy. However, 54 per cent were either farmers or traders. Almost 70 per cent were Christian, 30 per cent Muslim, and only one per cent described themselves as being adherents of the traditional religion. In terms of marital status, 24 per cent were not in a union at the time of the survey, 45 per cent were in monogamous marriages and 31 per cent were in polygynous ones. This level of polygyny, namely 41 per cent of currently married women having co-wives, is typical of the area and of much of West Africa. In terms of ethnicity and religion the sample approximated census and survey counts.

Vaginal drying and tightening

Vaginal drying and tightening has been widely reported in East, Southern and Middle Africa (Brown, Ayowa and Brown 1993; Runganga, Pitts and McMaster 1992; Caldwell and Caldwell 1993:829-832). Its most common purpose has been reported to be the male preference for such drying before sexual intercourse. It is probable that a high level of genital infections is the primary cause of vaginal wetness, and high parities cause vaginal looseness. AIDS researchers became interested in vaginal drying when it was established that substances were used which might change the vaginal mucosa and that leaves, rags and other abrasive materials were used for cleaning in such a way that the vaginal wall might be scratched. One common drying agent was the astringent, alum, which is widely used in the West for drying the blood produced by shaving cuts. Since the Nigerian research was undertaken a study has been reported of 329 women attending an STD clinic in Lusaka, Zambia (Sandala et al. 1995). Fifty-eight per cent were seropositive, one-third pushed cloths or leaves into their vaginas for drying and one-tenth of this group had swollen or peeling vaginal surfaces as a result, but no association could be shown between drying and infection with AIDS.

In the Southwest Nigerian study nearly all women reported that they cleaned and dried their vaginas before sexual activity, but none that they used tightening agents. The cleaning was largely external and there was very little internal douching. They reported that the cleansing was needed to prevent infection resulting from intercourse and to reduce the level of vaginal odour. The emphasis on reducing odour rose with education and other socio-economic indices and was greater in urban areas. This presumably demonstrated both greater fastidiousness and easier access to piped water and other facilities. Nevertheless, it may also have shown that these women were more sceptical of the thesis that such cleaning and drying could protect them from infection.

Nearly all the elite and most urban women said that the cleaning and drying was for the benefit of both sexual partners. In rural areas, one-third of women said that they carried out these procedures only for the benefit of their male partners and to meet their demands. This is evidence of a situation which is clearly passing but where not long ago the male demand was paramount. Nine out of ten men in both urban and rural areas, with little socio-economic differentiation, still expect such cleaning. When asked what happened if the husbands knew or suspected that such cleaning had not been done only one-tenth of the female respondents said that sexual intercourse would go straight ahead. One-third said that their male partner would just give up the idea of having sex at that time, while the rest reported that he would scold them and tell them to clean themselves. Husbands were less likely to make such complaints or to terminate sexual activity among the urban elite but this probably
demonstrates little more than lower levels of vaginal infection and higher levels of vaginal hygiene among their wives or other female companions.

The major finding in this study is set out in Table 1. That finding is that there is very little use of harmful substances or objects in the washing and drying. A few rural women do use cloth and this might scratch or might not be clean. But there is no parallel to the dangerous cleaning methods reported for other parts of Africa. It is possible that the Southwest Nigerian pattern is widespread in West Africa and that this accounts for the lack of West African research reports on the matter. Possibly there is some cause for concern among the one-sixth of women who report employing antiseptic solutions, especially as most of them do so two or three times a day. More generally, there may be concern for the higher frequency of internal washing practised by these women.

**Table 1**

<table>
<thead>
<tr>
<th>Vaginal cleaning and drying (1,976 female respondents)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Urban respondents</strong></td>
</tr>
<tr>
<td>(N=1,073)</td>
</tr>
<tr>
<td>Frequency of cleaning and drying (%)</td>
</tr>
<tr>
<td>Rarely or not regularly</td>
</tr>
<tr>
<td>Once daily</td>
</tr>
<tr>
<td>Twice daily</td>
</tr>
<tr>
<td>Three times daily</td>
</tr>
<tr>
<td>More often</td>
</tr>
<tr>
<td>Methods of cleaning (%)</td>
</tr>
<tr>
<td>Soap and water</td>
</tr>
<tr>
<td>Antiseptic solution</td>
</tr>
<tr>
<td>Water only</td>
</tr>
<tr>
<td>Vaginal cream</td>
</tr>
<tr>
<td>Other (cloth etc)</td>
</tr>
<tr>
<td>No response</td>
</tr>
<tr>
<td>Does not clean regularly</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

Once these matters would have been taught as a preparation for marriage, usually formally as part of puberty rituals. Nowadays, half the women claim to have been given no instruction but to have followed their own commonsense. Nearly all the rest were instructed by parents or relatives, mostly the former in towns, while in rural areas, where there is still a concept of the appropriate relatives for such a task (maternal grandmothers or aunts usually), two-fifths of the instruction was given by other relatives.

**Scarification**

Scarification is making incisions in the skin. Traditionally for protective purposes, it was universal among Yoruba males of southwest Nigeria. This is still generally true, for, among respondents whose children were regarded as old enough for scarification, 95 per cent of parents had had it performed.

Scarification can lead to very considerable bleeding, and has aroused the interest of AIDS researchers especially when group scarification takes place using the same instrument.

Perhaps the most interesting finding from the research was the evidence that scarification was showing little sign of decline. This was established partly by the continuing high level of the practice and partly by the almost complete lack of socio-economic differentials in its
practice. The only differences — and these were not statistically significant — were that every adherent of traditional religion carried out the practice, and that only 93 per cent of the secondary educated urban elite under 35 years of age had carried it out compared with 96 per cent of the rest of the population.

Scarification is almost entirely practised for protection from disease, ill-fortune or witchcraft and other evil forces. Nearly all rural respondents answered immediately in these terms, as did 92 per cent of the urban respondents. The remaining eight per cent claim to do it simply because it is cultural or traditional.

The key responses which indicate whether scarification could increase the risk of HIV transmission are given in Table 2.

Table 2
Scarification of sons (1,425 mothers of sons who have reached the suitable age)

<table>
<thead>
<tr>
<th>Urban</th>
<th>Rural</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>When was it carried out? (%)</strong></td>
<td></td>
</tr>
<tr>
<td>Before going to school</td>
<td>8</td>
</tr>
<tr>
<td>Before going to new places</td>
<td>5</td>
</tr>
<tr>
<td>At festivals</td>
<td>11</td>
</tr>
<tr>
<td>When needed or there is a divine sign</td>
<td>9</td>
</tr>
<tr>
<td>No particular time, no response</td>
<td>67</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>100</td>
</tr>
<tr>
<td><strong>Who did the scarification? (%)</strong></td>
<td></td>
</tr>
<tr>
<td>Traditional specialist</td>
<td>8</td>
</tr>
<tr>
<td>Traditional doctor</td>
<td>32</td>
</tr>
<tr>
<td>Other healers(^a)</td>
<td>52</td>
</tr>
<tr>
<td>Others (relatives etc)</td>
<td>8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>100</td>
</tr>
</tbody>
</table>

\(^a\)Herbalists and some persons claiming contact with the modern health system (nurses, dispensers etc.)

There are several important findings in Table 2. The first is that less than one-tenth of scarification is now associated with festivals or rituals, a situation which must reduce the chance of rapid, successive scarification. The second is that there is probably still a substantial amount of scarification done to meet crises, and this could well mean more than one family member being done at the same time with a raised risk of intra-family HIV transmission.

The medicalization of traditional practices, which we have already reported in the case of circumcision (Caldwell, Orubuloye and Caldwell 1995), may also be taking place to a limited extent with scarification. Many of these procedures are now carried out by persons claiming contact with the modern health system, some presumably in hygienic conditions and with the sterilization of instruments. Three-quarters of the scarifications performed on the sons of the modern, urban elite are done in this way. The danger of group scarification is presumably largely confined to traditional practitioners.

**Blood oaths**

Solemn agreements were signified in the days before written documents by the participants cutting themselves and sucking each other’s blood. Clearly the risk of HIV transmission would be high when people had cut lips or mouth sores. We heard persistently that such oaths were still performed and accordingly we directed questions to the practice. The oaths
increasingly became part of the initiation ceremonies of secret cults and of criminal organizations. They are practised among secret societies in universities and schools and such societies are becoming more numerous.

Surprisingly, eight per cent of rural respondents and five per cent of urban respondents reported that they had participated in at least one contract of this type, and the levels were probably higher among their husbands. Participation appeared to decline with urban residence and steeply with education and other socio-economic indices but as the cults require an oath of secrecy this information must be suspect. As a form of agreement it remains mainly a practice of the illiterate and is their form of documentation. The scars remain. In addition there is a religious element in that this ritualistic agreement is made in a way that is noted by the ancestors and the gods.

Summary

In Southwest Nigeria, vaginal cleaning and drying is of a type that is unlikely to augment the AIDS epidemic. There is no vaginal tightening. In contrast, scarification on the existing scale must present some danger. This statement should be qualified by noting that the proportion of group scarifications is probably small, and that half of all scarification is now carried out in the modern medical sector. Blood oaths are still practised by some people, and would appear to be exceedingly dangerous in terms of potential HIV transmission.

References

Prostitution and the risk of STDs and AIDS in Nigeria and Thailand

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Research on AIDS in sub-Saharan Africa is determined by the nature of the epidemic in that region. All evidence continues to show that, apart from vertical transmission from mother to child and some continuing infection from blood transfusions, it is almost entirely a heterosexually transmitted epidemic. Both patient histories and physical examinations rule out the possibility of any significant level of transmission through homosexual activities or intravenous drug use. This evidence is supported by the parity by sex of the infected persons.

Because of the very slight chance of an infected person transmitting the disease to another during each sexual act if they are otherwise healthy, there clearly must be other special circumstances necessary to sustain a fully heterosexual epidemic. Several possible factors have been studied: unusually high levels of sexual activity outside marriage; unusually high recourse by men to prostitutes; an unusual level of other sexually transmitted diseases (STDs) which act as co-factors; lack of male circumcision. A factor in the epidemic which allows the testing of the hypotheses is the fact that levels of the disease are much lower in most of West Africa (the exception being Côte d'Ivoire) than they are in much of East and Southern Africa. After a dozen years of the epidemic this contrast can no longer be explained by diffusion from an original source.

Research seems to show that the level of non-marital sexual activity, particularly by males, is high but no higher in East than West Africa or in some other populations outside Africa (Orubuloye et al. 1994). The focus of this non-marital sex on prostitutes is probably greater, at least in some of the larger cities, in East than West Africa but it is doubtful whether the margin is sufficient to explain the contrasting levels of the epidemic. There is probably a different incidence in the probable co-factors, with perhaps no differences in the overall levels of sexually transmitted diseases (STDs), but with East and Southern Africa displaying a higher incidence of the most likely co-factors, genital ulcerating diseases (GUDs), especially chancroid. This leaves us not only with the question of why there is a higher incidence of AIDS in parts of East and Southern Africa, but why there is a high level of chancroid. The answer may well be that these are the parts of the continent where males

* The research reported here has been a joint program beginning in 1989, of the Faculty of Social Sciences and the Centre for Population and Health Research, Ondo State University, Ado-Ekiti, Nigeria and the Health Transition Centre, National Centre for Epidemiology and Population Health, Australian National University, Canberra. The program has been successively funded by the Australian National University, the Rockefeller Foundation and SAREC (the Swedish Agency for Research Cooperation with Developing Countries). The principal investigators have been I.O. Orubuloye, John Caldwell and Pat Caldwell. The joint project organized this research within the framework of WARGSN (the West African Research Group on Sexual Networking). The visit to Thailand was co-ordinated by Wassana Im-Em. Assistance in Canberra was provided by Wendy Cosford and Pat Goodall.
remain uncircumcised or to which uncircumcised men migrate (Caldwell and Caldwell 1993, 1994). The greatest contrast between East and West Africa is not in the level of the disease in high-risk populations but in the level in low-risk populations (Health Studies Branch 1993). It seems likely that the epidemic is self-sustaining in most of West Africa, and certainly in Nigeria, only among the high-risk groups, while in considerable parts of East and Southern Africa it might continue even in the absence of high-risk populations. The levels in city high-risk populations, city low-risk populations and non-city low-risk populations are, for instance, 69, 33 and 10 per cent in Rwanda, and 29, 18 and 13 per cent in Zimbabwe, compared with 12, 1 and close to 0 per cent in Nigeria.

In all of sub-Saharan Africa, high-risk populations may constitute significant sources of infection, but in West Africa they may constitute almost the only source and may be a significant proportion of the population suffering from the disease. These high-risk populations are usually defined by attendance at STD clinics. In Nigeria most of those attending are prostitutes, pimps and other men constantly with the prostitutes, and, to a lesser extent, long-distance truck-drivers, itinerant hawkers and some other occupations.

There is, then, a strong case for studying commercial sex workers, not as deviant groups — there is indeed some doubt as to how deviant they are — but as persons at special risk and whose companions and clients are at special risk. In the process of research we discovered that most of them wanted better advice on health and were pleased to have been part of the research project for this reason.

Naanen (1991), writing of the history of prostitution in Nigeria's Upper Cross River Basin during the first half of this century, traced the rise in commercial sex activities and blamed colonialism, and even the sexual habits of the colonists. There was, in fact, only a very small colonial population in Nigeria. Because of polygyny, most Nigerian men had always married late and sought female sexual companions in the meantime. In earlier times much of this companionship was found within the extended family. In addition, polygyny implied that men were unlikely to be satisfied by a single woman so even married men sought sex elsewhere if only on the pretext of finding another wife. Missionaries condemned sexual activity within the family as being close to incest, and colonization led to an increasingly monetized economy where sex could be bought. Towns grew where both goods and sex could be more easily bought. The earlier evidence was that most prostitutes were young widows, separated wives or wives thrown out of marriage because they were sterile. There is evidence from Ghana that this position may have been changing and that the sex industry has begun to recruit young single women (Peil 1981). There is evidence from Gambia that prostitutes are not below average in education, and, given their educational level, can earn much more from prostitution than from any other occupation (Pickering and Wilkins 1993).

The collaborative project of Ondo State University and the Australian National University had, in a field research program beginning in 1989, thrown light on the context of the STD epidemic and the threatened AIDS epidemic (Orubuloye et al. 1994). There was a fairly high level of premarital and extramarital sexual relations, with most men exhibiting higher levels than the majority of women, and with such relationships being somewhat more frequent in urban than rural areas. Most men sought sex for enjoyment but a substantial proportion of women who had extramarital sexual relations did so with a semipermanent partner in order to augment the support for themselves and their children. In most cases this probably did not involve a serious health risk, but it did mean that the community's attitude to transactional sex was ambivalent.

The majority of Nigerian men, even in the cities, do not have their non-marital sexual relations with prostitutes: that is, with women who usually charge for each sexual episode, have quite a large number of different partners and are often attached to an institution like a brothel, hotel or bar. In some societies such institutional sex might be the most strictly
supervised in terms of checks on sexual diseases and the practice of safe sex, but this is not so in Nigeria. Almost certainly commercial sex plays a disproportionate role in the spread of STDs and may play such a role in the spread of AIDS. The Nigerian situation is aggravated by a high level of ignorance about specific STDs and their symptoms, and also by frequently delayed or inappropriate treatment for financial or other reasons.

**The study**

In 1992 in four southern Nigerian cities, Lagos, Ado-Ekiti, Benin and Port Harcourt, plus Kaduna in the north, a study was conducted of commercial sex workers, aimed at identifying them and the health risks they were running. In addition, in 1993 in Lagos a sixth study was carried out seeking additional information on the recruitment of the prostitutes and the economics of the industry (Orubuloye, Caldwell and Caldwell 1994). The work drew on two earlier investigations (Orubuloye, Caldwell and Caldwell 1991, 1992).

The six studies consisted of a questionnaire followed by a long discussion focusing on the job and its health risks. The studies confined themselves to institutions in the form of brothels, hotels and bars. The primary reason was that these could be identified in prior investigations of the areas selected by the sampling procedure. It had the advantage of focusing on the most commercial and anonymous sexual activities, where the number of clients was probably highest. The sex workers here were the young women who were probably taking the greatest health risks but who were in a situation where this could be most easily reversed by intervention programs.

The whole of each city was sampled except in the case of Lagos where two difficult and atypical areas were omitted: the downtown islands with their international hotels, and the squatter fringe areas. Within each institution sampling quotas were based on the estimated number of women in each institution and the total population for each sample tract. In all but two of the investigations male interviewers were employed because they could get into familiar joking relationships with the young women without causing embarrassment or resentment. In Kaduna in the Muslim North, where the position of prostitutes was more difficult and isolated, good interviews were obtained by female health workers who showed concern for the risks to the women's health and provided information. In Benin the interviews were carried out largely single-handedly by a woman anthropologist who had worked extensively in this population. It is clear that the prostitutes were reluctant to identify their place of origin too accurately, probably understated the degree to which their home-town people suspected what they were doing, and, for occupational reasons, revealed fewer infections by STDs than had really occurred. But most of the data collected appeared to be trustworthy.

**Commercial sex workers**

Half the women were under 25 years old and over three-quarters were under 30. Indeed all see prostitution as a stage in the life cycle because men demand young women. Unlike the situation in some other parts of the world, there is very little demand in these institutions for

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1 The joint project carried out the Ado-Ekiti and Lagos (1993) Surveys and the other surveys were carried out by other members of WARGSN (the West African Research Group in Sexual Networking). The directors for the other segments were: Kaduna, M.N. Kisekka, Centre for Social and Economic Research, Ahmadu Bello University, Zaria; Port Harcourt, Gloria Vincent-Usaghae, Department of Sociology and Anthropology, University of Benin; Benin, Francisca Isi Omorodion, Department of Sociology and Anthropology, University of Benin; Lagos (1992), Felicia Oyekanni, Department of Sociology, University of Lagos.
older women for managerial and other posts, as these are mostly occupied by men. The women see this period as one where they can and must save for later investment back home in a house and often a shop, investments which are very likely also to result in marriage. Many view this period in their twenties as a kind of city baptism, providing excitement in their youth, teaching them sophisticated city ways, and ultimately giving them memories. Their educational levels were somewhat higher than the average in their states of origin. Nearly 60 per cent claim to be single and nearly all the rest say they are divorced or separated. Half were supporting children, mostly looked after by the women's mothers back in their home villages or towns. Probably a substantial number of the single were really separated or divorced, as had been determined by a previous study (Orubuloye et al. 1991:63; 1992:347-348) but, as both school leaving ages and marriage ages increase, there is clearly a growing group of young women who regard prostitution as the interim activity between schooling and married life.

The supply of commercial sex workers

The positive aspect of supply is that prostitution, even after food and clothing and the institution's cut are taken into account, is lucrative. The average prostitute makes as much money as the salary of a senior civil servant or professor. Most Nigerian women long to own a small business and, for most, this is the only way of ensuring the purchase of a shop or a house by their late twenties. The flow of sophisticated young women from villages and provincial towns to the cities is also a product of modernization and especially of the education system. Most girls in southern Nigeria now have some secondary education, and many secondary school leavers feel themselves to be unsuited to the traditional occupations of farming (i.e. shifting cultivation using short-handled hoes) or trading. Many regard these jobs as more degrading than selling sex in the cities. Furthermore, they have a strong desire for the clothes and other possessions that go with a high-earning occupation in the city and envy the well-dressed young women who come back temporarily from urban life. There are local recruiters whom they can seek out. Interestingly, these recruiters do not seem to encourage girls before their late teens and, at least in the institutions, there seems to be no great demand for the very young.

More important is the negative side: the lack of the strong sanctions found in South or East Asia. Traditional religion has always associated the greatest sins with barrenness rather than sexual activity. The transactional element in much of the sexual activity means that there is no clear border between that and accepting payment for each episode. Young women are expected to be discreet about what they do in the city and the greatest indiscretion would be to put it into words. Besides there is deliberate confusion not only in the minds of their families but among the sex workers themselves about exactly what they do. They are also entertainers in the sense of offering men drink or food, and eating, drinking and talking with them. Some go away with men for weekends or longer. In addition, success counts and most families and communities are keen to receive the revenue brought back by successful city women and are pleased to see them later prospering in the community. It is a society which deliberately does not ask too many questions if things are going well (Cf. Bleek 1976). Naanen showed that half a century ago the remittances alone from prostitutes into Obubra Division, Southeast Nigeria, amounted to more than double the public revenue, contributed to house building and family support, and set up in other business not only the women but even their brothers, (Naanen 1991:64-65, 69, 72-73).

The essential point is that the young women do not expect social outcasting or irrevocable breaks with their families. Nearly all the women interviewed expected to marry, except some of the divorcees who much preferred to remain as single business-women. Other sources in Nigeria say that ex-prostitutes are more likely to become second wives than first
ones. This cannot be tested as it is impossible to identify the women and get accurate testimony about their earlier life once they are in the next stage of their life cycle. It may not greatly matter in modern Nigeria, where the nature of marriage and its formation are changing so that ill-defined states of marriage are common.

**Health risks and safe sex**

All prostitutes were apprehensive of STDs, and two-fifths, doubtless an undercount, reported having been infected. In spite of government campaigns, very few feared AIDS. The great majority claimed to know no one who had died of AIDS or even been infected with it. This was true even in Lagos in spite of surveillance figures claiming HIV levels of 12-20 per cent for high-risk groups (Orubuloye, Caldwell and Caldwell 1994). Perhaps there is some kind of selective mechanism operating in the surveillance system. Possibly sick young women just disappear back home. Certainly, the government’s campaign against AIDS has made people aware of the disease but fear of it will come only when people know of persons who have died, or when they read convincing accounts of deaths in newspapers.

Because of national and international programs, condoms are now readily available. Many of the young women would like to use them most of the time, largely because they fear STDs — mostly gonorrhoea — but some because of the protection against pregnancy. In fact only one-third consistently suggest their use to clients, while a similar proportion of clients raise the question. Probably the majority of commercial sexual encounters are still without condom protection. The main reason is that the managers, and the shadowy associated network of pimps and boyfriends, put practically no pressure on the prostitutes and their clients to use condoms, and the management does not provide them.

**Thailand**

Thailand is now suffering from a major AIDS epidemic. The modes of transmission are more complex than in sub-Saharan Africa because intravenous drug use plays a significant role and homosexual transmission probably plays some part. Nevertheless, it is clear from the infection histories of many of the men that commercial sex is also an important source of the disease. Commercial sex is part of the life of a significant proportion of Thai men and forms a greater proportion of all premarital and extramarital male sexual relations than is the case in Nigeria.

Prostitution is illegal in Thailand but is tolerated and is a source of revenue for many people, doubtless including the police. Most of the establishments involved are more conspicuous than in Nigeria and are listed by the Health Department inspectors and by the police.

The Government has carried out a vigorous program for mandatory condom use in commercial sex establishments with the threat of closure for non-compliance. The responsibility is put on the management to provide condoms, to pressure the girls into always using them on pain of dismissal, and, even more importantly, to give young women unqualified support in rejecting clients who refuse to use them.

This program appears to have been very successful in the better defined institutions, although it may have been partly undermined by a transfer of a significant proportion of commercial sex to restaurants and similar places. Furthermore, it has not really reached single operators and less institutionalized commercial sex. Certainly in the brothels there is evidence from the regular medical check-up of a steep decline in the incidence of STDs. This is also reported in the national STD figures. It is too early to tell whether there will be the same impact on HIV transmission but it seems probable that this will be the case.
Transfer of the Thai model to Nigeria

Clearly, an attempt to transfer the Thai model would be well worthwhile. It is doubtful whether it would work as efficiently in Nigerian conditions as in those of Thailand but it might have at least partial success.

There would be problems. Many of the establishments are harder to define and persons with managerial responsibility even more difficult to pinpoint. There is a danger that the police would become more interested in receiving bribes for not enforcing the regulations than they would in making sure that the programs worked efficiently. It is possible that the same kind of relationship might develop between the managers and the prostitutes. It is probable also that many of the clients would not be as compliant as in Thailand. A partial solution would probably be the organization of the prostitutes into self-support groups with some kind of external support. Success in this may come only if the incidence of AIDS rises or if the young women become more conscious and afraid of it.

The argument for such an approach is the almost completely heterosexual nature of the African AIDS epidemic. Supporting arguments are the near-impossibility of restricting the flow of new recruits into the occupation and the extreme difficulty of changing male sexual behaviour.

References


Mental health implications of the commercial sex industry in Nigeria

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Department of Psychology, Ondo State University, Ado-Ekiti, Nigeria

The history and some of the consequences of the growth of the sex industry in Nigeria have been identified and discussed by previous researchers (Little 1973; Caldwell, Caldwell and Orubuloye 1992; Orubuloye, Caldwell and Caldwell 1991, 1994). These authors have contributed immensely to providing fundamental information that may be useful in preventing or at least minimizing the hazardous effects of the sex industry. They stress the vital roles played by the sex workers in transmitting STDs and HIV/AIDS and suggested how the situation can be controlled. There are however, some issues of psychological importance that are yet to be examined. For instance, we are interested in knowing what prompted the interest of the women in the business, the occupational hazards in the sex industry, the coping mechanisms adopted, what is keeping the sex workers on the job in spite of the occupational hazards, their level of satisfaction with the business, and most importantly, the mental health implications of the growth of the sex industry in Nigeria.

The present study was an attempt to give a psychological analysis of commercial sex in Nigeria and to appraise the prevalence and level of psychopathological symptoms among sex workers. Findings from this study not only will suggest how to arrest the growth of the sex industry in Nigeria but also may alert the Federal Ministry of Health and other health organizations to the mental health implications of commercial sex.

Methodology

One hundred and twenty-five sex workers and an equal number of women of other occupational groups participated in the study. The sex workers were the experimental group while the other 125 women served as a control group. The control group includes students, apprentices, artisans, traders and civil servants of equivalent age. Subjects in the control group lived in the same location as the hotel or bar where the sex workers stayed. The survey was carried out in Akure and Ondo.

The major instruments for the study are the Awaritefe Psychological Index (Awaritefe 1982) and the Eysenck Personality Inventory (Eysenck 1976). The Psychological Index, a paper and pencil test, consists of 51 items eliciting general psychopathological symptoms. The instrument is divided into eight subsections, each measuring the following disorders: sleep, intellect, heat, sensation, affective, speech, head and general somatic. The addition of all the subsection scores represents the level of general psychopathology. It is an interval scale and the higher the score the higher the level of manifested psychopathological symptoms. The Eysenck Personality Inventory is similar to the Psychological Index except that it consists of 48 items measuring two personality dimensions; neuroticism-stability, and

* The author acknowledges the kind assistance of Miss Adenike Olanipekun during the data collection exercise. The author is also grateful to Miss Victoria Bose Ejimokun who typed the manuscript.
extraversion-introversion. The neuroticism-stability dimension of the scale consists of 26 items while the extraversion-introversion dimension consists of 22 items. The psychometric properties of both instruments have been discussed elsewhere (Awaritefe 1982; Akinnawo 1989). These instruments, supplemented with a structured questionnaire, were administered to the sex workers and the control group by the author and a trained female research assistant. The resulting data-set was subjected to statistical analysis.

Results

The mean age of the sex workers was 30.45 years; 52 of them are single and 73 are either married, separated or divorced. The mean age of the control group is 29.82 years, 55 of them are single and 70 are either married, separated or divorced.

Factors influencing the growth of the commercial sex industry in Nigeria

Table 1
Some factors influencing the growth of the sex industry in Nigeria

<table>
<thead>
<tr>
<th>Frequency (N = 125)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial handicap</td>
<td>58</td>
</tr>
<tr>
<td>Death of parent/husband</td>
<td>18</td>
</tr>
<tr>
<td>Divorce/separation from husband</td>
<td>16</td>
</tr>
<tr>
<td>Unemployment</td>
<td>10</td>
</tr>
<tr>
<td>Peer influence</td>
<td>10</td>
</tr>
<tr>
<td>Desire for sex</td>
<td>7</td>
</tr>
<tr>
<td>Husband's unco-operative attitude</td>
<td>6</td>
</tr>
<tr>
<td>Occupation hazards in the sex industry</td>
<td></td>
</tr>
<tr>
<td>Poor health/diseases excluding STDs</td>
<td>56</td>
</tr>
<tr>
<td>Risk of STDs</td>
<td>25</td>
</tr>
<tr>
<td>Embarrassment from the public</td>
<td>17</td>
</tr>
<tr>
<td>Feeling of rejection</td>
<td>12</td>
</tr>
<tr>
<td>Rivalry/jealousy among fellow-sex workers</td>
<td>9</td>
</tr>
<tr>
<td>Shame</td>
<td>6</td>
</tr>
<tr>
<td>Coping mechanisms adopted by sex workers</td>
<td></td>
</tr>
<tr>
<td>Seeking medical attention</td>
<td>36</td>
</tr>
<tr>
<td>Endurance</td>
<td>27</td>
</tr>
<tr>
<td>Self-medication</td>
<td>25</td>
</tr>
<tr>
<td>Adaptation</td>
<td>23</td>
</tr>
<tr>
<td>Consulting herbalists</td>
<td>14</td>
</tr>
<tr>
<td>Why sex workers stay on the job in spite of the reported hazards</td>
<td></td>
</tr>
<tr>
<td>Monetary rewards</td>
<td>78</td>
</tr>
<tr>
<td>Caring for children</td>
<td>20</td>
</tr>
<tr>
<td>Unemployment</td>
<td>11</td>
</tr>
<tr>
<td>Inability to secure a man for marriage/divorce</td>
<td>10</td>
</tr>
<tr>
<td>Interest</td>
<td>6</td>
</tr>
</tbody>
</table>

Why some sex workers plan to quit the business

<table>
<thead>
<tr>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>To establish a more acceptable business</td>
<td>30</td>
</tr>
<tr>
<td>To live a happy life</td>
<td>24</td>
</tr>
<tr>
<td>Commercial sex is not a good business</td>
<td>20</td>
</tr>
<tr>
<td>Poor health</td>
<td>15</td>
</tr>
<tr>
<td>Plan for marriage</td>
<td>11</td>
</tr>
<tr>
<td>Not applicable</td>
<td>25</td>
</tr>
</tbody>
</table>
The major reported reasons for engaging in commercial sex include financial handicap, death of parents or husband, divorce or separation from husband, unemployment, peer influence, desire for sex, and husband’s unco-operative attitudes. These reasons can be regarded as socio-economic factors encouraging the growth of commercial sex in Nigeria.

The reported occupational hazards in the sex industry are poor health (mental and physical health excluding STDs), risk of STDs infection, embarrassment from the public, poor self concept, and rivalry among sex workers. Seventy per cent of the sex workers did not have foreknowledge of the reported occupational hazards. One would expect these hazards to be strong enough to have an adverse effect on the growth of the industry. The sex workers, however, cope with their occupational hazards by seeking medical attention, endurance, self medication (drug abuse), adaptation, or consulting herbalists. Also, in spite of the occupational hazards experienced, the sex workers remain on the job because of the monetary rewards, intention to care for their children, unemployment, divorce, or interest.

Seventy-nine per cent of the sex workers would not have engaged in commercial sex if they had had better options and none of them would like any of her children to engage in commercial sex; 80 per cent intend to quit the business very soon, when they have saved enough money to start a better business, or when their children can take care of themselves. They will give up prostitution in order to establish a more acceptable business, live a better life, or plan for marriage. Many intend to leave the business because of poor health or because commercial sex is not a good business. Those who want to remain on the job (20%) till the end of their lives, either felt that there is no better way of making quick money or they have no other place to go owing to old age or ill-health.

The above analysis not only provides evidence of dissatisfaction with the business as well as dissatisfaction with their lives, but also suggests that some socio-economic factors encourage the growth and maintenance of the sex industry in Nigeria while ill-health and some psychological factors destabilized the industry by pushing sex workers out of it.

Prevalence of psychopathological symptoms

The prevalence of psychopathological symptoms among the sex workers is abnormally high. The prevalence ranged from 11.2 per cent (speech disorder) to 32.0 per cent (general psychopathology) among the sex workers, and from 3.2 per cent (sleep disorder) to 17.6 per cent (general psychopathology) among the control group. This shows that most of the sex workers are psychopathological. Detailed information on the prevalence of psychological symptoms among the sex workers is shown in Table 2.

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Prevalence among commercial sex workers %</th>
<th>Prevalence among control group %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sleep disorder</td>
<td>17.6</td>
<td>3.2</td>
</tr>
<tr>
<td>Intellectual disorder</td>
<td>31.2</td>
<td>8.0</td>
</tr>
<tr>
<td>Affection/mood disorder</td>
<td>28.8</td>
<td>15.2</td>
</tr>
<tr>
<td>Speech disorder</td>
<td>11.2</td>
<td>7.2</td>
</tr>
<tr>
<td>Head disorder</td>
<td>30.4</td>
<td>12.8</td>
</tr>
<tr>
<td>General somatic disorder</td>
<td>24.0</td>
<td>16.0</td>
</tr>
<tr>
<td>General psychopathology</td>
<td>32.0</td>
<td>17.6</td>
</tr>
<tr>
<td>Neuroticism</td>
<td>20.0</td>
<td>13.6</td>
</tr>
</tbody>
</table>
Mental health status of the sex workers

Table 3 shows the comparative analysis of the mental health status of the sex workers and the control group. The sex workers, as a group, were observed to obtain higher mean scores than the control groups in all the subsections of the Awaritefe Psychological Index and the Eysenck Personality Inventory-neuroticism dimension. The observed differences were found to be significant at the 0.05 level of significance. This is an indication that the sex workers are significantly more psychopathological than the control group. The sex workers were also found to be significantly more neurotic and less stable than the control group. The above findings imply that the mental health status of the sex workers is poor or at the least poorer than that of the control group.

Table 3
Comparative analysis of mental health status of sex workers and control group

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Group</th>
<th>N</th>
<th>X</th>
<th>SD</th>
<th>t-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sleep disorder</td>
<td>Sex workers</td>
<td>125</td>
<td>5.78</td>
<td>3.01</td>
<td>4.56</td>
</tr>
<tr>
<td></td>
<td>Control</td>
<td>125</td>
<td>3.96</td>
<td>4.69</td>
<td></td>
</tr>
<tr>
<td>Intellectual disorder</td>
<td>Sex workers</td>
<td>125</td>
<td>6.30</td>
<td>3.38</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Control</td>
<td>125</td>
<td>3.27</td>
<td>2.85</td>
<td>5.61*</td>
</tr>
<tr>
<td>Affective/mood disorder</td>
<td>Sex workers</td>
<td>125</td>
<td>15.79</td>
<td>7.16</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Control</td>
<td>125</td>
<td>12.88</td>
<td>4.38</td>
<td>6.16*</td>
</tr>
<tr>
<td>Speech disorder</td>
<td>Sex workers</td>
<td>125</td>
<td>5.18</td>
<td>4.32</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Control</td>
<td>125</td>
<td>4.31</td>
<td>1.87</td>
<td>3.90*</td>
</tr>
<tr>
<td>Head disorder</td>
<td>Sex workers</td>
<td>125</td>
<td>4.63</td>
<td>3.52</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Control</td>
<td>125</td>
<td>3.13</td>
<td>2.57</td>
<td>2.73*</td>
</tr>
<tr>
<td>General somatic disorder</td>
<td>Sex workers</td>
<td>125</td>
<td>7.31</td>
<td>4.59</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Control</td>
<td>125</td>
<td>6.26</td>
<td>3.57</td>
<td>4.10*</td>
</tr>
<tr>
<td>General psychopathology</td>
<td>Sex workers</td>
<td>125</td>
<td>47.49</td>
<td>19.73</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Control</td>
<td>125</td>
<td>40.05</td>
<td>12.79</td>
<td>15.958*</td>
</tr>
</tbody>
</table>

* P<.05

Discussion and conclusion

Socio-economic factors such as financial handicap, divorce or separation from husband, unemployment and peer influence were found to be major factors encouraging the growth of the sex industry in Nigeria. This finding is consistent with Orubuloye et al. (1994). Ill health and some psychological factors such as poor self-concept, dissatisfaction with commercial sex and self-dissatisfaction may be capable of destabilizing the sex industry.

The prevalence of psychopathological symptoms is very high among the sex workers. The obtained prevalence is not only higher than that of the control group but also higher than what had been previously obtained among other groups in Nigeria. For instance, the prevalence of psychopathological symptoms ranged from 9 to 21 per cent among Nigerian nurses (Akinnawo 1992) and between 6 and 16 per cent among female self-employees of Ado-Ekiti community (Akinnawo, in press).

The finding that the sex workers were significantly more psychopathological than the control group is also an indication that commercial sex either creates a conducive atmosphere for the development of psychopathology or maintains the growth of psychopathology. Two possibilities can be examined from the above findings, since a causal relationship could not be sufficiently established. First, there is the likelihood that people are already psychopathological before engaging in commercial sex. This possibility is, however, ruled
out by the fact that Orubuloye et al. (1994) did not find anything to discriminate between women who would go into prostitution and those who would not, except 'marriage breakdown' and 'pressure to support children'. We recognize the fact that marriage breakdown and pressure to support children are capable of inducing psychopathological symptoms. It should, however, be noted that not all cases of marriage breakdown or pressure to support children lead to mental breakdown. If there is nothing to show that people engage in commercial sex because they are psychopathological, the only plausible alternative is the second option, that sex workers develop psychopathological symptoms as a result of their involvement in commercial sex. In fact, some of the reported occupational hazards and some of the reasons given for intention to quit the business suggest that commercial sex is capable of inducing psychopathological symptoms.

We can conclude from the study that the growth of the sex industry in Nigeria is influenced by socio-economic, ill-health and psychological factors; also that commercial sex has adverse effects on the mental health of the sex workers.

The occupational hazards and the mental health effects of commercial sex should be stressed by our various health agencies, in order to discourage people, especially our youth, from engaging in commercial sex. A new national economic policy that will reduce the present level of unemployment and the consequent financial handicap may reduce the number of young women engaging in commercial sex. Finally, the policy makers should include the sex workers in the national mental health policy, since it may not be possible to eradicate commercial sex in Nigeria, in this era of depressed economy.

References


The effects of HIV and AIDS on fertility in East and Central Africa

Philip Setel
National Centre for Epidemiology and Population Health, The Australian National University

Abstract
Concern has been expressed about the fertility of people infected with HIV: the worry has been that on learning of their condition, HIV-affected individuals may attempt to accomplish unmet reproductive goals knowing that they will not live a normal life span. This article addresses the potential effects of AIDS on fertility and reproductive decisions in East and Central Africa. The problem is seen in terms of a tightly knit continuum of biological, epidemiologic and cultural contexts, and the prevailing conditions of response to the epidemic. AIDS can influence fertility among individuals and groups regardless of any awareness of serostatus by increasing death rates among reproductive populations, and damaging the physical capacities of infected men and women to reproduce. In much of the region, high prevalence of STDs may simultaneously impair the fertility of men and women and increase their risk of contracting HIV. These biological conditions are compounded among those for whom fertility is a highly valued marker of adult status, where the social and economic marginality of young women contributes to reliance on commercialized sex, where the mobility of young men leads to instability in sexual partnerships and frequent partner change, or where women lack the ability to negotiate their fertility with spouses. It appears that even focused programs of testing and counselling with HIV-positive women in Europe and in Africa have not motivated a significant change in reproductive action. Were there a demonstrable effect of counselling on the fertility choices of infected persons, there are numerous practical limitations on the role that interventions can play in affecting the fertility of HIV-positive people.

An overview of the problem
As the AIDS epidemic continues, the question of how HIV will affect fertility and reproductive decisions in sub-Saharan Africa has been raised in many settings, from fieldwork interviews with rural Tanzanians to international conferences attended by professional researchers. Specifically, the concern has been voiced that men and women who are infected with HIV may attempt to 'hurry up' their fertility. This concern derives from the centrality of reproduction to life courses, adult identities, and access to social support, particularly for women, in many African settings. Were a 'hurrying up' of fertility to become a characteristic response to having AIDS in heavily affected communities, there would be understandable concerns about short-term service needs and quality-of-life issues for perinatally infected infants and children, and long-term care and quality-of-life issues for children destined to lose one or both biological parents. This article draws on published material from several countries, and upon fieldwork conducted between 1991 and 1993 on cultural dimensions of AIDS in Kilimanjaro, Tanzania, to puzzle out some of the potential fertility-related consequences of the epidemic.
While awareness of AIDS has brought about changes in some aspects of sexual life, AIDS may not be substantially influencing choices about reproduction in most contexts. Understanding why this is the case depends upon viewing the disease in the context of closely interrelated social and epidemiological conditions, and against a background of HIV detection systems with limited resources and coverage. Although there are reports from Uganda that prospective spouses and partners in some heavily affected communities have begun to voluntarily seek out premarital or pre-relationship testing and counselling (Mukizaga-Gapere and Ntozi n.d.), in most settings, few individuals appear to be motivated to do so without being prompted by the knowledge that a partner, spouse, or child has AIDS. Limited identification of asymptomatic cases through other routes restricts the number of HIV-affected individuals who will know about their condition to a small proportion of the total number of those infected. Many who do become aware of their serostatus will do so upon progressing to symptomatic HIV disease, and are not likely to remain well long enough to significantly alter their total fertility. Thus, the fertility decisions of the majority of HIV-infected people will probably not depend on an awareness of their serostatus.

For those who are in good health and who are also aware of having HIV, decisions to continue reproducing will depend on a variety of personal and socio-cultural factors. Although interventions have been shown to foster risk reduction, particularly among stable HIV-discordant couples, reproductive responses to AIDS cannot be expected to be based primarily upon personal assessments of risk to self, partner, or child that derive from HIV counselling programs. A decision by a healthy HIV-infected person to continue childbearing is likely to be influenced by the importance of fertility for men and women in tenuous socio-economic contexts, and by how reproductive power is configured in culturally supported hierarchies of gender and generation. In some cases, continued reproduction may not be a matter of choice. For those women who lack the power to negotiate fertility, it seems plausible that those who become infected with HIV may also be reluctant to reveal their serostatus to partners. As recorded by Biswalo and Lie (1995:229-230), even women who receive intensive counselling may not feel willing or able to discuss their status with spouses or family, despite being pressed by spouses to have more children. In-depth interviews with a small sample of HIV-positive men and women in Tanzania during the early 1990s, however, revealed that most were either too ill to consider having children, or were more concerned with providing for existing children than having additional ones.

Direct and indirect effects of HIV on reproductive capacities

High levels of adult mortality due to AIDS, combined with HIV-related damage to the reproductive capacities of infected men and women, must be taken into consideration over and above any responses motivated by being diagnosed with the disease. Although this article does not address demographic projections about the effect of AIDS on fertility rates, it seems clear that AIDS will decrease the rate of population growth in several countries in Eastern and Central Africa, mostly by raising mortality rates (United Nations 1994). Although HIV reduces the reproductive capacities of infected men and women, whether the epidemic will alter fertility rates is unclear.

In men, HIV disease causes progressive damage to sperm morphology and function (Krieger et al. 1991; Crittenden, Handelsman and Stewart 1992; Gresenguet et al. 1992; Politch et al. 1994). Many HIV-positive men experience these effects, although in the early stages of disease they also appear to retain seminal parameters consistent with fertility⁴. As

⁴In less heavily affected countries in Africa where trends toward lower fertility have been demonstrated, it will probably not further reduce fertility rates (cf. Ainsworth 1993), although the aggregate effect of
the disease progresses, however, the motility and quality of sperm decrease. One study from Central African Republic has shown high rates of seminal abnormalities likely to affect fertility among men as HIV disease becomes more severe (Gresenguet et al. 1992). Among women, research in Africa and Europe indicates that positive serostatus may lower fertility rates in all HIV-infected birth cohorts (Batter et al. 1994; Johnstone 1994). HIV-positive women also have significantly more negative pregnancy outcomes than uninfected women, including miscarriages, spontaneous abortions, and stillbirths (De Cock et al. 1994; Temmerman, Chomba, and Piot 1994); in later stages of disease they may also suffer from menstrual disturbances (Strecker et al. 1993).

These fertility-related effects of disease progression may combine with other social and epidemiological factors that influence fertility and risk for HIV. For HIV-positive women in sub-Saharan Africa who are trying to have children, higher rates of stillbirth, spontaneous abortion, or infant and neonatal mortality will eliminate or truncate culturally prescribed periods of abstinence. This is one way in which HIV can play an indirect role in reproductive decisions among infected persons. In addition, a history of STDs in both sexes (especially repeated or untreated episodes of disease) is related to risk of HIV infection (Germain et al. 1992; Grosskurth et al. 1995), and HIV itself may increase susceptibility to certain STDs.

Chlamydia and gonorrhoea appear to be increasing in several locations (Brunham, Garnett et al. 1991; Brunham, Cheang et al. 1993; Temmerman et al. 1992). The socio-economic characteristics associated with high risk of HIV infection in occupational subgroups common among young adults, for example, itinerant businessmen and market women, women engaged in temporary bar work, and male transport workers (Mhalu et al. 1991; Orubuloye, Caldwell and Caldwell 1993; Talle 1995:22) along with instability in long-term relationships (Nabaitu, Bachenga and Seeley 1994), have been linked to STD-induced infertility in both sexes (Evina 1991; Imae et al. 1993). Given this conjunction, STD-induced infertility among men and women may be more prevalent among those with HIV and AIDS, and create what has been called, in another context, a ‘synergism of plagues’ (Wallace 1988; see Larson 1989:203–204; Schoepf 1992).

Because social behaviour, sexual risk, fertility, and vulnerability to STD/HIV infection are often so intertwined in Africa, as Ainsworth and Over (1994) point out, comparing fertility rates among infected and uninfected women becomes extremely complicated. In one study of pregnancy rates among HIV-infected women in Rwanda, the combined effect of factors simultaneously associated with different levels of HIV infection and different levels of fertility meant that researchers were unable to determine the role of testing and counselling in accounting for different pregnancy rates within the study cohort (Allen et al. 1993).

**HIV detection: how many do not know?**

Constraints on the early detection of cases limit the scope of conscious, intentional fertility-related responses among those who are infected with HIV, and have clear implications for individual or familial coping strategies across the gamut of issues evoked by being HIV-positive. The later in their disease diagnosis takes place, the more likely individuals are to be suffering the effects of HIV disease on their health and fecundity, and to die before they can increase their fertility.

Sentinel surveillance programs monitoring HIV prevalence and incidence in East and Central Africa are not designed as screening programs to detect and notify at-risk individuals;
they are meant to serve as markers of the epidemic’s progress in sub-groups which represent various sections of the overall population and various categories of risk. The programs are frequently conducted using anonymous and unlinked blood samples from hospital blood donors, pregnant women attending antenatal clinics, or STD-clinic attenders. Thus, those with asymptomatic HIV disease who are tested in such a program will not receive notification of their serostatus.

The identification and counselling of HIV-positive people without symptomatic disease has largely been confined to mechanisms such as participation in community-based serosurveys, longitudinal cohort studies, and research undertaken in tertiary care facilities. Even when counselling and test results are made available to study participants, they may not receive them. In one community-based study of STDs and HIV, only 40 per cent of study subjects who stated that they wanted to know their test results returned to collect them (Klouman et al. 1995:213). Some cases may be detected through having an infected and often symptomatic partner or child. Results from my fieldwork interviews with young adults in Tanzania indicated that some people were prompted or coerced by a partner to seek out testing, or underwent testing voluntarily because of fears they might have been infected. Taken together, however, informed HIV-positive study subjects can only make up a small percentage of all those affected by the disease, and voluntary testing among the so-called ‘worried well’ is not widespread.

Once they are diagnosed, men living in Europe who have HIV infection and who use available drug therapies have a one-in-four chance of surviving twenty years after seroconversion before developing AIDS (Phillips et al. 1994). After diagnosis with AIDS, European men and women have a median survival time of seventeen months (Lundgren et al. 1994). In sub-Saharan Africa the estimates of the latency period from infection to symptomatic HIV disease for men and women are much shorter, ranging from five to ten years (Killewo et al. 1993; Ainsworth and Over 1994). If many of those infected were identified soon after their infection, they might be able to alter their short-term fertility, although probably not by much. At an individual level, any ‘extra’ children that infected persons might have through a strategy of hurrying up their fertility would be offset by children they will not be able to have later in life.

Most of those diagnosed with HIV outside the context of prospective studies or serosurveys are identified when they develop symptoms—well into the course of the illness—and not through linked HIV testing when asymptomatic. Yet governments of countries with severe epidemics, such as Tanzania, have estimated that under-detection of symptomatic cases, itself a difficult task (Evans 1991:1261), has contributed to the inability to identify and report on more than 25 to 33 per cent of those afflicted with AIDS (NACP 1994). A number of African studies have placed the mean and median survival times among men and women with symptomatic HIV disease in the range of three to six months for those with HIV-1 (Mbaga et al. 1990; Whittle et al. 1992) and thirteen months for those who have HIV-2 (Whittle et al. 1992); data from Eastern Zaire indicate that there are few differences between male and female survival times (Salinari, Filippo and Claudio 1990).

Under such circumstances, many infected people who become aware of their illness will not live long enough to alter their fertility, even if they want to. In fact, many of those who are diagnosed with AIDS contact the formal health care sector so late, and with such severe super-infections, that their survival after diagnosis is a matter of days, not years, particularly if they cannot afford expensive medications to treat secondary infections (Mbaga et al. 1990; Naucler et al. 1992). Clearly this influences the scope and character of responses that individuals and groups might be expected to have to this disease; if only a small proportion of HIV-positive people are identified and notified overall, regardless of the clinical stage of disease, knowledge of serostatus will have a small effect on the fertility objectives and
reproductive action among them. In the absence of widespread early knowledge of HIV status, there can be few planned responses of the kind we are concerned with here.

**Knowledge of HIV serostatus and possible responses**

If these substantial obstacles to early case detection can be overcome, the range of possible fertility-related responses to knowledge of HIV infection is limited to continuing or discontinuing contraception among those already using a contraceptive technique; or starting or failing to start to use contraception among those who are not users already. Women may also have the option of terminating pregnancies, usually illegally, and often under dangerous and unhealthy conditions (Mpangile, Leshebari and Kihwele 1993; Rogo 1993; IPPF 1994). While the hypothesis that knowledge of having HIV will lead to increased fertility objectives has not been the central concern of focused research, findings from a few African cohort studies among urban women indicate a need to combine a clear understanding of cultural and social responses to AIDS with an analysis of the cultural context of fertility.

Even under carefully designed HIV testing and counselling programs, and with good communication between heterosexual partners about HIV status, condom use can be sporadic (Mayes et al. 1992; de Vincenzi 1994) and the effect on future reproductive decisions insignificant (Higgins et al. 1991; Sunderland et al. 1992). An initial intent to cease reproduction may give way, in time, to a desire for children that overrides considerations of transmission risk to an uninfected partner or child (Green 1994). One meta-analysis of studies from around the world found 'little evidence for the impact of counselling and testing on pregnancy and/or pregnancy termination rates for seropositive or seronegative high-risk women' (Higgins et al. 1991:2419), although there was often substantial risk reduction among HIV discordant couples.

In sub-Saharan Africa, HIV and AIDS counselling services in general are not as well developed as in Europe and America, and informing a partner or spouse about serostatus often carries the threat of negative consequences that militate against open communication (Ryder et al. 1991; Temmerman et al. 1993), thus hampering the negotiation of subsequent fertility. Nevertheless, HIV counselling in Kigali that included the male partners of HIV-infected women resulted in much higher rates of condom use than among those women who either told their partners or spouses of their serostatus and were not counselled as a couple, or who withheld the information about their HIV infection from partners (Keogh et al. 1994). In Kinshasa, where HIV testing and counselling among HIV-infected women did not include many partners or spouses, there were much higher rates of intention to use condoms, but no correlation of such intent with an increase in actual condom use; there were, however, slightly higher rates of hormonal contraception use after counselling (Heyward et al. 1993). Studies in Nairobi found that testing and a single session of counselling did not have much effect at all on the subsequent reproductive behavior of HIV-positive women (Temmerman et al. 1990; Temmerman et al. 1993).

The Kigali cohort study in particular affords a glimpse at some of the complexities in fertility-related responses to knowledge of HIV infection (Allen et al. 1993). To summarize some of the findings, Allen et al. reported significantly different odds of becoming pregnant among two groups of HIV-positive women, and between the HIV-negative and HIV-positive women in the cohort. In the first two years of follow-up after HIV testing, seronegative women were significantly more likely to become pregnant than HIV-positive women, partly because HIV-positive women were also more likely to be single, hormonal contraceptive
users, and be less sexually active\(^2\). Among HIV-positive women, however, those with fewer than four children were more likely to become pregnant than those with four or more children, and married or cohabiting women were more likely than unmarried women to become pregnant.

Lower completed fertility among HIV-negative women was not associated with increased pregnancy, and married women who were HIV-negative were also less likely to become pregnant. Significantly, the use of ‘injectable hormonal contraceptives was associated with a decreased incidence of pregnancy, condoms and spermicide were not’ (Allen et al. 1993:709). Because of difficulties in controlling for potential confounding variables, the significantly lower rates of pregnancy among HIV-positive women could not be attributed primarily to testing and counselling. Furthermore, despite counselling, the desire to have children among HIV-positive women remained high, at 40 per cent, while 49 per cent of seronegative women stated a desire for more children. Allen et al. speculated that ‘for women who must live with HIV, becoming pregnant may also be a way to continue a normal life-style to reduce the risk of losing spouse and family support’ (p. 709). At one level, becoming pregnant may serve as a social and psychological coping mechanism for HIV-positive women. Yet the matter is probably a good deal more complex.

The finding that testing and counselling can lead to risk-reduction (i.e. higher reported condom use) without bringing down fertility among infected women suggests that distinctly different sets of considerations relating to sex and reproduction are called into play. Therein lies one of the cruellest paradoxes of AIDS; regardless of concerns about the risks of perinatal transmission, fertility for women in much of sub-Saharan Africa is inextricably linked to broader concerns that touch upon almost every aspect of their adult lives. Similar conditions can be assumed to pertain to African men, despite the fact that general reproductive concerns among them are not well documented, and even less is known about the relationship between knowledge of HIV-status and subsequent male fertility.

During the course of my fieldwork, it appeared that for HIV-infected individuals who were in relatively good health, the main concern was providing and planning for the children they already had. Several HIV-positive individuals, some in reasonably good health, were interviewed. Most of them had children. For them, there was no hint that their diagnosis had brought about an urge to have more children. In one case, an HIV-positive man was concentrating his efforts on arranging for his children’s school fees to be paid after his death, and upon the completion of a well constructed house for his family. At the time he learned of his serostatus, this man was the primary source of financial support for thirteen people including his parents, seven of his children, and some of his siblings and their children. Although he had been told that he could expect to live for at least four or five years after being diagnosed HIV-positive, additional children were not a consideration. Similarly, a young HIV-positive woman with one son was putting a great deal of energy into making fostering arrangements for him. Most other infected persons interviewed were extremely ill when they became aware of their serostatus, and the majority did not often leave their beds before dying.

**Conclusions**

In Africa, public and professional sentiment has actively discouraged women with HIV from becoming pregnant and has even advocated legalizing abortion services for them.

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\(^2\) The difference in pregnancy rates was not related to educational status, type of marriage, or partner’s participation in testing, and the differences persisted when the cohort was stratified by age, marital status, and level of sexual activity.
The effects of HIV and AIDS on fertility in East and Central Africa

(Reproductive Health Matters 1993; Strebel 1994). Yet it appears that the former objective may not be accomplished, and the latter may be politically unfeasible, regardless of the demand there may or may not be for abortions among HIV-positive women. While most studies indicate little or no effect on subsequent pregnancy rates, the Kigali study suggests that a subset of HIV-positive women—those with greater completed fertility and those who received counselling as part of a couple—may be much less likely to conceive after diagnosis. Experience among a small number of HIV infected people in Tanzania also demonstrates that for some, extending their fertility is not an issue.

What, then, are possible directions for further unravelling the complex relationship between AIDS and fertility, and for searching for points of entry into an aspect of the AIDS epidemic that many feel ought to be addressed through policy and intervention? From a policy and program perspective, men must be firmly incorporated into services and interventions, even when the primary objective may be to improve the condition of women; HIV prevention, family planning and reproductive health services can be integrated; and the limitations on programmatic responses from the formal health care sector should be candidly assessed. For example, the intensive services offered to women after diagnosis in Nairobi, Kigali and Kinshasa are probably not sustainable or replicable in more than a few well-funded projects elsewhere on the continent.

Since resources for testing and counselling are so scarce, some researchers assert that finances should be directed toward providing condoms in places such as bars rather than toward counselling (Pickering et al. 1993). Still, others find enough encouragement to advocate continued confidential counselling programs focused on HIV-positive women and cohabiting partners. They argue that counselling can substantially increase rates of condom use (Allen et al. 1992), and perhaps reduce the possibility of perinatal transmission or orphanhood for additional uninfected children among some of the service recipients.

In terms of research, better cross-cultural understanding of sexuality and fertility can inform testable hypotheses regarding fertility-related responses of individuals and groups to the AIDS epidemic. An initial step in this process might be to undertake a project of ‘re-situating’ the way in which reproduction is understood in relation to social, cultural, historical, and political-economic conditions (Greenhalgh 1995; Kertzer 1995). To this list might be added the perceptions of local actors to the disease ecology of STDs and HIV. The goal is to move from simple notions of risk groups and risk behaviour to a more dynamic understanding of contexts of vulnerability and the motivations for action.

Overall, the fertility-related responses of individuals to knowledge of HIV-status is not something we know a great deal about at present. On the other hand, the empirical findings to date do not suggest—as some have feared—that AIDS has been leading to a ‘hurrying up’ of fertility in African contexts. Furthermore, given low rates of contraception in much of the continent, it is questionable how much more fertility could occur to those few infected people who consciously decide to increase their fertility.

In sum, HIV and AIDS may well diminish the fertility of affected individuals and groups in Africa, but probably not through conscious action on the part of infected persons themselves. The damage done by the virus to reproductive physiology, its effects during pregnancy, its synergistic relationship with STDs and the conditions of risk for HIV that relate to STDs and STD-induced infertility, will all contribute to a spectrum of interconnected effects that could lower fertility among people with HIV. Under present circumstances, it seems unlikely that a sufficient number of infected people will know about their disease early enough to respond in such a way as to affect the total fertility of large groups or nations.

The numbers of infected individuals for whom certain knowledge of HIV-status can be factored into reproductive choice will be further reduced by the relatively short period
between infection and death in sub-Saharan Africa, and the fact that the small proportion of infected individuals who are identified are diagnosed late in their disease. All of these AIDS-specific issues, in turn, exist within cultural frameworks and socio-economic conditions that form a substrate to sexuality and fertility for adults in any society. Future understanding of how AIDS and fertility interrelate, and the design of interventions to address this matter will depend upon taking all of these factors into account.

References


Impact of AIDS on the family and mortality in Uganda

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The world is now in the middle of a second decade since the first cases of AIDS were identified among the homosexuals of United States around 1980 (Grmek 1990). Since then, many more cases of the disease have been observed in ten regions of the world: North America, Western Europe, Oceania, Latin America, sub-Saharan Africa, the Caribbean, Eastern Europe, the Southeast Mediterranean, Northeast Asia and Southeast Asia. Mann, Tarantola and Netter (1992) estimated that between 38 and 110 million people would become HIV-infected and about 25 million would develop AIDS by the year 2000. By 1 January 1992, out of a total 12.9 million HIV-infected cases in the world, 10.9 million or 85 per cent were estimated to be in the developing countries. More serious is that sub-Saharan Africa, with less than 10 per cent of the total world population, contributed 68 per cent of the HIV-infected cases in the world.

The first AIDS case in sub-Saharan Africa was diagnosed in Rakai district of Uganda in 1982 (Serwadda et al. 1985). At present the disease has become an epidemic in many countries of the region, concentrated in the subregions of central, eastern and southern Africa. For instance, by December 1992, the cumulative total of AIDS cases reported through the official AIDS surveillance system was 27,901 (Brunborg, Fylkesner and Msiska 1993). Given the inefficient vital registration systems in these countries, this figure is a gross underestimate.

Perhaps the sub-Saharan African country most affected by HIV and AIDS is Uganda. The profile of the HIV/AIDS epidemic in Uganda can be summarized in the following terms: by December 1993, the cumulative AIDS cases reported by the official health system stood at 43,875 (ACP 1994); with about equal numbers by sex, with 47.7 per cent and 52.3 per cent of male and female cases respectively, the age-sex distribution showing female to male ratios of 4:1 and 2:1 in the age groups 15-19 and 20-24 respectively. This is followed by about equal numbers of both sexes at age-group 25-29 and a slight excess of males in all age groups thereafter. Although all 39 administrative districts had cases reported by that date, there are significant variations in the severity of the epidemic from district to district, with cumulative cases per thousand population in 1993 varying from less than one in some remote districts to more than 144 in Kampala city. The distribution by residence indicates a more severe urban
than rural epidemic, with trading centres being in between in severity; nationally, the frequency of AIDS-related deaths is increasing and AIDS is touching most people's lives directly or indirectly.

Many researchers have conducted studies of transmission, progression rates, sexual behaviour, patient care and the impact of the disease in Uganda (e.g. Konde-Lule 1992; Serwadda et al. 1992; Barnett and Blaikie 1992; McGrath et al. 1993; Mulder et al. 1994). The findings of these investigations have greatly enhanced the understanding of the disease and its impact on Ugandans. However, most of these studies have been limited in coverage of the country; they have concentrated on Rakai, Masaka and Kampala districts which are most affected by the disease. This paper reports the findings of a study on the impact of AIDS on the family and mortality covering six districts in the west, southwest, south and east of Uganda.

**Methodology**

Against this background, a study to examine household composition and family structure under the conditions of high AIDS-related mortality was carried out in six districts in Uganda: Hoima, Iganga, Kabale, Masaka, Mbale and Mbarara. The study was in three phases: the first involved the review of ethnographic materials on the populations in the six districts and collecting information from elders and youth through focus-group discussions.

Phase 2 involved administering an individual elders' questionnaire and carrying out a large-scale household survey in the six districts in order to document the recent changes in the household composition and family structure. The third phase will be carried out three years after the second phase. During this phase the areas covered in the second phase will be resurveyed to determine subsequent changes occurring in the communities, especially those due to AIDS.

The data collection for the first two phases is complete and this paper presents the results from the elders' survey which was carried out in the six districts. A total of 143 elders, 109 men and 34 women, were interviewed. The distribution of the respondents according to the six districts was as follows: Hoima, 26; Iganga, 23; Kabale, 24, Masaka, 24; Mbale, 24; and Mbarara, 22. The respondents were aged at least 45 years and all were heads of households which were selected using a combination of purposive and random cluster sample design. Counties in the districts most affected by AIDS were identified, and the most affected subcounties and parishes in these counties were picked. Out of a list of Resistance Councils of villages in the most affected parishes, a random number of the Councils were selected. On the advice of Resistance Councils chairmen and chiefs, households headed by people aged at least 45 from the Councils were included in the final sample. The interviews were conducted by the postgraduate students in demography at Makerere University, all of whom were fluent in both English and the local languages. To ensure that the same questions were asked, the questionnaire was translated from English to the local dialects. The interviews were therefore conducted in local languages and immediately transcribed to the English version of the questionnaire.

**Results**

The information collected in the elders' survey covered household composition, mortality, morbidity and their causes, impact of AIDS on the family, general health status of the community and migration.
AIDS and the family

The household is the basic unit of subsistence production in Uganda, and its existence within the extended family system has enabled it to weather the many stresses of war and social dislocation which have occurred in the country for over two decades. It is suspected, however, that the increased stress occasioned by AIDS is getting too much for the extended family system to bear in the long run (Mukiza-Gapere and Ntozi 1993).

AIDS is a family matter and has a major impact on all parts of society. It attacks families in a variety of ways. Ankrah (1991) found that, although the virus affects an individual, the impact of the disease is felt by the wider group, the family and the community in which the family lives, either because of the incapacitating effect on the breadwinner or through increasing expenditure at the household level, all of which increase the scarcity of social and material needs. Large sums of money are spent treating the patients, as HIV/AIDS leads to a gradual rather than sudden deterioration of the infected individual. In a study by Davachi et al. (1988) it was reported that a single admission of an infected child costs the equivalent of three months of a father's salary.

They also concluded that a child with AIDS and his death can have an immense economic effect on the immediate and the extended family. In another study by Hassig et al. (1989) it was found that, while the cost of hospitalization was about the same for HIV-positive and HIV-negative patients, the infected persons had spent twice as much for treatment before hospital admission as had the non-infected individuals. Hassig concluded that HIV infection puts a high financial burden on the people with AIDS and their families. The fact that an AIDS sufferer continues to survive for periods of 24 or more months may adversely affect the living standards of a family. The expenditure on medicines and hospital care, as well as on special foods, all takes extra money from the whole household budget.

In populations where the HIV/AIDS epidemic is mainly transmitted heterosexually, the chances are that if one member of a relatively steady union or couple contracts the infection, the other also will. AIDS patients are cared for by their families with most of the burden borne by women including wives, mothers, sisters, daughters, aunts and grandmothers (Orubuloye et al. 1994:241). Some AIDS care is given by the modern medical system, but it is the family that in most cases gives care (Ankrah 1991).

When respondents were asked whether AIDS had affected household composition and family structure in their communities, over 83 per cent responded that it had. The main reasons given were that many families had lost members especially from AIDS, and also in a number of households the members were increasing because of orphans.

AIDS has also had some effect on the traditional way of managing the household when the head dies. For example, 37.8 per cent indicated that there was no more inheritance of widows in their communities. As a consequence new headship structures are emerging. There are now quite a number of households headed by widows, single women who never married, widowers and children under 18 years of age who are orphans.

AIDS and mortality

The AIDS epidemic is unusual in that its chief targets are not the old and the weak. Although AIDS kills people of any age, unlike other major killer diseases in Africa, AIDS deaths are concentrated among the sexually active adult population that is also the most productive. It is selectively killing the generation of adults who are the main breadwinners, leaving large numbers of vulnerable survivors with no means of support (Ainsworth 1991). Fostered AIDS orphans are also different from other children. They are subject to higher mortality than children living with both parents, partly because there is some dispute about who should meet medical costs, and the care they receive in general is inadequate.
There are socio-economic implications in these high levels of mortality: they threaten the functions of household life. The death of parents creates large numbers of orphans; younger family members cannot care for the sick and elderly; and young adults are not present to manage the household, or make income-generating decisions for meeting consumption, education expenses and the provision of an adequate diet. The death of producers has caused a deterioration in the producer-consumer ratio within some farm households, particularly since mortality is concentrated in the most productive cohorts. As a result, the range of crops, the amount of lands cultivated and the marketed surplus tend to decline. The absence of future producers may have a profound effect upon the demography and economy of Uganda. There is increased mortality of young children through paediatric AIDS, there are probably also raised mortality levels among surviving and seronegative children from AIDS-affected families through reduced nutrition and poorer care (Barnett, Blaikie and Obbo 1990). Palloni and Lee (1991) point out that adult mortality excesses lead to orphanhood and widowhood. The levels of paternal and maternal orphanhood at young ages (between 0 and 10 or 15) will rise, reflecting the increased mortality of young parents. In a study in Tanzania, it was found that the increase in infant and child mortality due to AIDS infection will probably offset recent successes in lowering childhood mortality. AIDS will also raise child mortality indirectly by throwing into poverty the healthy orphaned children of parents who have died from AIDS (Ainsworth 1991).

In the present study we tried to identify the deaths that had occurred in the households ever since they were formed. Respondents were asked about the relationship of the deceased to the head of the household, sex, age at death, year of death, cause of death and changes the death caused in the household. A total of 442 deaths had occurred in the study households with a slight majority (51.1%) being females. One-quarter of all deaths had occurred under age 15. About three-quarters of all deaths had occurred after 1985.

On the question of cause of death, AIDS was found to account for 32.8 per cent of the deaths, AIDS-related diseases (including malaria and fevers) accounted for 12.3 per cent and 'other diseases' for 54.9 per cent. More females than males had died of AIDS: 52.2 per cent of AIDS deaths were of females.

On the effects the deaths of these members had on the households, 25 per cent of respondents said that they miss the advice and company of the deceased, 25 per cent said they lost financial assistance, and about 10 per cent said they had been left with the problem of orphans to care for. Other reasons, like loss of support in labour and home deterioration and home management problems, were also given.

Respondents were also asked what they thought were the major causes of death for the different groups of the population. For the under-ones the causes were given as diarrhoea, measles and fever in that order. AIDS was mentioned by about five per cent of the respondents. Of the infants who were identified as having died of AIDS, 98.5 per cent had died before the age of five months. The major causes of death among children aged one to five years were given as 'measles and fever' and diarrhoea and vomiting in that order. The major cause of death at ages 18 to 35 years was given as AIDS by 85 per cent of respondents; AIDS was also given as the major cause of death among adults aged 35 and over. Other diseases such as tuberculosis and diarrhoea, which have symptoms related to those of AIDS, were reported by about 15 per cent of the respondents. These findings are similar to those reported by the health information system (ACP 1994).

The respondents were asked their opinions as to who was dying most from AIDS and the majority thought that it was males in the age group 18-35 years; the major reason given was that this group was sexually active. Respondents were also asked about people's response to death. About 20 per cent said that they worried about it and an almost equal percentage said that people no longer fear death, that they are now used to it, since it is too frequent. They

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were asked how people are now treating the ceremonies relating to death. The majority suggested that the ceremonies are not as much respected as they used to be in the past; there is a lot of haste involved. Concerning burial, the biggest percentage said the ceremony used to take some days in the past, and the dead body was wrapped in traditional materials like bark cloth; these days, burial is immediate and the body is put in a coffin. As for mourning, it was noticed that it is given less time because of so many deaths; in the past, mourning lasted a long time. The ceremony of the last funeral rites now takes only a short time, usually on the same day as the burial; in the past, people would come in advance to prepare for the rites; the ceremony took many days and was held several months after the burial. On the issue of inheritance most respondents noted that now property is left to the orphans and widow; and men no longer inherit widows for fear of AIDS. In the past, women were taken over and the clan members used to share property with orphans.

Discussion

Family composition and structure

This survey shows that a new structure is emerging for households in Uganda. Households are headed by widows, widowers, single women and even children under 18 years of age as well as orphans. Widows are heading the households because the old practice of widow inheritance by brothers-in-law is disappearing since they fear contracting HIV from the widow. Widowers are also finding it difficult to get remarried because women are afraid of being infected by them.

With a few experiences of their relatives and friends who married, contracted HIV and died, many single women prefer to stay unmarried for fear of death. A more serious household structure is that headed by children who are orphans under age 18. These are children whose parents have both died and who either are unwilling to be looked after by extended family members or have no close relatives to assist (Barnett and Blaikie 1992). In a study of a group of HIV-positive women in Kigali, Rwanda in 1988-91, Keogh et al. (1994) found that 30 per cent of the women and 44 per cent of their partners had no relatives nearby. Almost a third of the women had no partner willing or able to care for the children when the woman died. McGrath et al. (1993) report that in Buganda newly married couples migrate away from their parents' village to other villages to ensure independent living. It is therefore probable that with high internal (rural-rural) migration in Uganda, some orphans find themselves without close relatives nearby to help. The implications of this on the development and growth of these children and those under their care are serious for psychological, economic, social and health reasons.

An increasing proportion of the household is orphaned; this means a heavy burden on the households looking after the orphans. For instance it has been found by Müller and Abbas (1990) that 47 per cent of the children of fostering parents in Kampala do not go to school in comparison to ten per cent of children of non-fostering parents. The foster parents’ own children have to share with orphans other facilities in their homes, such as food, clothing, rooms and beds, which may worsen their welfare and particularly health. It is possible these children will grow up resenting the fostered children and perhaps the system of child fosterage. The situation is likely to be worse for the orphans who may have little right of protest in their foster-parents' homes. Although the relatives are still willing to help it seems the problem of orphans has gone beyond the capacity of extended families and outside assistance is urgently needed.
AIDS deaths

The study showed that three quarters of the deaths in respondents' households occurred after 1985; this is an important finding in two respects. First, although the respondents' households had been formed at least fifteen years ago, three-quarters of the deaths had taken place in the seven-year period 1985-1992 when AIDS had gained momentum in Uganda. Secondly, the data reveal the large impact of AIDS on mortality. This is consistent with the reports of elders that AIDS-related diseases had caused 45.1 per cent of deaths, and close to the findings of Mulder et al. (1994) that 50 per cent of mortality in Masaka district is due to HIV-1 infection.

Another interesting result of the study is the female-male ratio of deaths. It is now known that, because of biological, behavioural, cultural, demographic and economic factors, the rate of HIV transmission is higher in women than in men (Persson 1994). We found that 52.2 per cent of the AIDS-related deaths were of females, and 47.8 per cent were of males. This finding is close to what other researchers have found in Uganda using the national serosurvey data. Berkley et al. (1990) concluded that women were 1.3 times more likely to be infected with the virus than men. Mulder et al. (1994) reported that while 53 per cent of female deaths were attributed to AIDS, the corresponding percentage for males was 47. Much closer is the December 1993 report of the National AIDS Surveillance System which found 52.3 per cent of AIDS cases were females and 47.7 per cent were males.

As expected the age pattern of AIDS deaths shows that ages 18-35 were reported to have suffered most from AIDS mortality, reflecting the high rate of sexual activity in this age span. The disease accounted for 85 per cent of deaths in this age group. This finding agrees with results from earlier studies in Uganda showing that young adults were most affected by the disease. For instance, Konde-Lule (1992) claimed that because of a high rate of sexual activity, adolescents in Rakai had 11.2 per cent seroprevalence. A two-year HIV-1 study of a Masaka area by Mulder et al. (1994) found that mortality due to AIDS among those aged 13-44 was at least 80 per cent.

On the causes of deaths, the results indicate the re-emergence of old killer diseases in the population. Owing to major health campaigns, diseases such as diarrhoea, measles, malaria and tuberculosis had subsided. Unfortunately, the advent of HIV infection means reduced bodily immunity against disease: this has encouraged diarrhoea, measles and malaria to kill children and tuberculosis to claim a heavy toll on adults.

The elders claimed that of the infants identified as AIDS cases, 98.5 per cent died in the first five months of their life; although it is true that babies born with HIV die very fast, the percentage given seems too high. Goldfarb (1991) reported that most children born with HIV in Africa die by the age of 18 months and 80-90 per cent by five years. It appears the elders failed to give a good estimate of the period of survival for children who are HIV-infected because they could not easily separate other causes of death from AIDS-related diseases. In any case, most major killers of infants in Uganda are malaria, measles and diarrhoea which are AIDS-related.

Feelings of loss by elders

It is important to know about the loss suffered by the elders and how they feel. Their major concerns are the physical loss, financial problems and coping with orphans. They feel the physical loss because most of those dead are their children and grandchildren whom they loved and expected to be their heirs and descendants of their family or clan line (Ntozi et al. 1990). Now that they are gone the elders have an empty life without kinship links. Barnett and Blaikie (1992) describe a Rakai man who had lost a wife and eight sons and daughters as destitute, isolated and much older than his age. It is an extremely bad situation, and beyond description.
An equally important effect of AIDS on the elders was the financial loss. Most of those who had died belonged to the economically active segment of the society. As Barnett et al. (1990) schematically demonstrated about Rakai, the financial loss to households in Uganda due to AIDS is enormous. AIDS deaths mean loss of farm and business labour from children, family income from members employed outside the home and other resources contributed by family or clan members during emergencies. Consequently AIDS-afflicted family farms have become bush, businesses have collapsed, family incomes have dwindled and family resources have declined. In the long run, the national economy will be greatly affected.

Another growing concern to elders arising from AIDS is the problem of orphan care. Thirty years ago Richards’s study of Buganda household composition did not mention orphans at all because they were not a problem (Richards 1966). Since the onset of AIDS, the increasing magnitude of the problem of orphans in Uganda society has alarmed researchers. Hunter (1990) estimated the number of orphans in Rakai alone in 1989 to be 25,364: 12.8 per cent of the number of children under the age of 18 in the district; and the proportion was increasing fast. It is therefore no surprise that ten per cent of the elders were concerned with orphan care as a problem created by the disease. Perhaps the ten per cent reflects the proportion of the people already overwhelmed by this problem.

Changes in funeral rites and inheritance

In the past, mourning for the dead, burials and last funeral rites lasted long periods because few deaths occurred. From the elders’ survey, it was clear that this had changed to shorter periods. Owing to the need to keep economic production going, the almost daily deaths are no longer mourned by the whole village in the form of stopping economic production, especially farming. If this past practice were followed strictly, some villages would spend months without working on the farms and hence have nothing to harvest, which would be a disaster. Instead close relatives of the deceased and those involved in the burial arrangement are the only ones who do not work in the fields. Even for the close relatives the period of mourning before and after burial has been shortened to 2-3 days instead of the previous 1-2 weeks.

The burials have also changed: in the past, they were elaborate, involving wrapping the dead in many traditional materials such as bark cloth in Buganda, and making many long speeches. This practice has given way to hasty ceremonies, the use of coffins and a few short speeches. Often two or three burials take place in the same village according to a tight time schedule; long speeches would delay the arrangements.

A new development in the burials is that in some parts of Uganda there is advance raising of funds to ensure successful ceremonies. This new practice, known in Mbarara as bataka kweziika (association for self burials), has been occasioned by the frequent burials which have overburdened individual households. In order to reduce the financial burden, the communities have formed these associations and set up a fund contributed to by all members who would be assisted with the basic needs at a burial. For instance these associations provide a coffin, a cloth for wrapping the deceased and food on the burial day, as well as digging the grave. The associations own some facilities such as those for cooking and saucepans which are hired out when they are not needed by members, and the money generated is added to the association’s fund.

It is worth mentioning that the whole idea of burial associations is alien to the culture of Ugandans. In the past, death was feared, unexpected even by the sick and never planned for. Anyone who tried to plan for their own death or that of relatives or friends was referred to as enkunguzi (prophet of doom) and never tolerated by the society. The formation of burial associations is therefore a reflection of the realities of the AIDS epidemic and a mechanism to cope with it. It is also evident that the Uganda community is fully aware of the epidemic.
The last funeral rites have also undergone major changes. In the past, it took a long time to prepare the last rites. Several months after the burial in Buganda, many relatives and friends would arrive at the home of the deceased several days in advance to prepare for the ceremony. Sexual intercourse with non-relatives attending the rites was encouraged by custom to ensure replacement of the dead. In the face of the AIDS epidemic, all this has changed. Funeral rites take place soon after burial for short periods and are attended by the close relatives of the bereaved family. The sexual orgies are disappearing and are discouraged by the elders.

A custom related to the funeral rites is widow inheritance, which was common in many societies of Uganda (Roscoe 1911, 1915, 1923; Kagwa 1934; Edel 1957; Southwold 1965). The successor to a deceased married man inherited his wives so that they would continue producing children for the clan and he would look after all their children as his. The major advantage of this custom was to ensure the care of orphans. Unfortunately, because of the fear of HIV infection, this custom is fast disappearing. No man can risk marrying widows even if they are HIV-negative. This has meant that at present no relative of the deceased is solely and culturally obliged to look after the orphans and the widows. The suffering of the widows, widowers and orphans has therefore increased through the change of the custom.

**Conclusion**

Although the method of study of questioning 143 opinion leaders who were not completely randomly selected is less than statistical, it is reassuring that the findings of the study are remarkably close to the results of other studies on the subject in Uganda. The effect on the household composition and structure is dramatic. Infant, childhood, adolescent and adult mortality rates have increased substantially. The study is revealing a major change of customs in order to cope with the epidemic. This may result in a future Ugandan society with new values, customs and practices.

**References**


Impact of AIDS on marriage patterns, customs and practices in Uganda

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Uganda has one of the highest numbers of reported AIDS cases in sub-Saharan Africa. This is mainly due to a number of historical and political factors. The government of Uganda has openly dealt with the AIDS crisis since 1986 but before that the socio-economic and political chaos in the country created an ideal situation for HIV to spread widely in both rural and urban areas. The HIV infection rate varies among different population subgroups: the 1987/88 sero-survey showed variations among regions and between rural and urban areas. In the most urbanized central region, 21.1 per cent of urban and 12.1 per cent of rural residents were estimated to be HIV-positive. In Western Region which is less developed than Central, 29 per cent of urban and 5.7 per cent of rural residents were infected. In contrast, in the remote and rural West Nile Region, 7.7 per cent of urban and 6.6 per cent of rural residents were HIV-positive (Azedri 1989).

There is now a sizeable body of research in Uganda on sexual behaviour, social networking and HIV transmission, including sexual partner studies and studies of changing sexual behaviour in response to the epidemic (e.g. Berkley et al. 1990; Serwadda et al. 1992; Konde-Lule, Musagara and Musgrave 1993; Mulder et al. 1994). However, there is a need for more research on the impact of AIDS on the individual, the family and the community. Little is currently known about changes in households, extended families and their coping mechanisms, and the impact of AIDS on future productivity at the family level and within the community.

The household is the basic unit of subsistence production in Uganda, and its existence and that of the extended family system within which it is embedded has enabled the society to weather the many stresses of war and social dislocation which have occurred in the country for over two decades. It is anticipated, however, that the increased stress occasioned by AIDS will be too much for the extended family systems to bear in the long run.

Methodology

Against this background, therefore, a study to examine household composition and family structure under the conditions of high AIDS-related mortality is being carried out in six districts in Uganda: Hoima, Iganga, Kabale, Masaka, Mbale and Mbarara. The study is being carried out in three phases, of which the first involved the review of ethnographic materials on the populations in the six districts and collecting information from elders and youths.
through focus-group discussions and also administering an individual elders’ questionnaire. Phase 2 was a large-scale household survey in the six districts to document the recent changes in household composition and family structure. Phase 3 will be carried out three years after the second phase. During this phase the areas covered in the second phase will be re-surveyed to determine subsequent changes occurring in the communities.

The data collection for the first two phases is complete and this paper presents the results from the focus-group discussions held for all the six districts during Phase 1. The groups comprised young people and elders of both sexes. The total number of female elders who participated in twelve focus-group discussions in all the districts was 104 and their ages ranged from 35 to 90 years. Most of the female elders were married but some were widowed and others were separated or divorced. Most of them were peasant farmers. Twelve focus-group discussions for male elders were held in the six districts, involving 128 male elders aged from 38 to 92 years. Their occupations varied but a number of them were retired civil servants like teachers and clerks, some were businessmen but most were engaged in peasant farming. The majority were married and a few were widowers.

Eleven focus group discussions for young females and eleven for young males were conducted in the six districts. There were 114 females aged 14-34 years and 103 males aged 19-34; some were employed and some were students.

Results

The focus group discussion topics solicited information on the status of marriage in the communities; the normal age at first marriage for boys and girls; prevalence of polygyny; marriage customs and practices and effect of AIDS on marriage in the communities. The participants were encouraged to compare the past and the present in their discussions.

Marriage in the past

All the participants agreed that marriage as an institution was respected and it was almost everyone's desire to marry. It gave parents pride to have their children married and established in stable homes: for this reason parents were obliged to look for well behaved, obedient and respectable partners for their children. In Mbarara, it was the duty of the boy's paternal aunt to look for a wife for him; in Kabale, once a suitable partner was identified, the parents would look for a mediator who knew both sides well to bring the girl and the boy together. In other districts parents helped in identifying and selecting suitable partners for their children. In all the districts the parents played a big role in the selection of their children's partners.

Historically, because parents wanted their children to have successful marriages, they took it upon themselves to train the children in issues pertaining to marriage. The girls and boys were taught how to handle certain roles and responsibilities appropriate to their sex. In Mbale, for example, the boy had to be circumcised and had to have a house of his own as a sign of maturity and responsibility before being considered for marriage.

Once a marriage partner was identified the children never objected to the choices made for them. This was mainly because they had to be obedient and the parents had tried their best to make the right match for their children. The parents carried out investigations to make sure that the chosen partners came from respectable families.

The participants reported that most girls got married with traditional legitimacy, that is with the consent of their parents. After identification and agreement, bridewealth was negotiated and when it was paid the girl was free to go to her husband. The departure day was celebrated with a big feast.
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In Mbarara and Masaka the bride's aunt escorted her and took back the bedsheets which the couple had slept on; this was for proof of virginity, the virgin bride's bedsheets being bloodstained. A bride who was a virgin brought pride to both her parents and her husband and for this presents were given to her and her parents. In the past most girls were virgins because premarital sex was not allowed. If a girl was found not to be a virgin on the consummation night, her in-laws would send a copper coin with a hole in it to her parents. In Kabale they would send a hoe without a handle to the bride's parents. Premarital pregnancies were punished severely, sometimes with death but at least with banishment from home.

The participants noted that marriages in the past were stable because women were obedient to their husbands and there were enough resources to manage homes. It was the duty of the boy's parents to give a firm start to their son by providing him with enough land and paying his bridewealth. In Mbarara it was reported that because of the authority parents had over their children, elopement was very rare. If it happened, the young man would formalize the marriage later, but after paying a fine to his partner's parents for staying with her illegitimately.

**Current status of marriage**

All participants agreed that marriage has changed from what it used to be several decades ago. Parents no longer help to identify and select potential partners for their children. All groups in Iganga and the youth group in Kabale noted that present-day marriage is mainly by individual choice. The intending marriage partners meet and make their own decisions. In Mbarara all groups observed that current marriages are on a trial basis, where a girl stays with a boy before involving their parents. Elders in Hoima pointed out that at the present time boys and girls meet in social gatherings and decide to get married. One female elder in Hoima comments that 'these days the girls simply go'. Youths from Mbale complained that marriages of today do not last long. Young females of Mbale emphasized the fear of HIV/AIDS which has 'poured cold water' on the institution of marriage. They further argued that marriages are difficult because of mutual suspicion among couples. There are still promiscuous men and women who destroy marriages. Mbale young people say that modern marriage is expensive; so one has to 'think twice' before getting involved in it.

In Masaka participants classified the current types of marriage into three. The first one is the traditional type, where parents and relatives still play a big part in selecting the marital partner, and provide guidance in their children's marriage. This type is common in rural areas and for children who have not had much education. The second type is one based on modern individual choice: these marriages start as love affairs, usually at school or places of work. Parents are informed later and then marriage follows. The third type is cohabiting: for such reasons as lack of bridewealth, which is high in some communities, young people may cohabit before marriage in the hope that the relationship will mature into a formal marriage. They noted that this approach is risky because there is no legal bond between the cohabiting individuals. The female elders felt that this has resulted in prostitution.

**Causes of change in marriage**

Marriage has changed a lot from the past. This is not only because of AIDS but because of other forces of social change which have affected marriage and the family over the years.

The participants were asked what they thought was causing the changes in marriage. The following factors were identified: limited resources coupled with economic problems that have resulted in a high cost of living and high unemployment rates especially among youth; modernization and the influence of Western cultures; high bridewealth; intermarriages between ethnic groups; education; modern religions; society's acceptance of cohabiting; lack of...
of parental guidance; lack of trust and confidence among married couples; promiscuity and AIDS.

These have been important factors in changing or even eradicating some of the marriage customs and practices. People used to adhere to the traditional customs for fear of being cursed by the ancestors unlike today when education, modernity and Christianity have brought changes. Modern religions have diluted some of the previous practices by adding a religious tint but have not eradicated earlier forms. Only those rituals considered to be pagan practices have been eradicated. For example, in Iganga the bridegroom had to take a goat to the bride's home for sacrificing to the gods but this has changed with Christianity.

**Prevailing marital customs**

The participants were asked about the marriage customs in their communities. All the participants agreed that brideprice is one of the old customs which has survived, although with some slight changes. In the past payment took the form only of animals but today it can be made either in cash or animals or both but it is still strictly observed. Some of the other practices that were highlighted by the different groups are indicated below.

According to the elders in Mbale, elopement is still handled according to custom. When a girl elopes with a boy, relatives of the girl go to the boy's home and are given a goat and then matters are sorted out normally. The other marriage custom in this area is that the boy must be circumcised and must have a house of his own as a sign of maturity and responsibility before he is allowed to marry.

In Mbarara, at the time of their introduction the boy's family has to take beer to the girl's home and pay bridewealth before the wedding takes place. Dowry (*emihingiro*) in the form of clothes and other items to assist the couple to start a home is still being given by the bride's parents and a formal wedding ceremony is still required. The girl's family has a ceremony at the end of the bride's seclusion period (*okwaruka*). A goat is also given to the girl's maternal uncle and paternal aunt.

In Hoima the boy's family chooses some respectable elderly men to go to the girl's home and pay bridewealth before the wedding takes place. Dowry (*emihingiro*) in the form of clothes and other items to assist the couple to start a home is still being given by the bride's parents and a formal wedding ceremony is still required. The girl's family has a ceremony at the end of the bride's seclusion period (*okwaruka*). A goat is also given to the girl's maternal uncle and paternal aunt.

In Kabale, the girl's aunts give her advice on how to behave in marriage. A boy is given land by his father so that he establishes himself in preparation for marriage. Once bridewealth is paid the girl is considered as the man's property because he has 'bought' her. The parents of a non-virgin girl receive a coin with a hole in it or a hoe without a handle. A fine (*omutango*) is paid in the case of elopement.

In Iganga, a letter of introduction is written to the girl's parents to inform them of the boy's intention to marry their daughter. The introduction ceremony follows. There should never be marriages within the same clan.

And in Masaka there has to be a formal introduction (*okwanjula*) of a future son-in-law. The paternal aunt and other elderly women make sure that the girl is properly prepared for marriage.

**Basic marriage practices that should be promoted**

We asked what people would like to see as the basics that are retained in order for marriage to have meaning. The participants dwelt mainly on bridewealth. They argued that bridewealth formalizes marriage, gives it a stable foundation and yields a respectable marriage. All agreed that, in order to safeguard the marriage institution, the traditional customs should be maintained. Bridewealth must be paid but the amount of money or the number of animals
asked should be reduced so as to be affordable and parents should participate in identifying and selecting partners for their children.

In general, there is agreement that the customs and practices concerning marriage make sense and are meant to strengthen marriage and the family. Since there are fewer marital disruptions where they are observed, they should be sustained.

**Effects of AIDS on marriage**

The discussions included the proposition that the AIDS epidemic has had an effect on various aspects of marriage.

All participants agreed that the institution of marriage has been greatly affected by AIDS. Marriage has been affected through all its stages, right from the identifying of partners to the time of dissolution. Participants in all the districts reported that people fear to get married because they are not sure of the sero-status of their potential partners. In Hoima, for example, the youths said that 'men avoid women these days'. In Kabale, all the groups reported that boys and girls are not eager to marry for fear of AIDS. In Mbale, the male elders said that AIDS has resulted in people fearing others, especially women. Each woman is looked upon as an AIDS victim or HIV carrier. The young males added that it is not only women but almost all people who seem to be 'moving corpses'. In Iganga a female elder reported that her son refused to marry because many newly married people are dying of AIDS, so there is no point in soliciting death through marriage. In Masaka, the male and the female elders held the view that AIDS is discouraging marriages among young people. The male elders say that ‘one who forgets marriage altogether is now better off’. In Hoima and Mbale, participants reported that infected people return from towns, especially Kampala, and spread AIDS to rural dwellers. People are now very suspicious of urban-to-rural migrants. The frequency of marriages has declined because of fear of AIDS, according to male elders and youths from Mbarara and male elders of Kabale.

While some participants said that AIDS has made people firm in their marriages, others said that it has increased the rate of separation and divorce. For example, female elders, young males and young females in Masaka claimed that AIDS had resulted in increased separation. The female elders said that when one partner is infected couples can separate or continue staying together but abstain from sex. The young females said that women and men separate from partners who are unfaithful and are therefore likely to bring HIV into the home. This same view was held by old and the young females of Mbarara who said that, while some couples just abstain from sex and have separate beds, others seek divorce because, with the former arrangement, the couple may be tempted to sleep together again. Therefore, to avoid this, couples are divorcing. They say that in the past divorce was looked upon as belonging to the Western world, but today AIDS has encouraged it because people are not willing to stay with unfaithful partners. The young females of Iganga add that AIDS has put married people's lives at risk because they cannot simply divorce even if the partners are not faithful.

In contrast to the above statements, some participants, like the young males of Mbarara and Iganga, male elders from Masaka and young females of Iganga, argue that AIDS has made married people firmer in their marriages. Couples have decided to 'zero graze' and stick to their partners so as not to contract AIDS. The Masaka youths say that AIDS has led people to seek proper and permanent relationships, to be faithful and to engage in stable marriages in contrast to the pre-AIDS times when men and women would have several sexual partners. Female elders in Mbarara argue that people are not separating. They add that married people cannot separate easily. They have to stay in their marriages and if the partner brings them HIV then it is their fate. On the issue of sticking to partners, the male elders of Iganga add that there is extra strictness even in polygynous families. Co-wives co-operate in spying on their husband to make sure he is not lured out of the ring.
Participants say that, while AIDS has ‘poured cold water’ on the institution of marriage, there are people who have ignored the presence of AIDS and have continued with their previous life styles. For example, women elders of Iganga say that there are people with the ‘I don’t care attitude’ who say ‘I am not a piece of wood’. This means that human beings are destined to die unlike wood which can be used for some other end product. They add that some men have not changed and maintain that AIDS affects only those who have an affinity for it: silimu asima mubiri. With such tendencies and ideas, the participants agree that it is hard to reduce HIV infection among people. The male elders of Mbale add that rich men give money to girls and infect them with AIDS; and such men do not care about their wives.

People with this ‘I don’t care’ attitude are even unwilling to go for HIV tests to ascertain their HIV status. The women elders of Hoima say that when such people fall sick with AIDS they claim it is witchcraft and not AIDS. Some people no longer even believe in results from the testing machines because they claim that one may test negative when in fact one is positive. Female elders of Mbale add that marriage and sexual behaviour have not been affected by AIDS. They maintain that those who want to marry do so without fear. They argue that after all many cars collapse while on the road, and, if the owner did not want to be in it when it collapsed, then he would not use it. Few people take this view. Contrary to this idea of marriage and sexual behaviour not being affected by AIDS, the young females in Mbale say that people are careful and conscious about risky behaviour. People used to look forward to attending ceremonies following somebody’s death but today they are conscious about risky behaviour at funerals. It is believed among the Baganda, for example, that during the last funeral rites people should celebrate and engage in merrymaking activities like having sexual relations in the hope of replacing the dead person.

AIDS has threatened circumcision in Mbale district. The Mbale youth noted that there is a tradition that after circumcision a boy looks for a woman to teach him about sexual relations, and, after he has learnt, the relationship ends, but with AIDS this practice has died out. AIDS has also threatened the practice of widow inheritance. In the past, widows would be inherited, but, with AIDS, this has stopped. Young males in Mbarara claimed that women have ‘lost market’ because of AIDS.

On the question of age at first marriage there were differing opinions. Some participants said that girls in the past married when they were old while others said that they married at an early age. They argued that, as soon as a girl started menstruating, she was considered old enough for marriage. They attribute this to the betrothal of girls, when young, and, because girls did not go to school, they were there for marriage. Currently, owing to education, girls get married when they are old, some as old as 25 years. For the boys, the participants had diverging ages for marriage. Some said that these days boys marry at an early age (18-20) while others said that they marry at a late age when they are already established. The elders said that, in the past, the reason for marrying early was that the boy’s father would pay the bridewealth for him.

The participants were asked whether it was common for men in their communities to marry more than one wife these days. The elders generally pointed out that it is not common for a man to marry more than one wife. They noted that most men have one official wife. The female elders said that it is the Muslims who have more than one wife but all these wives are official and are known to each other, unlike the practice among non-Muslims who have other wives secretly. The young also agree that most men have only one wife although some have concubines: the reason they gave for having one wife is the fear of AIDS.
Discussion and conclusion

The evidence from the focus-group discussions is that marriage customs and practices have changed over time because of factors related to socio-economic development, modernization and Western culture. More recently the changes in marriage have been closely connected with the AIDS epidemic in Uganda. However, many customs have persisted, such as parental participation in the introduction and negotiation for children's marriages, bride price, dowry, circumcision of boys before marriage, fining boys who elope with girls and rewarding virginity at marriage. The societies where these practices exist want them to continue because they regard them as good.

It is also clear Ugandans are aware of the profound impact of AIDS on marriage as an institution: fear of potential partners being seropositive is holding back girls and boys from marrying, and this may have several effects. The reported promiscuity in some of these societies (Ntozi and Lubega 1992) may decline: Konde-Lule (1992) reported lower levels of sexually transmitted disease among adolescents in Rakai, perhaps as a result of reduced sexual activity. Since most adolescents do not use condoms (Konde-Lule 1992), premarital sexual activity is likely to decline.

The choice of a partner in future may be more careful than at present. The current 'love at first sight' may gradually be abandoned in preference for more research on the background of the suitor, as happened in the past. HIV testing centres in Kampala are reporting growing numbers of urban and educated boys and girls testing before making a commitment to marriage. This is to avoid HIV infection from a spouse who is infected before marriage.

However, because of modern circumstances, it is the concerned individuals who will be doing the research on their potential partners in contrast to the past when the parents did it. Unlike the situation in the past, the parents and society are likely to be tolerant and understanding of delayed marriages in future. They would rather have unmarried boys and girls than their coffins. Once this trend is accepted, delayed marriage may lower the very high fertility rates in Uganda.

Another consequence of AIDS is its effects on the stability of marriage. 'Zero grazing' or one-partner culture may be catching on. Although the elder participants were divided over the morals of divorce and separation in the face of AIDS, the young unanimously accepted it. This implies that in future society may no longer condemn those spouses who leave their partners because of unfaithfulness at a time of fear of AIDS. This change of attitude by the society may lead people to seek permanent relationships with one partner and abandon the practice of several sexual partners in order to save their nuptial unions. Polygyny may also decline in the long run even among the Muslims.

With increased knowledge of the harm some customs are creating, they are likely to be abandoned or modified to suit the circumstances. For instance, widow inheritance is declining fast although this has serious consequences for orphan care. Further the Baganda's sexual indulgences at the last funeral rites, the Banyakore's practice of having one wife for all brothers, and the Bagisu's sexual orgies at circumcision ceremonies are likely to be abandoned through fear of HIV infection. Already the last funeral rites in Buganda are no longer celebrated as in the past because the number of funerals has become too large; the performer of circumcision changes blades with individuals; and the Banyakore marriage practice has been condemned by the civic and religious leaders in the area. It will therefore be interesting to know what marriage in Uganda will be like in the post-AIDS era.

Further, it is unfortunate that women are being stigmatized by the society because it is feared of the disease. Although research so far has indicated that women are more affected by HIV/AIDS than men with an odds ratio of 1.4 times (Berkley et al. 1990), it is not true that they are the only carriers of the virus. In Uganda and Rwanda it is believed that the disease was spread from the cities to the rural areas by labour migrants who were mostly men.
working in towns. Being lonely, the men are tempted to satisfy their sexual desires with prostitutes or 'free town women' from whom they may contract the virus. They then infect their faithful rural wives on the occasional visits to the villages (Ntozi and Lubega 1992). Research has also found that the higher rate of HIV infection of women is not because they are more promiscuous than men, but due to biological, economic, demographic and cultural factors which make them more vulnerable to the virus. For instance, Persson (1994) has reported that, because of the heavy virus load in the ejaculation of an infected male, there is much higher efficiency in male-to-female transmission than vice versa. The stigmatization of women as 'virus carriers' by some focus groups is a relic of the traditional belief that any evil in the home was brought there by women, who are regarded in some of the societies as outsiders to the husband's extended family (Ankrah 1991).

In addition, there are disturbing reports of an 'I don't care' attitude, mostly among young men and women who may already be HIV-infected. The society is worried about their behaviour and attitude towards the epidemic; it seems their aim is to spread the disease so that they do not die alone. The social workers, AIDS counsellors, chiefs and policy makers should target this group and influence their behaviour in order to save the population from more suffering. Although the Ugandan Parliament has recently passed a law to punish such people, its implementation needs the co-operation of all segments of the population.

References
‘Bring us the female condom’: HIV intervention, gender and political empowerment in two South African communities

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The quotation which heads this paper encapsulates two important issues in AIDS research in South Africa: the one is substantive, the other methodological. The link between them is the rapid spread of HIV/AIDS in the country and the indication not only that women are more at risk of infection than men, but that, as in many other parts of the world, much of their vulnerability is gender based. ‘Bring us the female condom’ sums up the response of one particular group of black South African women to AIDS education. Their demand was a reflection of their relative domestic and gender empowerment - and also a high degree of political mobilization. However, their position is not necessarily shared by other black women. But the call for the female condom went further: it was a challenge to rethink our position as researchers and particularly to face the implications of commitment to a participatory model of community based intervention research.

The interface between research and action

As the AIDS crisis looms ever larger on the South African public health horizon, the call is for research not only to understanding the dynamics of HIV transmission, but, virtually simultaneously, to piloting and launching intervention strategies. The perceived need among many researchers and certainly among health authorities, and often among funders, is for ‘action’ rather than ‘pure’ research. Combining these is a difficult and challenging task. As elsewhere in the world relatively little attention is paid in the local literature to the dynamics of sexual interaction and negotiation, or to the full range of factors impinging on sexual decision making. A serious commitment to action may, furthermore, result in the temptation to cut the time and resources available for good holistic ethnography on which to base solid interventions. While it is true that in the cases described below we were working against a background of considerable sociological knowledge of the major structural features of the communities concerned and, at a general level, we had a fair picture of gender relationships in them, in practice we leant many important details of local circumstance ‘on the job’. This related, in particular, to the possible effect of women’s political empowerment and mobilization on their response to AIDS education.

Reflexive exercises such as this paper represents are important in that they contribute to the construction of a body of local ethnography about not only AIDS/HIV in general, but the complexities of HIV intervention in itself. The themes raised here have a wider resonance; what is reported echoes studies done elsewhere in Africa and also in other parts of the world. A growing body of international literature suggests that gender empowerment is the key to women’s ability to protect themselves and their children from HIV infection. For women in traditional and transforming societies, political as well as domestic empowerment may necessarily have to precede or, go hand-in-hand with individual sexual empowerment.
Evidence is drawn from one of the first HIV/AIDS research and intervention projects to be carried out in KwaZulu-Natal, a geographical and political region situated on the eastern seaboard of South Africa. The majority of the population of the region speak Zulu as their home language and two contrasting Zulu-speaking communities were chosen for study, one largely rural and structurally traditional in organization, the other a far more rapidly transforming informal shack settlement abutting the largest urban-industrial area in the region. At the time of fieldwork KwaZulu-Natal was characterized by considerable social and economic change and was undergoing fundamental political transformations. In both the communities local support was overwhelmingly for the African National Congress which was to win the national elections and it was, indeed, through the ANC local structures that we gained entry to both communities. In terms of policy, the ANC had already come out strongly in favour of women's empowerment and their local representatives reacted to our focus on women both seriously and supportively.

In planning our intervention strategies we made mistakes and missed a number of opportunities, but we could not have acted very differently because our research was constrained in two important respects. First it was focused at the level of micro-interaction where the nature of domestic and neighbourhood relationships, not to mention the influence of dominant personalities, competing interpersonal loyalties, reciprocities and local power struggles, necessarily dominated the processes both of data collection and how we planned and conducted our intervention. Secondly and probably more critically, we were committed to an 'action' and, moreover, a consciously participatory model of research and intervention. We worked with and within two communities and we planned that our intervention was to be community rather than merely individually oriented. We set out to interact closely with, and respond to the unique circumstances of each community. We regarded the women (and to a lesser extent the men) as research partners, and we did our best to allow them to set the pace and actual direction of our intervention strategy. However, this approach presented us with a number of dilemmas which, in turn, raised the more general question of who sets the ultimate 'direction' and where the final 'ownership' lies in programs which are based on a participatory research model.

The problems raised by the micro-level focus and participatory nature of our research are not unconnected. What differentiated the two communities was the degree of local political and domestic empowerment enjoyed by the women in each. There is a possible connection between the degree of political mobilization of women, their ability to negotiate sex and HIV prevention (Susser forthcoming); also, a critical was role played in each case by the persons identified by us as community liaison persons. Here too, is an important item of local difference. In the case where we believe that our intervention has had most effect, the liaison person was herself a political activist and the platform from which she launched our program was that of the Woman's League of the African National Congress. Although both communities were ANC-dominated, in the first the women were not strongly organized on that political platform, while in the second our intervention went hand in hand with their political mobilization. There were, of course, other factors differentiating the two communities. They turn, however, very largely on the degree of domestic freedom and gender empowerment which the women in the two communities enjoyed or believed that they commanded in their relationships to the men who were their husbands, lovers - and their elected political leaders. These factors allowed the women in the second community to challenge us to bring the female condom to them. They firmly believed that they would be able to negotiate its use with their sexual partners and could persuade and empower other women in the community to follow suit.

What is the magnitude of the HIV/AIDS crisis in South Africa, and particularly in KwaZulu, and who is most at risk? To answer this will explain why the projects described
here focused on Black South African women and on issues of gender and empowerment. A brief sketch of the nature, organization and methodology of the study is followed by a contextual description of the communities with which we worked; the paper concludes with analysis of the course which our intervention took in each community.

The KwaZulu women and AIDS project

The original motivation for the Women and AIDS Project was the need to identify the factors which might prevent black women in KwaZulu from adopting preventive measures against HIV infection. We also aimed to test general knowledge of HIV/AIDS in the areas studied and, at an early stage of the research, we decided to offer information and advice as well as any practical assistance we could, to the communities. The core of our research team were women and the project drew together academics, members of the health profession and community representatives in a co-operative response to the threat presented by the spread of HIV/AIDS in KwaZulu. Our team consisted of epidemiologists, anthropologists, and a medical doctor working as a researcher for the Medical Research Council. We recruited other health workers and graduate students to assist in the fieldwork and, where possible, we drew on the support and assistance of clinic staff working near, and used by, the two communities studied. Once established, our link with the communities was, however, through a number of community liaison workers who were paid by the project.

Rooting AIDS information in the community: the role of the liaison people

We hoped to root AIDS information and awareness in the two communities through a continuing and interactive combination of 'pure' and participatory research in which the academics and heath practitioners on the core team would be linked to each community through the liaison people chosen by the communities themselves. There were three reasons for having community liaison workers on the research team: first to create direct and two-way access to the communities through which we could communicate the AIDS message and through which the community could communicate their ideas and needs, as well as their reactions to our message and activities; second, to facilitate the collection of research material which we believed should inform our intervention practice; and third, to develop a local and, it was hoped, long-term resource for raising and sustaining AIDS awareness and providing AIDS information within the community members.

So they could be an informational resource for the communities, we gave each liaison person an AIDS education course. This took place at the Medical Research Council’s Durban office to which they came on average once a week to begin with, and about once in two weeks as the project matured and they needed less support. The object of these visits was also to debrief them regularly on what people were thinking and saying about AIDS in the community. We encouraged them to keep field notes either in English or Zulu and, as they got used to the idea of research, we gave them topics to pursue in discussions with some of the groups they set up, or even simply with friends and acquaintances. Examples of such topics are the issue of sex for money or how AIDS was being interpreted and fitted into the meaning system of the communities concerned. These notes, which, with the exception of the specific topics mentioned above, we encouraged to be as open and undirected as possible, proved to be an invaluable source of guidance on what was going on in the communities and the effect we were having on AIDS awareness. When the first AIDS death occurred we tracked its repercussions through these diaries, and they warned us of potential pitfalls in our

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1 The study was facilitated by the International Centre for the Study of Women, Washington DC with funding from the Health Office of the US Agency for International Development.
original research strategy. The diaries and the regular meetings with the liaison people were vital for the qualitative side of the research.

The liaison people also provided a welcome and relatively inconspicuous source of condoms to the community. In the first area studied, although the local clinic dispensed condoms freely and easily, the supply ran out on occasion and some people were embarrassed to be seen going to the clinic for condoms 'too often'. Youngsters who were intimately known to the more mature locally based clinic staff were not surprisingly reluctant about such clinic visits. Although they worked closely with local clinic sisters, the liaison people were 'of the community' rather than part of the formal health care structure of the area; in this lay the prime 'participatory' and 'action' component of the project as well as its hopes of sustainability. As it turned out things worked out rather differently in the two communities.

The communities studied

The two communities which were the target of our research are situated on the outskirts of Durban, the largest city and source of employment in the KwaZulu region. Durban is the most important port on the east coast of South Africa and is the centre of a rapidly growing and diversifying urban conurbation. The business and industrial hub of the region is surrounded by sprawling black settlements made up on the one hand of the 'townships' in which the previous government provided limited low-cost housing for black families, and on the other, large informal shack settlements which have mushroomed as people have moved to the city in search of employment. In the latter, recent rural migrants live cheek-by-jowl with second and third generation urbanites who have been unable to secure settled accommodation either in the white-dominated city or the townships. In this heterogeneous and volatile environment the second of our research communities was located.

At its periphery the formal urban area of Durban shades into what was once its peri-urban and rural hinterland. Here both formal and informal urban spread meets and intermingles with predominantly rural areas inhabited by either white or black farmers, the former being substantial landowners and the latter subsistence peasants living in areas designated first as 'reserves', and later as part of the 'Bantustan' territory of KwaZulu, where authority is vested in hereditary chiefs and their chosen councillors and functionaries. Recently political parties and particularly the structures of the ANC have begun to influence the political process in some of these areas, but others are strongholds of traditionalism and support the major opposition party to the ANC. Land is held under communal tenure and is allocated largely to married men (Preston-Whyte and Sibisi 1975). In most of these areas it is still possible to obtain enough land to cultivate on a small scale and many households subsist on a combination of migrant wages brought in by men and some women, supplemented during the summer months by the fruits of indigenous crops such as maize and increasingly vegetables. The latter are, however, often sold locally rather than eaten by the household and there is a vibrant, if low, income-generating informal sector operating in most of these areas. This provides women who have few local sources of wage employment with some possibility of making money. In such an area, some 80 kilometres from the centre of Durban, KwaXimba, our first research area, is situated.

In formal terms the social structure of KwaXimba is male-dominated with men not only wielding political authority, but dominating in the domestic sphere as well. Members of the research team witnessed the election of office bearers to the newly formed civic structures and found that the majority of married women, although clearly well respected and influential in the community, would not allow their names to go forward for election because they had not got the prior permission of their husbands.

In contrast to rural KwaXimba, it is more than 20 kilometres from the centre of Durban to the second area studied, Nhlungwane, at the junction of what was originally one of the
largest of the city's formal black townships, and the informal shack area which has sprung up alongside it. The residents of Nhlungwane do not have fields or gardens and they pay high rents to local landlords for the small plots on which their shacks are built. Both men and women commute to work daily and the chances of either formal employment or informal money-making are far better than at KwaXimba. On the debit side, many women at Nhlungwane are not permanently supported by men. This is an area where single, divorced and widowed women have been able to establish households and it is widely known as an area where both older and younger women run their own households, giving them the independence which the married women in KwaXimba appear to lack. A number of outside organizations as well as the local ANC have run women's groups in Nhlungwane for some years: women were well versed in politics. Indeed, at one of our meetings, copies of the newly translated Freedom Charter was being distributed and eagerly discussed.

**KwaXimba: working through community structures**

At the time of fieldwork the KwaXimba Chief, who was a staunch member of the ANC, was in the process of democratizing the authority system of the community. A number of civic associations, commonly referred to as 'democratic structures', had been formed, including some focused on the youth and, at least theoretically, on women also. In order to gain entry to the community we worked through and sought the co-operation of all of these bodies. We began by explaining the purpose of our research to the Chief who was fortunately known to one of the core research team; he passed us on to the community-based structures and allowed us to address an open meeting of the whole community. Referred to in Zulu as an *imbizo*, this was not set up only for our message: it was one of the regular occasions for communication between community members and their leaders and happened to be one at which important elections to the civic structures were held. We thus met, and were met by, many of the key people in the community and we believed that agreement to our project was ratified, and the story of our work would begin to filter into the community through those present. In this we were largely correct and we are grateful to the KwaXimba male youth leaders, who arranged to meet our team over weekends in their precious free time and took a personal interest in our research. While it is true that these men facilitated our work, their involvement to the virtual exclusion of local women, with the exception of the clinic sisters, appeared to us problematic.

**Male permission to study women?**

In the early phases of setting up our research it was noticeable that, although the members of the research team were women, and the focus of the study was on women, it was men to whom we were talking and men whom we appeared to have to persuade. The clinic staff are women, and we visited them and solicited their co-operation, but the real permission came from male dominated community structures. Had these been threatened by our proposals we believe that we would not have been able to proceed, let alone put into operation any participatory research.

**Choice of liaison people**

Following the *imbizo* we began a series of smaller meetings with civic organizations and, in order to set these up and to root ourselves firmly in the community, we asked the Chief and civic association to provide us with a liaison person who would be paid by the project. Since the project focused on women, we thought that a mature local woman with a good profile in
women's organizations would be a good choice. It was suggested to us, however, that such women are very busy and that the position might be better filled by two people on a part-time basis. In the end, the names of two young women were put to us. Both spoke English well and one was already working as a secretary to the Chief, but, we were assured, had time to spare to assist us. Because she worked at the courthouse which was situated just beyond the local clinic, she was already at the centre of important civic and health related activities. The other had recently left school and was waiting to further her education. She was, however, the daughter of an influential middle-aged married woman who was active in local church circles and in her own right she was the centre of a considerable local youth network. The exact negotiations by which these candidates were decided upon was a 'community' matter organized through the local authority and power structures. The liaison people were, therefore, community appointees. As it turned out they were good choices and contributed greatly to the research and intervention: unfortunately one has now left the community to further her education and the other, now that the project funding has run out, is once more fully occupied with civic duties.

This raises serious questions as to whether the project is having any long-term effect, and it is possible that we did not manage, except in a marginal sense, to provide the community with a resource for dealing with the AIDS crisis as it developed. Whatever the case may be, working on the project was personally beneficial for both women. They developed their linguistic and writing skills, gained confidence in dealing with people and structures outside their own community and one earned the money to further her studies. At one level it could be argued that these are achievements in their own right, and that in broadening the base of experience and expertise of these young women and, in particular, through giving them experience of working on an AIDS program, we have added to the general capacity of the community, both in KwaXimba and elsewhere in KwaZulu-Natal, to cope with the coming crisis in health management.

The further, and more problematic, question must be posed of whether, and in what sense, the project was truly participatory, as opposed to being merely community based in that we were careful to work through the (male dominated) political structures. After all, gaining acceptance in the community is a basic sine qua non of most field-based social science. Was this project any different and did it have the elements of true 'action research' associated with it? Here we are more sanguine. The liaison people set up numerous meetings for the rest of the research team to speak to local groups: more important, in the first seven months of research we received no fewer than eight spontaneous requests for meetings. Had we had a larger team we might have been able to cope with more. Eventually the liaison people were able to address many of these meetings: an indication of the success of our training of them to take over the role of AIDS educators. Of course there were some failures. As is inevitable where telephonic communication is problematic some meetings did not materialize, to the frustration of those who had initiated them, whether research team or community group. Thirty-eight formal meetings with some 979 people were held in addition to the numerous one-on-one discussions and informal consultations with the research team which occurred when they were visiting the area. On the whole our public meetings were well attended and discussion enthusiastic, concerned and critical. We were called upon when crises occurred in the AIDS field, for instance when the clinic sister felt the need for counselling for the family of the first girl to sicken and die of AIDS; and we were invited to community events such as the celebration held to commemorate the heroes of the community who had sacrificed their lives for liberation. We believe that had the project been able to continue, these occasions for involvement and reinforcement of the AIDS message would have increased.
The reasons why this was not possible need to be seriously addressed. Like all externally funded aid programs, the project had a finite life span. When the funding ran out the liaison people found other employment and the academic members of the research team moved on to other tasks. At this point the project should have become self-perpetuating and self-sustaining. The work of the liaison workers should, perhaps, have been absorbed into the routine responsibilities of the clinic staff, and to some extent this was the case. The request by the sister for assistance indicated her awareness of the larger picture of the impact of AIDS/HIV on the community she served. Ideally funds should have been available from the state or the health structures of local government for retaining the services of the liaison people or for putting such a service onto a permanent footing. With its emphasis on primary health care and the training of grass-roots health personnel, the new government’s National Health Plan is, indeed, a move in this direction. In this connection it may be noted that the medical doctor on the research team is now the Minister of Health and the epidemiologist has been appointed the National AIDS Director in the new Department of Health (AIDS Analysis Africa, 5/6/95).

Locally, the picture is less good. One of the reasons why it became difficult for team members to continue to interact with the KwaXimba community is the violence which engulfed the area soon after the national elections. Outsiders were at times no longer safe nor welcome and even the clinic staff were beleaguered for periods and the health services curtailed. When the first two authors of this paper attempted to visit KwaXimba in 1995 it proved to be impossible because of the instability of the political situation leading up to the local elections. Robust local structures need to be in place to carry the burden of continuing AIDS awareness work.

Combining intervention and survey work with qualitative research techniques

Returning to the course of the Woman and AIDS research project, we comment now on the way we were able to combine AIDS education with the gathering of research data. The academics and medical specialists on the research team were often called on to speak on AIDS/HIV at many functions in KwaXimba: when this occurred we took the opportunity for data gathering. From the questions asked on these occasions we learned about local attitudes to sex, condoms and, indirectly, the position of women and gender relations. These discussions constituted the qualitative side of our research and on that basis we developed a questionnaire which was administered to women in a sample of some 100 households. Although the interviews were conducted by trained outside interviewers on the research team, the liaison people accompanied them to each home, introduced the survey and facilitated the interview. They got discussion going on the problematic issues of youthful and non-marital sex as well as knowledge and attitudes to HIV and AIDS. Although care was taken that the chosen respondent answered the questions alone, the rest of the informal team chatted to others in the household while this was going on and the occasions of the interview often resulted in informal and intimate discussion sessions. Women and sometimes men took part and, in this way, wide participation in the project was achieved at the household level. Subsequently, a second questionnaire was designed for men and administered in much the same manner with the same widespread result. Although we recruited outside male interviewers, the liaison women facilitated the interviews, thus, indicating clearly and publicly that AIDS is not divided on gender lines.

The field work done at KwaXimba was, an example of community research and intervention in action: the study was talked about, the message debated and the presence of the liaison people working with and leading the outside researchers helped to make it participatory, at least in some important senses.
Gender again - but age as well

In the meetings at which only women were present and in many of the small groups formed during the administration of the survey, the informal participation of the liaison people who were themselves women gave other women the opportunity to speak and debate what are essentially gender issues in real depth. Often in the larger meetings at which women were present with men, only a few local women, if any, spoke. The community is still sufficiently patriarchal for men, even if there are only a few present in relation to many women, to dominate discussion. If the men concerned are, furthermore, older or members of the senior 'tribal' establishment, the passivity of women and particularly young women, was even more pronounced. In contrast, in groups in which only women were present, they spoke out forcefully, although where there was an age difference, younger women were more silent than older women. In the groups in which young women and girls predominated, lively discussions emerged in which all took part. The fact that these sessions were presided over by the liaison people, who were themselves young, allowed for questioning and possibly, real learning in these groups through the discussion of shared experiences; so much of what we learned about the potential problem of HIV and AIDS in KwaXimba was refracted through youthful eyes. The choice of the particular liaison people was, as we have seen, a community one, and if it had drawbacks, we believed we had to accept them. Research which is participatory is led as much by the community and its internal dynamics as by the researcher.

In the long term we believe that the focus on youth is an expression, whether conscious or unconscious, of the KwaXimba community's response to AIDS and the questions which AIDS and HIV raise about youthful sex and sexuality. Indeed, a frequent concern voiced at our meetings focused on teenage pregnancy and the implication often seemed to be that we would be better occupied trying to deal with this long-standing problem than merely with the more recent AIDS problem.

AIDS is a woman's problem

Although men were often present at our meetings and we had had to get their permission to do the research, the decision to develop a male questionnaire, to involve men as well as women actively in our work and to include men in our research team, was made well into fieldwork. It was done at the suggestion of the liaison people. When a young woman died of AIDS — the first death in the community — they warned us that AIDS was being construed as a woman's problem and disease. The fact that our whole research team were women and most of our activity appeared to be directed to women, had only served to reinforce this perception. We were not doing true community-based participatory research because, in our concern about women and our own gender-based interests, we were excluding men. Paradoxically it was a lesson that confirmed what women were telling us about the constraints on their ability to say 'no' to unsafe sex.

Financial dependence on men

Much has been written on the unequal position in which most women, and especially those who are poor, find themselves vis-à-vis men in sexual relationships. As the KwaXimba women gained confidence in 'answering the experts back', an eloquent spokeswomen summed up:
It is all very well for you to tell us to protect ourselves against AIDS by sticking to one partner or using the condom. What if we and our children are hungry and we have no other way to get money? ...some local women who accept money for quick sex are not simply casual prostitutes. They are mothers and people with stomachs ... sometimes these women are young and sometimes old. Even married women are dependent on their husbands for money.

Her suggestion was that the project did a lot of talking but would be more helpful if it offered women some practical suggestions about how to solve their economic problems. Here the implication was clear that the research team did have well filled stomachs and were not participating in any sense in the life common to many KwaXimba women. Worse, we were not doing anything about it, or even attempting to do so. In her terms the research was neither participatory nor action oriented. Looked at in these terms she was right. Stung by these strictures and their implications we hoped to do better the next time around.

**Nhlungwane: working through women's groups**

People living in rural areas in South Africa are used to a certain lack of facilities. By no stretch of imagination is Nhlungwane rural: it is clearly part of the ever-growing conurbation of greater Durban. It offends, however, because it offers none of the usual amenities expected of urban life. In fact Nhlungwane has simply mushroomed as people who have been dispossessed of their land and homes in other places have sought refuge in what was once a rural backwater. They have built their own houses and shacks wherever they could beg or rent a small piece of land. There is a clinic at some distance but, save for the main highway leading past the area, there are no properly tarred internal roads. There is no regular refuse removal nor a postal delivery service to individual houses. Electricity is rare and has been installed at great cost by those wealthy enough to do so. One landmark dominates and this is the three-story ANC-built community hall which towers over the surrounding shacks. It is surrounded by a high fence and the key of the sturdy gate is kept by a caretaker who lives next door. Within the wire fence is a bank of post office boxes, witness to the failure of the post office to cope with either the rapid spread of shacks or the violence which is endemic in the area.

From our point of view Nhlungwane was an attractive site for research because there had been a fair amount of mobilization among women and many of the residents were single and running their own homes. This made them very vulnerable in economic terms, but also fairly independent and militant. A number of non-governmental organizations dedicated to economic upliftment, to 'development' and to political and social transformation, as well as the structures of the African National Congress, have been active in the area and it was possible to call a meeting of women without formally going through any male authority structures as we had done in KwaXimba. On our side was once again the fact that one of our research team was a high ranking member of the local ANC Women's League; her influence and presence at the initial meeting facilitated our entry to the community. Through her initial intervention the first community meeting focused on AIDS was called in the area. It was held in the recently completed community hall and people were informed of its time and purpose through the local ANC network. Although some men were present, the majority of the audience were women.

Having explained our project and intention we asked the women who had assembled to propose a liaison person to work with both us and themselves in AIDS education. The person who emerged was a mature woman with years of experience in community activism. Her command of English was not as good as that of the KwaXimba liaison people, but her
networking within the community was excellent and she had a wide range of contacts with older women and, incidentally, with men as well. In herself she is a community personage. She has also been and is seen in the community as being committed to 'community' work. In this sense her personality and personal history had much to do with the response to our intervention and to the course it took. Another lesson here for participatory intervention research: how much is the success of the method due to the luck of personality mix and personal initiative on the part of critical role-players?

**Empowerment - the female condom or jobs**

After the initial gathering our *modus operandi* in Nhlunwane was for the liaison person to call large women's meetings which drew on existing voluntary organizations and other informal groupings. At these one or more of the research team explained the purpose of the research, and introduced the critical issue of AIDS, HIV and the need for women to protect themselves; she then asked for comments and questions. The response was immediate and challenging. The existence of multi-partner sex was acknowledged without hesitation, but the women quickly analysed the barriers to protecting themselves. 'Bring us a female condom', they insisted, 'or give us jobs so we are not dependent on men'. They also pointed out that they had many problems to contend with: inadequate housing and shelter, no running water or electricity, few health care facilities, no vote or power to change this. It is not only in our perception that the answer to gender constraints on 'safe sex' lies in empowerment: they were only too aware of this as they are of the wider political struggle in which black South Africans are engaged. At the practical level, however, they spelled out the financial constraints governing their lives and came up with a few simple and practical suggestions: help with the purchase of sewing machines or a candle-making machine so that they could make money; and, of course, the female condom. The idea was to form co-operative working associations which would seek training together, and co-operate in the purchase of materials and possibly marketing. The project's liaison person was to be their facilitator.

**The candle-making project**

In the end, all that the group asked of the AIDS project was a small grant to buy materials and cover the costs of transport to make the necessary purchases to start the candlemaking project. The liaison person, using her considerable initiative, identified a local woman who owned a candle-making machine and who was willing to lend it for a few days, and to teach the new group how to use it. It was decided that the women would each pay a small sum into a common pool when they joined the group, but that they would get this back if they left the group. Those who could not afford this sum, but who wanted to join, were allowed 'credit' until such time as they made some money from the sale of communally produced candles. A small committee was formed but the major responsibility for arrangements fell on the shoulders of the liaison person who saw herself as working both for the AIDS project and generally for 'community development'. In fact her salary from the AIDS project covered some but not all of the the time and energy she expended on the candle-making project.

The making of candles is not difficult: having got the money to begin and after a demonstration and the loan of a machine, the project progressed well and began to generate some income for a core group of between ten and twenty women. Looked at in one way, this is, of course, a drop in the ocean of 'development' and, had the AIDS project continued we would surely have been approached with other similar requests. Other groups or lobbies would have emerged with their own demands and priorities. We have then to ask to what extent we could possibly have met these, or should have felt an obligation to do so.
The challenge to a participatory research model

In retrospect it is clear that the suggestions for forming a candle making-group, and the route that was taken in establishing the group, did not materialize from nowhere: the processes involved were part of the empowerment strategy and rhetoric of many development agencies which have been working in the region for some time. We were, in fact, being treated as another potential donor (virtually as an NGO) and as a resource to be tapped for money to enable some women to gain access to the skills and material base which would facilitate, if not 'jobs' exactly, at least the possibility of income generation. The challenge which this represented for the project was to sanction the use of research funds for a type of practical initiative never envisaged in the funding proposal; and one, moreover, with no direct link to either AIDS or heath promotion in even the broadest sense. This move, however, was where community involvement, and through that particular liaison person, participatory and action research, had led.

It was only after much discussion within our research team that we decided to accede to the request for 'seed money' to start the candle-making group. Reservations were expressed about what, to the medical people on the team, appeared to be an initiative only tangentially linked either to the objectives of the project or, indeed, to general health concerns. The anthropologists on the team were used to wide-ranging requests from research participants for practical assistance and, in keeping with their personal and professional belief in both the ethics and concrete advantages of reciprocity in research, they argued for the proposition. Their reservations lay in the doubt that, with the possible exception of the liaison person, any of the team had sufficient experience in development, and in applied work in the development field, to make the project a resounding success. They were persuaded, however, that if this was the way their community partners wished to proceed, the research team should accede to the request. In the end the logic of the participatory model persuaded all concerned. It was a judgement call, and even in the light of the fact that the group did not survive more than a year, we still believe that it was the right decision.

Reviewing the Woman and AIDS project

In mid 1995 two members of the research team returned to Nhlungwane. In contrast to what happened in KwaXimba, after the end of the Woman and AIDS project the liaison person at Nhlungwane has been employed by another non-governmental funded AIDS project. She has remained living near the community hall and has maintained her position in the ANC local political structures. Both her personal commitment to the role of community activist and the expectations of her new job take her into the homes of many of the local people. She is now a counsellor for people and the families of people with AIDS, but it is clear that she also still regards herself as an AIDS prevention educator. At a meeting which we held to demonstrate the female condom to Hlungwane women she arrived with a dildo and graphically took over demonstrations of the differences between male and female condoms. It is fortunate that her new job has carried on and deepened both her understanding of HIV/AIDS and, because her brief is to deal largely with the families of people living at Nhlungwane who are diagnosed as HIV positive by the largest referral hospital in Durban, she is heavily committed to AIDS as a continuing problem and is still associated with it in the minds of the community. The problem is that, as in the case of the Woman and AIDS project, her current employment is
only on a temporary contract. She is looking for another job and would clearly be attracted to one which is permanent, even if it were not in the AIDS field. Her undoubted skills as a community organizer and facilitator — which she has honed in her last two positions with AIDS education and care — will probably make her eligible for a number of positions which are in the Development rather than the AIDS and Health field. As at KwaXimba, this raises the problem of project sustainability in the face of a lack of civil service establishment posts for health personnel at the community level.

It might well be asked if her work over the last four years in the AIDS field has not served its purpose; are people, and particularly women, at Hlungwane not fully aware of the threat which HIV constitutes for them? We think that this may well be so. Certainly we found that women at the meeting which the liaison person convened for us were well aware of the threat which HIV infection holds for them and their children. When asked who was most at risk, they immediately replied that it was women, and commented that this was because their partners had other women and they, themselves, were dependent on men for support. As before they made the point that if they had jobs they would be able to refuse sex to men who refused to use condoms. The point was also made without prompting that women should be able to avoid unprotected sex with a number of men. ‘Poverty makes us to be prostitutes’, they said. Although most were not completely clear about the distinction between HIV positivity and full blown AIDS, this is by no means uncommon the world over. The connection between sex and particularly multi-partner sex and HIV infection was reiterated again and again. So was the fact that condom use prevents infection.

While, however, knowledge of risk and also of the role of male condoms in protection was generally present, when we asked if their partners were using male condoms, it was clear that very few were. This created some embarrassment as this response was clearly seen as reflecting poorly on them and on the liaison person. It led to a discussion of what are essentially the wider political problems of the area: poor housing and lack of employment. The point was made that there were numerous development projects in the area but they did not go to the heart of the problem. ‘They do not get us jobs... it is good to have women’s groups to help us but there is no group to support you when you are alone with your husband...’. One woman said then ‘it might be better if we had a female condom...’ and this led immediately to an excited discussion of the topic. One of us who has been active in promoting the female condom in the United States was able to describe the mechanism in some detail but the call was to ‘see one’. Hence the reiterated demand that we return with the female condom for them to see. On our next visit we did just that.

Although they are not readily available in Durban, we managed to borrow the demonstration kit issued by a well known brand of American manufactured female condoms from another researcher. The reaction was immediate and positive. About twenty-five women had collected in the Hlungwane community hall to meet us and after the demonstration they eagerly handled the condoms and jokingly practised using them on the dildo provided by the liaison person. When we cautioned that men might reject their use as they did the male condom, the women overrode our hesitation: ‘...we can use it and teach other people to use it ...it is better that you bring it quickly...and that it is free.’. This opened the way for a discussion once again of the problems which women face in the area, the lack of adequate housing and employment being paramount:

In these small two roomed shacks the children can hear everything...maybe it will be difficult to talk about this new kind of condom ...what we need is better houses.
It will be easy to use the female condom if you are working. You just say to your husband that you must not get pregnant or you loose the job. Even a woman can stay alone with her children if she has a job. So we need jobs.

...if we have this new condom we will get our men to use it ...it will help us a lot.

We are mostly relying on our husbands because of unemployment. The only way of leaving them is employment. If we earn money we have power .... if we can wear them we will be free.

Clearly the support for the idea of female condoms went hand in hand with notions of employment and independence from men. The fact that the women at Hlungwane were so responsive to the idea of female condoms was not unrelated to fact that they were already mobilized on the political front. Although they acknowledged very clearly their financial dependence on men, they believed that, given money, they would be in a position to call the tune in terms of HIV protection. Whether they are right or wrong, they believe that a different future and a different kind of relationship with men is possible. Although we could not revisit KwaXimba because of the violence in the area, we had never on our previous visits been made aware of a similar optimism and confidence. Nor did the field notes of any of our research team reflect such perceptions. While the KwaXimba women also called for jobs and money, they did not overtly take the next step in envisaging the possibility of a different gender dispensation in which these things might provide the basis for independence from male control, nor did they see the possibilities of the female condom in this respect. Cautious readers may believe that we are stretching our evidence too far, but they have not been present at meetings such as those held at Hlungwane where women demonstrate confidence in their ability to equal men — or live without them. Herein lie, we believe, the roots and evidence of gender empowerment.

It is, however, not only emerging empowerment with which we are dealing at Hlungwane. As suggested above, the women are seasoned political troopers. Female condoms, although available in some pharmacies in South Africa, are extremely expensive even for relatively wealthy middle-class women. The national AIDS program and the Ministry of Health intend to make them available free though clinic services, but there will be a delay of at least three months before this will occur. When we relayed this to the women at Hlungwane they were indignant:

You must tell the Minister (of Health) to send us female condoms first ... we need them here and we will show they can work.

Tell the Minister (of Health) to bring the female condom quickly ... if it should have come before we would have limited our families more easily...

After this they turned to another practical issue: the felt need for local women to be trained as community health workers. This is, in fact, part of the recently announced Health plan for the country and so, once again, we believe that the idea did not surface on its own. It is part of the political rhetoric of the ANC structures. In addition, of course, the women see the liaison person achieving well-paid employment as a result of her expertise and experience in the field of community based AIDS education, and these would like to be able to follow suit. A bone of contention in this respect concerned the age limit which is apparently being suggested for these workers — they have to be under forty:
There are lots of us who are older and who have much experience and are not too old to work hard.

Lessons from Hlungwane

What can we learn from the experiences recounted above? Most important, the women at Hlungwane felt able to make representations to government and we ended the meeting by writing a letter to the Minister. The women signed their names in an exercise book and spoke into our tape recorder so that 'she (the Minister) can know that no lies are being told'. While many of the women knew the Minister from her days in the local branch of the ANC, and the influence and leadership of the community liaison person was very clear, the women in the group were well aware of the fact that a political strategy was being played out. They had had experience of similar situations, and had been the beneficiaries of political mobilization before. In fact a concrete expression of the power of local political manoeuvring had been the building of the very hall in which we were meeting. At Hlungwane we suggest that political mobilization and gender empowerment reinforce each other. In the instance we have described, HIV/AIDS protection has been added to the equation. 'Bring us the female condom' might be taken as a symbolic statement of the social and structural transformation which is characteristic of some local shack areas where the space is available, both actually and figuratively, for women to create a 'New South Africa'.

The question arises, of course, why the same active response and willingness to try the female condom did not surface in KwaXimba. The main reason is that in that community the women, while active in women's organizations, had not made the move to active participation in the wider political arena. They had not been actively mobilized by the ANC, as shown by their reluctance to take public office without the permission of their husbands. In addition, most were living under the domestic control of husbands, fathers or other male guardians. Few had experienced great opportunities for independent money-making and, as they acknowledged, their main source of 'private' income was often in the field of either casual sex or longer-term sexual relationships. While the latter was also true of many of the women at Hlungwane, the geographical situation of the area so near to Durban means that there are more formal-sector jobs available to women and the informal sector is certainly more lively than at KwaXimba. Also, the fact that many women have no husband means that they must enter the labour market in some form. No doubt this experience is, in itself, liberating to a certain degree. Overall the positions of women in the two areas are qualitatively different.
Sexually transmitted diseases and condom interventions among prostitutes and their clients in Cross River State

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The Cross River State commercial sex worker project started in 1989 as a pilot program to test HIV/AIDS and sexually transmitted disease interventions among full-time and part-time sex workers, their partners and their clients. Three main locations were targeted: Calabar and Ikom in the Cross River State in the first phase of the program and Port Harcourt where outreach started in 1992 to test the replicability of the project outside the Cross River State. The project activities were co-ordinated from Calabar which is 200 kilometres from Ikom and 180 kilometres from Port Harcourt. Approximately 800 prostitutes and 2,000 clients in Cross River State have been reached through 17 sites (12 in Calabar and 5 in Ikom) for full-time sex workers and ten sites (6 in Calabar and 4 in Ikom) for part-time sex workers. In Ikom, a large population of paramilitary men, such as customs officials deployed at border posts between Cross River State and the Republic of Cameroon have been targeted. In contrast, of the 25 sites estimated for full-time and 15 sites for part-time prostitutes in Port Harcourt, only twelve were reached because they were more widely dispersed and prostitute groups were more diverse when gauged by social and economic indicators. The Port Harcourt project aimed to reach approximately 1500 sex workers and 3000 clients within an eight-month period, January to August, 1992.

Preliminary contact with prostitutes and their clients was made in 1987 in Calabar by members of the Cross River State AIDS committee. At the time, AIDS was hardly a topical issue for the generality of Nigerians. Primarily it was regarded as a subject of concern for prostitutes, foreigners, and Africans in East and Central African countries. It was not possible to initiate a formal project before 1989 because of financial constraints, resulting in a prolonged period of unstructured interaction with the target group. Nonetheless, this provided the opportunity to build understanding and trust and to sustain dialogue on issues of common interest with the target group. Also during this period, key members of the population such as ‘chairladies’ (leading prostitutes); their assistants; ‘policing agents’ responsible for maintenance of law and order and welfare of prostitutes; hotel proprietors and managers and others such as security agents with substantial influence or authority over the target population were identified, and their support secured. It became apparent through this interaction that the effectiveness of any HIV/AIDS and STD prevention and control program aimed at sex workers and their partners would depend on the active participation in project design and implementation of members of the target population.

The main objectives were to develop and implement an intervention program to reduce the transmission of HIV/AIDS and STDs among prostitutes, as well as their partners and clients, through providing STD services, condom promotion and health education.
Target population

This includes women in full-time prostitution, resident in hotels and compounds; part-time, non-resident prostitutes; clients and partners of prostitutes; and hotel owners and managers. Often, hotel owners and managers establish sexual liaisons with prostitutes in exchange for a wide range of favours.

Full-time prostitutes live alone or with their children and operate in easily identifiable sites with well defined community structures. These structures provide the basis for program implementation and sustainability. Low charges, approximately 50 cents per sex act, make it imperative for full-time prostitutes to entertain a large number of clients a day, ranging from two to twenty.

Part-time prostitutes who usually are low-income earners and students canvass for clients outside big hotels and night clubs. They lack a visible social structure and working norm, and often operate in small loosely organized groups. On the average, they receive one client per day and charge over six times more than full-time prostitutes for a sex act.

Description of intervention

A major problem at the onset of the intervention was the prevalence of misconception and apathy about HIV/AIDS and STDs, ignorance about condoms, and poor access to them, which were compounded by the poor state of available health information and services on these issues. To identify the specific knowledge gaps, and to determine the appropriate strategies for HIV/AIDS and STD intervention, the collection of baseline KAP data, focus group discussions and HIV seroprevalence survey were accomplished between 1988 and 1989. At the time approximately 1 per cent of prostitutes and 1.5 per cent of their clients were HIV-infected. No baseline data were available on the prevalence of other STDs. A project which focused on HIV/AIDS and STD prevention and control was overwhelmingly endorsed by the sex workers, and enthusiasm to participate was expressed by key members of the target group. These discussions buttressed earlier presumptions that health promotion activities would best be served in this population if tied with actions which responded to the perceived needs of prostitutes. These prompted the inclusion of additional activities including advocacy of reducing official harassment and extortion; welfare activities for children; improving the hygienic conditions of the hotels and compounds where the women live; and later skills training.

A project with three main components was subsequently designed and implemented with the following strategies.

(1) Health Education: on-site educational sessions held in the hotels and compounds for prostitutes and clients; group discussions with key members of the target group; film shows and distribution of materials, including condoms, in hotels and night clubs for part-time prostitutes; outreach to all project sites by male and female peer educators; HIV/AIDS and STD educational workshops for all members of the target population.

(2) Condom promotion and use were based on an initial distribution of free condoms through peer educators to all project sites and at the STD clinic. This was later replaced by a cost recovery arrangement which allowed condom vendors (‘chairladies’ and managers) to earn a small profit from sales. Stressing the benefits of regular condom use and the savings made from avoiding the practice of habitual self-medication with expensive antibiotics (normally used prophylactically for STDs) enhanced the acceptability of use of condoms.

(3) STD services dispensed through a project clinic encouraged early diagnosis and treatment of STDs and also provided a range of other clinical and preventive services including counselling. The ‘Special Clinic’ was set up with the support of the State Ministry of Health, which provided staff and equipment. The Clinic name and hours of operation were
determined by the target community, and in the first year it only admitted prostitutes and their clients. By the second year the Clinic was open to the public following decisions reached by the community members. Clinic attendance by prostitutes and clients was stimulated by adopting a number of approaches. These included the referral of clients through prostitutes.

**Sexual behaviour**

**Women's practices**

At the baseline survey, many prostitutes (40%) reported having more than five different customers per day, and 37 per cent reported between four and five customers. At the follow-up survey, 52 per cent reported having 0-5 customers in the last two days. Forty-nine per cent reported more than five customers in the last two days. The most common sexual practice for prostitutes was vaginal intercourse (97%). Very few reported other sexual practices.

Nearly half (47%) of the prostitutes at follow-up reported having worked in commercial sex for 1-2 years, and 38 per cent had worked for less than one year.

**Clients' practices**

It was evident from client reports at the baseline survey that frequent contact with prostitutes over a period of years was quite common for the population surveyed. Thirty-seven per cent of the men had visited prostitutes for 1-5 years, 31 per cent 6-10 years, 32 per cent for eleven or more years. Clients most frequently reported having between six and ten contacts (35%) per month. Twenty-nine per cent of men reported having 11 and 15 contacts per month, and 26 per cent reported between one and five contacts per month. At follow-up, men reported on the number of sexual encounters with all partners (including spouses and girl-friends) in the past week: 37 per cent of the men reported 0-1 sexual encounters, 36 per cent reported 2-3, and 27 per cent reported four or more. Because questions on the level of sexual activity were asked differently at baseline and follow-up, it was difficult to determine whether there was a change in the number of partners, although it appeared that the number of partners per week did decrease somewhat.

Men reported on the type of sexual encounters at the base-line survey. All of the clients reported practising vaginal intercourse, half reported oral-genital intercourse, and only two per cent reported practising oral-vaginal or anal intercourse.

**Male-female comparison**

Prostitutes had more sexual partners per day than the men, which was expected given the nature of their occupation. Both groups reported the most common sexual practice was vaginal intercourse. However, many more men than women reported oral-genital intercourse as practice.

**STD knowledge, history and treatment**

STD knowledge was measured at the baseline survey for both sex workers and clients. When they were asked to list which sexually transmitted diseases they knew, gonorrhoea was the disease most frequently mentioned (97% of women and 96% of men), followed by AIDS (17% of women; 34% of men). Knowledge of other STDs was quite limited. Only 14 per cent of prostitutes and 29 per cent of their customers listed syphilis, five per cent of prostitutes and 17 per cent of customers listed chancroid, and none spontaneously listed herpes or chlamydia.
High recognition by sex workers of gonorrhoea as a sexually transmitted disease may be related to prevention behaviour, as 96 per cent of them stated that they examined their customers for gonorrhoea or discharge.

At baseline, few prostitutes (14%) reported having had an STD in the past two years; 81 per cent of clients reported ever having had an STD.

When an STD clinic was established in Calabar for prostitutes and their clients in December, 1989, there was a demand for one in Ikom and this was established in 1993. There was no charge for examination and tests, but women and clients did pay for medicine and treatment. While 76 per cent of clients and 93 per cent of prostitutes were aware at the follow-up of the existence of the clinic, only one per cent of the men stated that they had attended the STD clinic established as part of the intervention. However, clinic records indicate that men are in fact attending the clinic. Eighty-seven per cent of prostitutes stated that they had attended the clinic.

### AIDS knowledge

#### Transmission

Knowledge of modes of transmission of HIV was measured for both groups at baseline and follow-up. While knowledge at baseline was low for both sex workers and clients, the men demonstrated greater knowledge than the women of sexual transmission (65% and 29%), transmission through dirty needles (15% and 3%), and vertical transmission from mother to child (4% and 2%). This discrepancy between prostitutes and clients remained at follow-up for knowledge of dirty needles as a mode of transmission (51% of clients, 8% of prostitutes) and mother-to-child transmission (25% and 4%), but a greater number of prostitutes than clients identified sexual intercourse as a mode of transmission at follow-up (90% and 61%). This was probably due to the intervention's intensive focus on sex as a mode of transmission.

Increases in knowledge of sexual and needle transmission were significant between baseline and follow-up for both men and women. Prostitutes' knowledge of sexual transmission increased from 29 to 90 per cent while the percentage of clients who identified this mode of transmission increased from 65 to 81.

A high percentage of prostitutes and clients at follow-up recognized that healthy people can transmit the AIDS virus (96% and 83%), compared to only 45 per cent of prostitutes at the baseline survey, when this question was not asked of clients.

#### Means of protection

Means of prevention were also identified at follow-up. Eighty-eight per cent of sex workers and 59 per cent of clients mentioned condom use as a method to prevent AIDS. Abstinence was identified as a preventive measure by 42 per cent of clients at follow-up; however, only one per cent of prostitutes mentioned abstinence as a method of avoiding AIDS. It seems logical that women in the sex industry would be unlikely to readily identify abstinence as an important prevention activity, as commercial sex is their primary or sole source of income.

#### Risk perception

Prostitutes and clients were questioned at baseline and follow-up whether they were worried about getting AIDS. A higher percentage of prostitutes reported concern about AIDS, both at baseline (84% of prostitutes and 68% of clients) and at follow-up (95% and 76%).
There was an association between ever-use of condoms and risk perception for clients. Seven per cent of clients at baseline who reported having used condoms were worried about AIDS, while only 31 per cent of those who had not used condoms were worried about AIDS. At follow-up 85 per cent of male condom users perceived themselves to be at risk, compared with 44 per cent of non-users.

This association was not apparent among prostitutes at baseline; 84 per cent who had ever used a condom perceived themselves to be at risk and 74 per cent of those who had never used a condom felt at risk. It is possible that prostitutes perceived themselves to be at risk because of their work, regardless of their specific sexual behaviour. Clients have been less likely to feel at risk.

**Condom use**

**Sex workers**

At baseline, 77 per cent of the women had ever used a condom, while at follow-up 97 per cent had used a condom at least once. The frequency of condom use also increased at follow-up. At baseline 11 per cent of sex workers always used condoms; at follow-up 23 per cent always used condoms. The number of prostitutes who sometimes used condoms increased sharply between baseline and follow-up, from 24 to 61 per cent. The percentage who did not often use, or never used, a condom decreased between baseline and follow-up, from 62 to 16 per cent.

**Clients**

There was also a slight increase in ever-use of condoms among the clients at follow-up, although the increase was not as large as among sex workers. Sixty-eight per cent of clients said that they had ever used a condom at baseline; 76 per cent reported ever-use at follow-up. The frequency of use actually decreased from baseline to follow-up although the decrease was not significant. At baseline eight per cent said that they always used condoms, and at follow-up four per cent reported consistent use. Similarly, 37 per cent reported that they sometimes use condoms at baseline, and 33 per cent reported this at follow-up. However, the number of clients who reported that they never used condoms decreased from 34 per cent at baseline to 29 per cent at follow-up.

**Relation to AIDS knowledge**

Condom use appeared related to the respondents' level of AIDS knowledge. While a higher percentage of prostitutes using condoms frequently than those using condoms infrequently were aware that AIDS could be transmitted sexually, there was a much greater relationship between level of condom use and AIDS knowledge with the client population. At baseline, only 49 per cent of clients using condoms infrequently knew that sexual intercourse was a primary mode of transmission, while 89 per cent of those using condoms frequently knew of this route of transmission.

Similarly, at follow-up 79 per cent of clients using condoms infrequently correctly recognized sexual intercourse as a mode of transmission, while 91 per cent of those using condoms frequently responded correctly. This suggests that if prostitutes and clients were aware of sexual intercourse as a primary mode of transmission, they may have been more likely to use condoms. Conversely, those men who use condoms frequently may have been more likely to learn about the possible role of sexual transmission.
Barriers and reasons for success

The major obstacles experienced occurred during the early part of the project. These included apathy to HIV/AIDS; lack of confidence and trust of project staff; lack of co-operation of hotel owners and managers; non-co-operation by clients or partners; irregular supply and poor quality of condoms; low self esteem of sex workers; self-medication; and reluctance to use condoms. While many of these have been satisfactorily addressed, adequate access to clients and partners, mobility of prostitutes, and an increasing influx of young girls into prostitution pose new challenges. The sale of condoms, though widely accepted, is hampered by the inability of prostitutes to purchase large numbers of condoms, making accounting and record-keeping tedious. The outreach program in Port Harcourt faced logistical problems, given the distance between areas with large pools of prostitutes.

The key reasons for the success of the program could be the following.
(1) The extensive period of interaction with the target population and its involvement in major decisions and activities of the program. Additionally, this interaction allowed the promotion of community cohesion and setting up of relevant bodies such as the 'chairladies' group and the hotel owners association with a mandate to discuss and decide on program issues.
(2) The ability of project staff to respond to delicate matters such as police arrest or detention, harassment and extortion, and their advocacy of appropriate rents and facilities for resident sex workers and higher charges for sexual services to reduce the number of clients per day.
(3) Official endorsement and support of project was an important factor in reducing stigma, marginalization and interference, and also helped to build confidence.
(4) The flexible approach adopted in the implementation of activities proved very useful, and allowed for greater participation in decision-making and reformulating aspects of the program which were not yielding satisfactory results.
(5) Through its response to the perceived needs of the community, the overall good intentions of the program became evident and attracted more co-operation. A narrow health focus among a population which had suffered a lot of marginalization and stigmatization was regarded as inappropriate to effectively mobilize the community for the program.

To conclude, the Cross River AIDS Committee intervention among prostitutes and their clients in Cross River State has provided a community-based model for intervention aimed at controlling the spread of HIV/AIDS and other sexually transmitted diseases. Condom promotion constitutes an important part of any strategy for prevention and the acceptability of condoms by prostitutes can be guaranteed when they are made affordable and available and the women themselves see a clear health and economic reason for using them regularly. Whereas prostitutes can be reached quite readily and are amenable to program interventions, the same cannot be said of their partners and clients. Specific strategies such as using motivated prostitutes, hotel managers, peers and outreach workers are useful ways of reaching this subpopulation.

It is also important to promote a program which includes the development of vocational skills to ensure that women in sex work do not depend exclusively on exchange of sex for money but are able to earn additional income through other options. A literacy component which includes literacy skills and reproductive health education has been introduced to build self esteem and allow women to understand in a holistic manner issues around reproductive health covering HIV/AIDS and STD; family planning, unsafe abortions, self medication and infertility. A community approach in our experience provides the best way to ensure that the program can be sustained long after donor grants become unavailable.
HIV/AIDS education and counselling: experiences from Ghana*

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The emergence of HIV/AIDS in sub-Saharan Africa presents a challenge not only to public health paradigms but also models for public health education. Although the nature and spread of the disease have common features with a number of known diseases, the initial reactions to the disease have contributed to produce what Jeanneney (1987) refers to as 'a collective emotional hysteria' characteristic of the debate on syphilis in the early part of the twentieth century.

Fear and ignorance associated with the hysteria have led to various reactions such as panic, scapegoating, stigmatization and denial (Jeanneney 1987; Awusabo-Asare and Agyeman 1993). As with some previous epidemics, the strategy has been to make factual and understandable information accessible to people (Carballo and Kenya 1994). The basic philosophy is that people should not die from ignorance.

For sub-Saharan Africa, some of the pertinent questions are: how do we provide culturally relevant and socially acceptable information within the existing socio-economic constraints? Given the high illiteracy rate how should information be presented so as to reach as many people as possible? How should audience segmentation be approached in view of the limited resources available for educational campaigns on HIV infection? What are some of the socio-cultural constraints to the counselling of AIDS patients and their relations?

The aim of this paper is to describe some of the approaches adopted in three settings in Ghana to provide community education and counselling for communities, patients and their relatives on HIV/AIDS infection. The three areas are Berekum District of Brong-Ahafo Region, Manya and Yilo Krobo Districts of Eastern Region and Assin District of Central Region (Figure 1). The services are operated from the Berekum Holy Family Hospital, the Agomanya Saint Martin de Porres clinic and the Assin Fosu Saint Francis Xavier Hospital. All three hospitals belong to the Catholic Church.

HIV/AIDS education and counselling

Nearly a decade and a half after the outbreak of HIV infection, education continues to be the main strategy available for controlling the spread of the disease. The aim is to change people's attitudes not only towards the disease and infected persons, but also to the adoption of lifestyles that will not predispose people to infection. The latter is meant to motivate

* The Ghana segment of the Social Dimensions of AIDS in Africa Project has been financed by the Swedish Agency for Research and Economic Co-operation with Developing Countries (SAREC). The project has also received institutional support from the National Centre for Epidemiology and Population Health (NCEPH) of the Australian National University. I am grateful to J.C. and P. Caldwell for their support.
Figure 1
Ghana: administrative regions and study areas

people to either avoid or shift from what is now referred to as 'risky behaviour' (Orubuloye, Caldwell and Caldwell 1992; Anarfi and Antwi 1993). Advocating behavioural change to prevent the spread of the disease, particularly in sub-Saharan Africa, is based on at least three reasons. First, a 'fix-it' approach through biomedical prevention and intervention is not possible in the next five years or so, particularly with the withdrawal of the United States from the mass immunization trials (WHO 1992). Secondly, even if a cure is found, African countries, confronted with major economic crisis, poor infrastructure (including health) and other health problems are less likely to benefit, at least initially, from any technological
breakthrough. Thirdly, even when a cure becomes available education will continue to be an important aspect of any prevention program.

The first set of information, education and communication (IEC) on health promotion is always in the form of general education through the mass media: television, radio, newspapers, distribution of leaflets etc. This is based on the model of an initial general information (through the mass media) to be later reinforced by other sources of information flow, and with person-to-person contact (counselling) at the bottom of the spiral of IEC activities (Figure 2). The general assumption is that

Mass media channels are often more effective at creating awareness and knowledge of a new idea, whereas inter-personal channels are more important in changing attitudes and social norms concerning the adoption of new behaviours (Lamptey and Coates 1994:522).

The initial IEC on HIV/AIDS gave basic information about the aetiology and mode of transmission of the disease. Subsequent messages have been geared towards achieving behavioural change, and dispelling rumours and misconceptions about the disease. As observed in other parts of the world, serious misconceptions abound about the origin and transmission of the disease. Witchcraft, act of God, punishment for disobedience, insect bites, continue to be quoted as sources of HIV infection in Ghana (Ametewe 1992; Anarfi and Antwi 1993) similar to those reported by Carballo and Kenya (1994) in other parts of sub-Saharan Africa.

Figure 2
Spiral of IEC activities

Adopted from Pistrow (1987:16)

Counselling is a relatively new concept in the overall health care system not only in Ghana, but also in the health care delivery system of a number of African countries (Ego and Moran 1993; Lamptey and Coates 1994). Generally, counselling in the health system in sub-
Saharan Africa has been mostly in the form of advice from ‘experts’ to patients and their relations.

On the other hand, within the traditional African system, counselling is offered informally by a plethora of people depending upon the situation and circumstances. These include parents, some family members, traditional healers and other influential persons within the community. For instance, Twumasi (1975) observed that in Ghana some amount of counselling exists within the traditional healing system. Counselling forms part of the holistic approach to healing. But, as pointed out by Lamptey and Coates (1994), the impact of traditional healers on preventive health care is yet to be systematically described.

The demand for counselling has become more pressing given the nature of AIDS and the inadequacy of the existing support services for sick people generally. Providing medical care in Ghana is itself a major task. The health system is plagued with shortage of staff, inadequate remuneration for the few overworked staff, poor logistic support (e.g. vehicles, equipment) and shortages of essential items. The 1991 *Annual Report* of the Epidemiology Division of the Ministry of Health, for instance, noted that guinea worm eradication in the Volta Region ‘ran into transport difficulties making it impossible to cover all sites regularly on a monthly basis...’ (Ghana, MOH 1992a:31), and ‘One of the factors identified [to hinder the clinical management of HIV/AIDS infection] was the perennial shortage of disinfectants, globes and other supplies’ (Ghana, MOH 1992a:37). Any program on HIV/AIDS education and counselling in sub-Saharan Africa will have to not only confront long held beliefs and practices, rumours and misconceptions, but also deal with basic institutional and logistic problems. Evidence on these aspects abounds from campaigns on issues such as family planning, female genital mutilation and STDs.

### Intervention strategies

Since the outbreak of the disease, various behavioural and biomedical intervention strategies have been developed or suggested to address the challenge posed by the disease. Table 1 attempts to summarize some of the intervention strategies adopted so far. These range from community-based strategies meant to sensitize whole communities, through small-group intervention programs, to approaches targeting the individual. While it is not easy to measure the effectiveness of the various strategies and approaches, they represent the attempts being made to stem the spread of the disease and to bring relief to those already infected.

<table>
<thead>
<tr>
<th>Intervention strategies</th>
<th>Target</th>
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<tbody>
<tr>
<td>Community level intervention</td>
<td>Entire communities, Peer-based, e.g. truck drivers, Identifiable groups - e.g. religious groups etc. Opinion/Community leaders</td>
</tr>
<tr>
<td>Small group interventions</td>
<td>Health care based, e.g. STD clinic attendants; needle-exchange patients, Work-site/group location-based, e.g. workers at work sites; street youth</td>
</tr>
<tr>
<td>Individual level</td>
<td>One-on-one counselling</td>
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Derived from Lamptey and Coates (1994)
National response to HIV infection in Ghana

Ghana acknowledged the potential public health hazard associated with the disease even before the first case of HIV-seropositivity in the country was diagnosed in 1986. In 1985, the government set up the National Technical Committee on AIDS. The Committee was charged with the responsibility of developing strategies for the prevention and management of HIV infection in Ghana: one of their immediate tasks was the establishment of an HIV/AIDS surveillance system. Guidelines for AIDS prevention and control were developed through the Epidemiology Division of the Ministry of Health in the mid-1980s and subsequently revised and expanded in 1992 (Ghana MOH 1992b). One of the strategies put forward in the initial document was the formation of District AIDS Committees within the Primary Health Care structure.

As indicated above, the first case of AIDS was diagnosed in Ghana in March 1986. Only 26 cases were reported by the end of 1986, but the number rose to 3,140 in December, 1991 and by September, 1993, the number of reported cases was 11,835. With the increase in the number of reported cases, districts began to set up AIDS committees. The scope and nature of activities of these committees vary greatly. There are a few that have developed intervention strategies in response to the number of diagnosed cases in the district. The intervention strategies adopted by three of such districts in the country are described in the next section.

Community-based care at Agomanya-Krobo

The community-based care of the Krobo district, originally known as the Domiciliary AIDS project, is based at the St Martin de Porres Clinic at Agomanya. Initiated by a team of medical personnel from the Korle-Bu Teaching Hospital in Accra in 1987, the project is aimed at studying the epidemiology of the disease in the district and assessing the efficiency of two herbal medicines from Korea and Zaire. The two districts were chosen because in 1987 the areas had reported the highest number of AIDS patients in the country. In fact, even so far the district has the highest incidence of HIV infection as well as the highest HIV prevalence rate among pregnant women attending prenatal clinics in Ghana (Antwi personal communication). This is not strange since females from the area have been found to predominate in the commercial sex trade both in and out of Ghana (Anarfi 1990).

Between 1987 and 1988, community and public health nurses and paramedics in the Yilo and Manya districts assisted in mobilizing 210 patients through churches and community members. These patients were identified, treated and followed-up in their homes. Most of the patients died and the project lost contact with the rest because of stigmatization (Safo 1993a,b). The lessons learnt led to an expansion of the project to include home-based care and with the following objectives:

1. To involve community members in education and support for HIV/AIDS patients and their relations;
2. To provide care for AIDS patients at home in order to avoid isolation and discrimination;
3. To use the home visits to educate the other household members and the immediate community about the disease;
4. To provide avenues for training and income-generating activities for the youth in the area as well as some of the HIV-seropositive patients.

The strategies adopted to achieve the above objectives are:

1. Case identification and follow-up;
2. Pre- and post-testing counselling for patients;
3. Pastoral care;
4. Social and economic support services: financial support for patients, support for the children of some patients in school, income-generation activities;

5. Community and small group education.

The team at Agomanya is headed by a Ghanaian medical officer who is a nun; because of her background she has been able to attract support from various sources in and out of the country. The project receives support from the hospital itself, individuals in Germany and the Medical Institute of Wurzburg. The Institute has consistently provided grants, and items such as reagents for testing and gloves. The Canadian International Development Agency also paid for two cassava-grating machines, two corn-mills and 100 bee-hives through the Ghana Regional Appropriate Technology Institute Services. In spite of these sources of funding, the project faces financial problems.

The continuity of the project, the first in the country to study and institute a community-based intervention project on HIV/AIDS in Ghana, will depend upon the continuous support and goodwill of its benefactors.

The Berekum Project

The community education and counselling activities in the Berekum district of the Brong-Ahafo Region are based at the Holy Family Hospital at Berekum, the town from which the district derives its name. The district borders Côte d'Ivoire, a location which has implications for the spread of the disease in the sub-region.

The Holy Family Hospital is the designated district hospital and has a Nurses Training School and a Midwifery Training School, the only nursing training institutions in the Brong-Ahafo Region (Ego and Moran 1993). The estimated population of the district in 1991 was 110,000. Given its location, it serves more people than those in the district.

In 1991 and 1992, 123 and 202 HIV-seropositive patients were diagnosed at the hospital (Ego and Moran 1993). The increasing number of HIV-seropositive patients prompted the beginning of the intervention activities. The project on community education was started in the late 1980s by two American nuns, one a nurse and the other a psychologist. As in the case of the Agomanya-based project, this also involves:

1. Case identification and follow-up;
2. Pre- and post-testing counselling for patients;
3. Pastoral care;
4. Social and economic support services: financial support for patients, support for the children of some patients in school, income-generation activities;
5. Community and small group education.

The activities at the Hospital are supported by a number of international organizations, notably the Catholic Bishops’ Conference of Germany and the Catholic Organization for Overseas Development.

The project at Berekum has one of the best developed counselling services because of the involvement of a psychologist. They have produced a manual on home-based care. A feature of the counselling service at the hospital is the addition of emotional support for the staff involved in the counselling service.

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1 This section draws on Ego and Moran 1993.
The community-based project at Assin-Fosu

This project is based at St Francis Xavier Catholic Hospital at Assin Fosu in the Central Region. The town is located about 80 kilometres north of Cape Coast. The district, the largest in the region, shares boundaries with a number of districts in adjacent regions.

The project started in 1990 with the formation of a District AIDS committee. Initially the project concentrated on community education, management and follow-up of HIV-seropositive patients. In 1991, some of the patients asked not to be visited at home because of the stigma. In response, the management set up a pastoral care team in 1992. The approach is to visit and pray with all sick people and the elderly in a given community but target AIDS patients for counselling, care and support for the carers. The view of the hospital management team was that ‘We shall be associated with any licit effort aimed at assisting AIDS patients and promoting good pastoral care for the people infected with HIV’ (Sanz et al. 1992:2). In 1991, the SAREC team in Ghana teamed up with the District AIDS Committee in community education and counselling. As in the other projects Catholic organizations in and out of the country support the project.

Discussion and conclusion

The strategies described constitute major innovations in public health education and counselling in Ghana. Pettigrew, Ferlie and McKee (1992) have identified four potential and alternative sources for initiating change in a health system. These are: social and social movement organizations; District Health Team members; general management; and individuals (clinical product champions). While it may not be easy to identify the source of innovation the breakdown provides an important starting point for analysing the source of innovative action.

The project at the St Martin de Porres clinic was initiated by a team of medical doctors based at the Korle-Bu teaching hospital in Accra in 1987. The initial impetus, therefore, was innovation injected from outside. These were individuals who championed a certain course of action. While the Berekum project was initiated by the management, that of Fosu was by the AIDS Committee. These represent different sources for innovation. In Ghana, the contribution of social organizations to AIDS education and counselling is yet to be developed.

All three projects depend on external assistance. This has implications for continuity and sustainability. This is a critical issue for a number of projects of that nature. Religious or spiritual support is also an important element in the counselling, an issue important for medical personnel. These are ‘private’ initiatives; governments need to examine how these can be extended. But, in general, replication of small-scale initiatives tends to have more complications than can be envisaged. In spite of these problems, these offer prototypes of intervention programs that can be used in HIV/AIDS education.

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Intervention strategies suggested by the Nigerian segment of the SAREC program on sexual networking, STDs and AIDS

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The primary purpose of this paper is to survey the behavioural findings of the Nigerian program and to draw conclusions about the most needed interventions, and those most likely to be successful, in combating sexually transmitted diseases and HIV/AIDS. The emphasis is on the reduction of transmission of these diseases, partly because the number of Nigerian AIDS cases is as yet much smaller than was feared when the research program began.

The Nigerian program began in 1989. It has always had two components. The first is a field research program, largely but not entirely focused on Ondo State; it was originally based in the Faculty of Social Science, Ondo State University, Ado-Ekiti, and has since been transferred to the University's Centre for Population and Health Research\textsuperscript{1}. Parallel to this work, there had been developed a research program initiated by the West African Research Group on Sexual Networking (WARGSN). This Group has comprised 20 researchers based in 15 institutions, mostly in Nigeria and Ghana\textsuperscript{2}.

Finally, the paper refers briefly to experience reported by the SAREC programs in Ghana and Uganda which have as yet no parallel in Nigeria, but which are important for a comprehensive examination of the situation.

The research program supports a few broad generalizations which are on a scale greater than can be met by any specific intervention, but which should be mentioned first.

The first is the level of multi-partnered sexual behaviour. The level of such behaviour is probably no greater in sub-Saharan Africa than among specific groups in the West, such as those found on university campuses. The latter experience a lower level of persistent STDs and HIV/AIDS, not because of lower levels of sexual activity but because higher incomes allow a level of treatment and of hygiene that controls the situation.

The second generalization is that the different levels of HIV/AIDS in East Africa and Nigeria are not explained by very different levels of sexual networking nor even by a greater recourse in some East African cities to prostitutes with very large numbers of clients. There are other factors involved, possibly different levels of Genital Ulcerating Diseases (GUDs), perhaps particularly chancroid, and perhaps male circumcision (Caldwell and Caldwell 1993).

\textsuperscript{1} Much of the research of this program is reported in a volume of collected papers, Orubuloye et al. 1994.
\textsuperscript{2} Some of this research appears in a volume of collected papers, Caldwell, Santow et al. 1993.
Nevertheless, two conclusions can be drawn. The first is that the major protection available in sub-Saharan Africa against HIV/AIDS, and probably most STDs, in the foreseeable future is sexual behavioural change. This may be attainable while Western levels of income, medical services and education systems are not. Nevertheless, access to health services in Nigeria has been limited by the application of the user-pays principle as part of the economic structural adjustment program; and access to schooling, especially of girls to secondary schooling, has become more difficult. Real living standards would rise, and the chance of controlling STDs and HIV/AIDS would increase, if the adjustment programs could be altered so as to return to something approximating the health charging system and the distribution of schools of a decade ago. The stress on schooling is made here because the evidence is clear that the more educated are more aware of the behavioural link with AIDS, more certain that AIDS is at present incurable, and more sceptical of the thesis that personal misfortune is largely predestined and beyond human control. Finally, the situation would probably be improved if African governments could prevail upon Western governments and international organizations to provide assistance to combat STDs on the same scale as has been the case with family planning programs. Indeed, both programs might be more efficient if there were a degree of fusion.

**Findings of the Ondo State research program**

The program has demonstrated that sexual networking can be accurately researched providing that the right methodology is employed and that the social science is of adequate calibre (Caldwell, Orubuloye and Caldwell 1994). In terms of interventions, this means that there are good reasons for governments and international organizations funding such research and putting into place mechanisms for ensuring adequate standards. This is necessary to provide indisputable evidence on which to base government programs and to supply information services and the media with unchallengeable facts. The media do have a sense for what is probably correct and their messages carry greater conviction if they believe the findings and can quote respected sources. Much the same can be said for convincing public servants and politicians that programs should go forward. In addition, intervention programs will need adequate baseline data and adequate subsequent re-surveys if the effect of interventions is to be convincingly measured. Only such measurement will establish the cost-effectiveness, or just the effectiveness, of such interventions so as to make revenue go further and maintain the morale of those participating.

Research on sexual networking in the Ekiti District (Orubuloye, Caldwell and Caldwell 1991) showed that premarital and extramarital sexual activity was at a level high enough to sustain the STD epidemic and probably to sustain an AIDS epidemic. It demonstrated higher levels of non-marital sexual activity among the single than the married, and higher levels among monogamously than polygynously married men, partly explained by the sexual unavailability of wives during the period of postpartum abstinence. It also showed that a high proportion of women had semi-permanent sexual relationships in order to get economic support. Nevertheless, an increasing number of women in urban areas and most men everywhere who practise non-marital sex have multiple sexual partners for the enjoyment and thrill of the experience. The research showed that informational interventions must, above all, be targeted at young males, especially single ones. This may well mean identifying institutions and places where they congregate. Clearly, there is also an argument for providing alternative sources of economic support for women, but this is necessarily a long-range strategy depending on the growth of the economy. The research also demonstrated the need for wives to be sexually available for a higher proportion of their married lives and
Intervention strategies suggested by the Nigerian segment of the SAREC program

hence the need for governments and family planning programs to stress the wisdom of substituting contraception for postpartum abstinence.

Research in Ondo Town and adjacent rural areas (Orubuloye, Caldwell and Caldwell 1992) confirmed that the majority of men's non-marital sexual relations were with women who were not regarded as prostitutes. It also showed that most adolescent girls have sexual relations with male partners of a similar age, but that some seek older well-off men as partners to help with the cost of schooling and fashionable clothes. The research demonstrated that most men underestimate the extent to which their non-marital sexual partners have other sexual partners and hence they underestimate the health dangers of the relationships. The research confirmed the strong cultural pressure on wives to ignore the extramarital sexual activity of their husbands and hence to play no role in its control. One of the implied interventions is the need for schools to stress the danger to girls of 'sugar-daddy' relationships. Ways should be found for keeping schooling inexpensive and for placing less emphasis on the standard of pupils' clothing. Informational services have to stress that men often know much less about their partners than they think they do. In the longer run, women will have to be empowered to realize that they must protect themselves by exerting some control over their partners' sexual activities with other women. This is a direct attack on the culture and will take time, but it should be begun in schools, in women's groups and in the media.

Research on changing patterns of sexual activities over the course of the present century (Caldwell, Orubuloye and Caldwell 1991) demonstrated the move towards a greater level of commercial sex with increasing urbanization and monetization of the economy and with less access to partners within the family system. It also demonstrated the demand amongst unmarried young men for sexual activity arising from the late age of male marriage, itself partly a by-product of the polygamous society.

There is, at least in health terms, a need for earlier marriage for men and a smaller age gap between spouses. Over the longer term it may be possible to encourage this but it is certainly not a high-priority urgent intervention in that change will be slow if it occurs at all.

An important research project was on the degree of control women exert over their relations with their partners when the latter are suffering from a sexually transmitted disease (Orubuloye, Caldwell and Caldwell 1993a). The research certainly appeared to show a considerably greater degree of control over their sexuality in marriage than has been reported in East and Southern Africa. In fact, the greater risk to women was shown to arise not from their lack of control, but from their unawareness of their spouses' condition. This was a product of their ignorance of STD symptoms, their inability to examine their husbands for symptoms, a lack of adequate communication between spouses, a lack of blame upon husbands for infecting wives, and a lack of appreciation by both partners of the seriousness of STD infection. Few men or women could identify any STD other than gonorrhea. There was a deep suspicion that condoms could easily be penetrated by the vicious pathogens that caused such unpleasant conditions as STDs and AIDS. The long-term basic intervention must again be the empowerment of women. Society as a whole must be encouraged to feel greater horror and hostility over the infection by one spouse of the other with an STD. There is an immediate need for much more knowledge about STDs and for a greater density of places where they can be treated and from which information can be derived. The health and family planning providers must emphasize the high level of protection that condoms provide against STDs and HIV/AIDS.

The research program identified and investigated occupations at high risk of STD and HIV/AIDS infection, such as truck drivers and young itinerant market women (Orubuloye, Caldwell and Caldwell 1993c). Drivers were found to be at high risk because of the time spent away from home, their high incomes, their need for company and a bed at night stops,
and the need for poor communities along the highways to tap some of the wealth from those roads. An associated project (Omorodion 1993) found all market women, especially those who travelled distances to purchase goods or to sell them at markets other than their own, to be at higher than average risk of unsafe sex and infection. The Ondo State project (Orubuloye et al. 1993c) found that young itinerant hawkers plying the roadside and lorry parks of Ibadan (in Oyo State) were at particularly great risk. Three-quarters of them were under 23 years of age and half were under 20 years. Many men assumed that the young women sold sex as well as goods, particularly as they frequented the lorry parks which can be rough and dangerous places. They had little of the protection that older and usually married women holding stalls in the adjacent market get from density of sellers in the market. They were surprisingly ignorant about how to protect themselves from disease or conception. Interventions are easiest for these groups because of their ready identification and the fact that they congregate in certain places. Drivers can be given information and condoms in the lorry parks or at their places of employment by welfare organizations, drivers' unions or their employers. Itinerant traders can be found in lorry parks though, in their case, the intervention agents should also be offering some kind of support or welfare services as well as more general family planning advice and provision of contraceptives.

A large collaborative research project gathered information on commercial sex workers in six cities of Nigeria (Orubuloye, Caldwell and Caldwell 1994b). It found that there was no likelihood of reducing the flow of young women into the occupation because it was relatively lucrative compared with the incomes from other occupations, was favoured by many over traditional farming or trading, and subsequently did not result in prohibitive social sanctions. It was found that many of the young women involved were attempting to use condoms but received little support and no pressure to use them from the owners or managers of the establishments where they worked. The pattern for interventions here has been clearly established by the successes obtained in Thailand. There most owners or managers supply condoms, strongly urge the young women to use them, and support them in rejecting customers who refuse to use condoms. They do this because the police, who have identified most institutions offering commercial sex, are prepared to close down institutions which do not collaborate. Similar activities in Nigeria might do much to curb the threat of an AIDS epidemic. There would be a need to identify all hotels, bars, brothels and other drinking and dancing places where commercial sex is available. Commercial sex is also available outside these places, but a sufficient proportion occurs there for them to play a key role in the spread of disease. It might be more efficient if those persons pressuring managers also provided a supply of condoms. It would, of course, be necessary for some establishments to be closed down and for these closures to be reported in the press.

A study of the role of religious leaders (Orubuloye, Caldwell and Caldwell 1993b) showed that the great majority preached against non-marital sex. They have also begun to warn about AIDS, but very few of them say much about STDs. Perhaps the most important finding was that the ministers, priests and imams say that their messages are so general, and their congregations so expect them to denounce sexual immorality, that a rapid change in sexual behaviour would not be likely to come from their efforts but from a strong governmental information program full of facts from research on sexual networking and HIV surveillance, supplemented by information provided by medical authorities on sickness and death. The religious leaders described the needed intervention accurately enough. There have to be grim warnings and these warnings must be effectively delivered through the media and the bureaucracy. These efforts will fail if they are found to be inaccurate or if they are not made realistic by referring to actual research programs and to individual hospitals or communities and burial grounds.
A broader project across sub-Saharan Africa looked at the underreaction to AIDS and the reasons that more effective intervention programs were not under way (Caldwell, Orubuloye and Caldwell 1992). The project found scepticism based on inadequate research and statistical data, a plethora of misleading information in the media, a belief that there was little that individuals could do to avoid infection, and a lack of adequate funding. It also found that governments, apprehensive of young adult males, concentrated mostly on captive school audiences. There were some good support systems such as TASO in Uganda, but more effort was being expended in providing support for victims than was going into the attempt to achieve behavioural change. It was found that family planning workers were confused as to whether they should recommend condoms rather than the contraceptives they considered to be the most effective; and they rarely encouraged the substitution of contraception for female sexual abstinence as a method of combating AIDS. Better and more statistics are needed and better advice should be given to governments. There should be a move towards attempting to achieve behavioural change, and family planning programs should move towards playing a combined role in reducing high fertility and reducing HIV transmission.

The effect of AIDS on African families has been treated in several projects (Caldwell, Caldwell et al. 1993; Anarfi and Awusabo-Asare 1993; Anarfi 1993). Where AIDS is a relatively recent occurrence, as in Ghana, family members are often worried about having too much contact with the infected person, and neighbours often avoid the person and even the whole family. Nevertheless, families often impoverish themselves by buying medicine in an attempt to relieve the symptoms. The most obvious intervention is counselling at the local level to raise the morale of the affected individuals and to reduce the level of fear in the family and community. An effective program to train counsellors has been mounted at the Holy Family Hospital, Berekum, Ghana (Ego and Moran 1993). Success has been obtained in employing seropositive persons and even those with symptomatic AIDS as counsellors, although difficulties have been encountered in meeting the emotional problems of counsellors themselves.

A recent pilot research project on both female and male attitudes to male sexuality (Orubuloye, Caldwell and Caldwell 1994a) has shown that at least half the community believes that married men can confine their sexual activity to marriage, and almost as great a proportion usually do so. Although a minority of men claim that men have an uncontrollable biological need for sexual relations with a variety of women, and argues that African culture recognizes and allows this, at least half the community argues that this is immoral and against religious teachings. The project confirmed the great reluctance of Nigerian wives to take note of their husbands' extramarital sexual activities and an abhorrence about doing anything about the situation. However, both parents do attempt to control the sexual activities of their children, although they are hindered by an unwillingness in the community to take youthful sexual activity very seriously, especially in the case of sons. In terms of interventions, there is already a solid base of persons opposed to extramarital sexual activities. This can be built upon, using health warnings, admonitions against destabilizing the family, and moral or Christian messages. In the case of premarital sex, the message of its dangers should be carried to schools and the general community. Once again, there is a clear case for attempting the greater empowerment of women.

A specific project examined sexual behaviour and attitudes among Lagos State high school students (Oloko and Omoboloye 1993). High levels of sexual networking were found with few fears about the consequences. A particular problem is the fact that those girls who desired a boy's friendship without sexual activity could hardly refuse when the boy made the accusation that refusal was a demonstration of lack of real affection. The intervention here is obviously in the educational process but possibly can be done better by students' groups or even NGOs' participation, than by the teachers themselves. The beginning of women's
empowerment might be an emphasis placed on a girl's right to refuse sexual relations. A more controversial innovation would be providing sexually active students with condoms.

Anarfi, in Ghana, has been emphasizing the greater danger to the school dropouts, especially those that form groupings or gangs in urban areas. He found that many of these groupings did have an informal organization or an older spokesperson who negotiated with officialdom. The danger to these groups came from the high level of sexual networking within them, coupled with the fact that some of the girl members earned additional money or obtained trading privileges from their sexual activities. The situation is doubtless similar in Nigeria. Anarfi believes that it would be possible to use both the informal gang structure and the spokespersons to provide both education and condoms.

**Priorities in a Nigerian intervention program**

1. The health system has to be once again upgraded with cheaper access to services. Hopefully with overseas aid and help from international organizations, there can be a greater emphasis on STD information, detection and cure. There is a need to stress the seriousness of STD infection.

2. There is a need to fuse family planning and STD/AIDS activities not only to provide better protection against AIDS but to ensure that women being provided with family planning are not continuing to suffer from reproductive tract infections. They should also be encouraged to substitute contraception for sexual abstinence in the postpartum period.

3. NGO's and religious leaders should be provided with accurate information on STDs as well as AIDS, which they can use in their teaching.

4. There should be a concerted effort to place pressure on all establishments where commercial sex is provided to ensure that the prostitutes have condoms, use them, and will turn down clients who refuse to use them. The central element in this should be forcing action from the owners and managers through the fear of closure if they do not fully comply.

5. Where there are other high-risk groups, such as truck drivers and itinerant hawkers, who can often be located in a specific location, use should be made of this fact to provide both information and condoms.

6. There is an urgent need not only for the widespread provision of condoms, which is on the whole occurring, but for a strong informational program stressing the protection they offer against both STDs and AIDS.

7. Probably the most important program is a major informational campaign to attempt to change sexual behaviour of young adult men. Ways need to be found to locate them and their organizations and to emphasize the health risks not only of AIDS, but also of other STDs. They should be told how little they really know about many of their sexual partners. The government will have to argue trenchantly that African culture neither teaches the need for a variety of women nor sanctions men's search for such a variety.

8. A similar campaign needs to be mounted against adolescent sexual networking, largely on the grounds of health risks. Schoolgirls will have to be persuaded of the enormous risks posed by 'sugar daddies'.

9. In the long run there will have to be a persistent move towards empowering women through schools, women's groups, organizations set up specifically for this purpose, and the media. It will have to tackle girls' rights to refuse sex to boyfriends and women's rights to take an active concern with their husbands' extramarital sexual activities.

10. Much greater emphasis should be placed on the collection of good behavioural data and also surveillance data on seropositive levels and symptomatic AIDS. This information must be the basis for successful government campaigns.
11. The need for support groups for AIDS sufferers is as yet small in Nigeria but such work should start in order to obtain experience and it should have a high profile as part of the campaign to increase public consciousness of AIDS. Families and communities need a different kind of door-to-door or community meeting counselling to convince them that AIDS patients pose them no kind of risk.

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Care for AIDS orphans in Uganda: findings from focus group discussions

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Since 1982 when the first case of AIDS was identified in Rakai district (Serwadda et al. 1985) the disease has moved like a bushfire and killed many people in Uganda. The records of the AIDS Control Programme (ACP) give reports of AIDS cases as 43,825 by December 1993 (ACP 1994). Because this figure is based on official health reports of the disease in a country without a vital registration system and where most people die outside medical units, it is a gross underestimate. Perhaps a close figure is four to five times the ACP report. According to WHO reports, Uganda's number of deaths due to AIDS is second only to that of the United States, a much larger country. In terms of percentages of populations, Uganda is perhaps the worst affected country with an estimate of 8 to 12 per cent HIV positive, although other African countries have not been as open to studies of the disease as Uganda has been. This implies 1.4 to 2.2 million out of a total of 18 million Ugandans may already be infected.

The impact of AIDS on the country has been devastating. The disease has killed many highly educated people, businessmen and economically active people, thus depriving the country of the entrepreneurship, technical and professional persons needed for high economic productivity. Both public and private health systems, working under strained budgets, are overburdened by the high cost of medication and care of AIDS patients. Many babies are born with the virus transmitted from their mothers, thus increasing infant mortality. The 1991 census reported an infant mortality rate for Uganda of 128 per 1,000, higher than in the 1969 census, when it was 120 (Republic of Uganda 1993). The adult mortality rate has also increased: life expectancy at birth went down from 47 years in 1969 to 42 in 1991.

Perhaps the most shaken is the socio-cultural system of the African extended family which hitherto was the foundation of caring for the sick and orphans in the society. Agyeman (1993) observed that in the past extended families in Africa were known to care for the aged, sick, weak, and the helpless. However, a recent dramatic increase in the number of orphans due to the AIDS epidemic in Uganda has threatened to break this major function of the extended family. According to the reports of the 1991 population census of Uganda, the number of children under 18 with one or both parents dead has increased between 1969 and 1991 (Republic of Uganda 1993). Muhumuza (1992) claimed that the orphans in Uganda totalled 1.3 million out of 8 million children, giving a high level of prevalence of 16.2 per cent. In the district of Masaka, which is one of the hardest hit by AIDS, the 1991 census figure of orphans was 102,542, about a quarter of the children in the district (Nampinga 1995).

Studies on HIV and AIDS in Africa have concentrated on behavioural aspects, transmission issues, AIDS progression rates and patient care (Serwadda et al. 1992; McGrath, Rwabukwali, et al. 1993). Even recent work on the impact of AIDS on population is mostly focused on the economy, health system and mortality (Gregson, Garnett and Anderson 1994;

Perhaps the pioneering study of orphans in Uganda was by Hunter (1990) who was alarmed by the high proportions of orphans in the population. She found that 23 per cent of the children in Rakai district did not have both parents in comparison to 12 per cent in Hoima; she predicted that the usual coping mechanism of the extended family would not be adequate to handle the problem. Another study, by Barnett and Blaikie (1992) in the Rakai district, narrated the experiences of different groups of orphans. Despite the existence of the extended family system in the area, Barnett and Blaikie found some of the orphans stunted and malnourished because they could not cope with orphanhood. The study concluded that most orphans were deprived of education, parental care, nutrition, shelter, clothing and the legal protection of their parents’ property. However, these two studies were limited in the coverage of Uganda to the south and central regions and one district in the western region. This paper reports findings of a recent study of the care of AIDS orphans in several regions of Uganda. It is also the purpose of the paper to investigate how the various societies in Uganda have coped with the orphan problem since the onset of the AIDS epidemic. Changes in past and present coping mechanisms are discussed and recommendations for the future are made.

Methods

A study entitled 'Evolution of Household Composition and Family Structure under the Condition of High Mortality in Uganda' was conducted in 1992 in six districts of Uganda: Hoima in the west, Kabale and Mbarara in the southwest, Masaka in the south and Iganga and Mbale in the east. None of the northern districts was studied because of the political security problems at the time; apart from Gulu, other districts of the north are not as seriously affected by the disease as those in the south, southwest and east. Ethnographic materials on the major tribes in the districts were prepared by anthropologists in Makerere University, providing information on the past. Data were collected from focus group discussions with elders and youth in each of the districts; there were twelve male and twelve female elders' groups totalling 128 males and 104 females, aged between 35 and 92 years. Most of the elders were married, but some were widowed, separated or divorced; although most of them were peasant farmers, the occupations of the rest varied from retired civil servants, such as teachers and clerks, to traders.

Eleven male and eleven female youth groups with 113 males and 114 females participated in the discussions. The male ages ranged from 19 to 34 and the females from 14 to 34. The youth were in various occupations and included a sizeable proportion of students. Among other topics, the discussions were on orphans and orphan care in the community in the past and present as well as how the community was coping with the increasing AIDS orphans and the fostering of them.

In contrast to random sample surveys, focus group discussions do not provide a statistically representative sample of respondents. However, the participants in the discussions were carefully selected to represent all the age groups from 14 to 92 years. The groups in all the six districts were selected on the basis of different levels of HIV/AIDS prevalence. Postgraduate students in population studies, knowledgeable in qualitative data collection techniques, fluent in English and the dialects of the areas and under the supervision of anthropologists, worked as moderators and recorders of the discussions. Field reports show that the discussions achieved an in-depth interaction within the groups on issues and hence brought out explanations that would not have surfaced in the surveys. Another advantage of the focus-group approach to research was the convenience and time saving for the discussion participants and researchers.
However, in comparison with the personal interview method, this technique may have a problem of lack of confidentiality and shyness. The participants may have avoided answering some questions directly for fear of divulging embarrassing information on the community or even people around; others may have been too shy to speak on some issues. All the records on the issues of orphans and orphan care were summarized by research assistants.

**Results**

**Orphan care by a surviving parent**

It was reported that in the past one of the parents usually survived. If the father survived, he would have the means to look after the orphans. In fact, in all the six districts, a child with a father was not considered an orphan, because the father would marry other wives who would look after his children using his wealth. For example among the Bakiga of Kabale and Banyankore of Mbarara, the father of the deceased wife would offer the widower another daughter to replace her sister and look after the orphans. Roscoe (1923) wrote of the Banyankore:

> If a wife died leaving children, her sister might come and take charge of them. She was then known as the heir of the dead woman and generally married the husband.

Unfortunately it emerged from most of the discussions that at present many AIDS widowers are already sick with AIDS themselves and are often too weak to fend for the children. Few women now agree to be married to a widower even if he is HIV-negative. Where the men are HIV-negative, the cost of treating the deceased wives would have been very great and would leave them with little to spend on the orphans.

In the case of widows, successors to the deceased husband were in the past selected by the husband before death or by his clan to take care of the family as a guardian. This successor could be a brother, cousin or the eldest son of the deceased. His role was to inherit the wives of the deceased and look after the children. The heir, who was not necessarily the successor, was also expected to use the inherited property to take care of the welfare of his siblings. For instance, he would use the property to pay the school fees and bridewealth of the young siblings. If the widow did not want to be inherited, she would return to her natal home and remarry elsewhere provided her bridewealth was returned to her deceased husband's family. She would surrender all her children to her husband's family who would look after them.

The participants informed us that, since the advent of AIDS epidemics, the widow's situation had deteriorated. At the time of the husband's death, she is probably an AIDS patient, too sick to care for her children. Even if she is HIV-negative, the husband's male relatives would fear to inherit her because of the AIDS scare. If there is no successor to her husband, no relative is obliged to care for the orphans. It is now difficult for women to migrate to other areas to find another man for remarriage. In some instances, the widow is considered by her in-laws a witch who has killed her husband, and they may isolate her and her children. Despite this, some widows have refused to have their children fostered because of fear of relatives who could harm them. The husband would have spent most of his wealth on his treatment and hence little would be left for the widow and children. Additionally, there were many reports of husband's relatives grabbing the deceased's property, especially land, and leaving the widow and children empty-handed. In most cases, men do not have wills to be used in the distribution of their wealth and thus do not protect the orphans' future.
Care by the relatives

All participants agreed that, as in the past, most relatives feel that the extended family is obliged to assist orphans. AIDS orphans are distributed to various relatives to be looked after; unfortunately, in the districts hardest hit by AIDS, such as Masaka and Mbarara, the relatives are complaining of looking after too many orphans. Some of the relatives who would assist are sick themselves, most probably of AIDS, and too weak to help, which reduces the number of relatives able to care. Of the remaining healthy relatives, there are many who are economically unable to look after more than one or two orphans in addition to their own large families. While in the past these orphans needed food which could be produced on abundant land and simple shelter and clothing, today the requirements are far greater and more expensive including payment of exorbitant school fees. In contrast to the past, the government no longer assists most of the foster families to pay the school fees. Other relatives refuse to look after orphans of some people considered to have been rich, educated, arrogant and unfriendly when alive. Because some wills state that the orphans should not be moved out of their homes, the relatives are afraid of evil spirits of the deceased parents and ancestors if they take action contrary to the wills.

Some youth groups reported that the orphans are stigmatized; often relatives suspect that the young orphans are HIV-positive and hence fear for themselves and their own children the danger of infection in the process of caring for them. Further, the children of some of the foster parents also believe that the orphans are infected and hence tend to isolate them to avoid infection.

The problem of food shortage was also mentioned by the discussion group as important. In the past, land was abundant to many families who would use it to produce a lot of food for any size of household. Today, there is a critical shortage of land in two of the six sample districts, namely Kabale and Mbarara, with serious consequences for food production.

It was further found out in the discussions that many relatives are either too young or too old to care for the orphans. Additionally, there were complaints from the elders of orphans being too difficult to manage. Some orphans had refused to work; others had decided to run away from relatives and went to towns to fend for themselves as servants or street children, a fast growing problem in Kampala city. Conversely, some relatives were reported by the youth groups to have abused orphans by overworking them and confiscating their parents' properties.

Other assistance to orphans

During the discussions, it was reported that in the past there were few 'Babies Homes' to look after homeless babies; since the AIDS epidemic started, many non-governmental organizations have assisted orphans. These include Uganda Women Efforts to Save the Orphans (UWESO) launched by Janet Museveni, the President's wife, the AIDS Support Organisation (TASO) started by a group of AIDS widows, Orphans Community Based Organisation (OCBO), World Vision, Save the Children Fund, church organizations and individuals. These organizations and individuals have set up institutional orphanages, placed orphans in individual households, paid school fees and provided clothing and other essential commodities of life. In addition, local communities have assisted in building homes for orphans to live in with relatives.

Discussion and conclusions

Orphan care has changed since the onset of the AIDS epidemic in Uganda; the changes have largely been due to the large number of orphans who have overwhelmed the extended family.
Care for AIDS orphans in Uganda: findings from focus group discussions

system. The death of both parents within a short time span has worsened the orphan's situation since there is no parental care. The social stigma on healthy widows and widowers ended the practices of widow inheritance and the marriage of widowers to sisters-in-law which used to ensure efficient orphan care.

However, it is reassuring to find that relatives still care for the orphans despite their own problems. This has led to a heavy financial burden on the carers, leading to their children often being economically deprived. For instance, Muller and Abbas (1990) found that 47 per cent of the households in Kampala supporting orphans did not have enough money to send their own children to school, compared to only 10 per cent of the households without orphans. It is logical to expect that at the same time a much higher percentage of orphans was not going to school since they take second place to the parents' own children in priority for education. Now, five years later, the situation must have deteriorated further. To alleviate the situation, the government and non-government organizations should increase assistance to households caring for orphans.

A further problem arising from the current orphan care situation is the higher mortality of orphans. Apart from the mortality due to perinatal AIDS which has been discussed elsewhere (Goldfarb 1991), the HIV-negative orphans are likely to experience higher mortality than other children because of lack of parental care. Since the extended family system is becoming increasingly strained and some orphans abused, it is expected that the infant and child mortality of these children will rise. Although the practice of fostering of children when their mothers are alive is common in Uganda, most of the children used to be boarded out at ages 4 and above. Where younger children were fostered, reports abound of their reacting with appetite loss leading to kwashiorkor (Gaber and Dean 1955). In Sierra Leone, Bledsoe, Bledsoe and Isiugo-Abanihe (1988) found evidence that, among the Mende, fostered children were apt to be nutritionally disadvantaged and had reduced access to modern medicine when they were sick; consequently their mortality was higher than average. As Uganda privatizes the medical services and health care, it will be necessary for the government and non-government organizations to support these services for all the orphans. This may encourage the foster parents to seek medical care for the orphans whenever they are sick and hence keep their mortality in check.

Another interesting finding is that many orphans' carers are too old or too young to meet the responsibility. Most of the old carers are grandparents and the young ones are siblings who are still children themselves. Hunter (1990) reported that 43 per cent of the guardians in Rakai were over age 50, and 31 per cent of the orphans were under the care of their grandparents and grandmothers. Since the grandparents may be too weak to create the wealth needed to cater for the orphans' requirements, orphans under their care receive little material assistance which puts their future welfare in doubt.

For the orphans under the care of fellow-children, it is a double tragedy. In their study of Rakai district, Barnett and Blaikie (1992) found many orphans aged below 18 looking after their younger siblings and living in their deceased parents' homes. The reasons for this situation are threefold. First, the orphans fear that if they left their parents' homes, their land could be seized by greedy landlords, neighbours or relatives. Their relatives therefore advised them to stay and defend their land rights. Secondly, because of much internal (rural-rural) migration in many parts of Uganda, often close relatives of orphans are too far away to help them: for instance, among the Baganda, newly married sons migrate from their parents' village to another village to ensure independent living (McGrath, Ankrath et al. 1993). The third reason is that the wills of some parents insist that their children do not leave their ancestral homes. Unfortunately, the older children themselves need the care which they no longer have and the young ones may not get the psychological and material support from...
them that they need to grow up properly. If not properly guided, these young children are bound to have health, psychological, emotional and economic problems in future.

There is a growing number of orphans on the streets of Kampala. Some of them ran away from their relatives' homes but others were forced by economic conditions to leave and fend for themselves. Of the latter group, some may have been dispossessed of their parents' property. Some unscrupulous successors to dead fathers no longer use the deceased property for the advancement of orphans and then distribute it when the children are adults as is expected of them; instead, they sell off the property and throw out the orphans. Under the Mailo land tenure system operating in Buganda where most peasants are tenants of the landlords, the legal rights of orphans on their parents' land have caused a serious situation. Heartless landlords have evicted orphans from the land because the latter are not able to pay rents (busulu and nvujjo) in time (Barnett and Blaikie 1992). In other cases, landlords have argued that the tenancy of land was between themselves and the deceased parents and not the orphans. Land-hungry neighbours have also tried to take advantage of the orphans' youth to take their father's land; as a result, many cases on the land rights of orphans are now in courts of law. The village civic leaders (Resistance Council Officials) have helped to protect the legal rights to land of orphans but their powers under the law are limited. A law to protect orphans and widows' rights to their father's or husband's property is urgently needed to deal with the problem. It is also imperative for the AIDS patients to be made aware of the value of making wills to prevent their children being dispossessed after the patients' death. Such wills would strengthen the law against the culprits in the land and property seizure. Equally important is a law to keep children out of the streets of cities before they become thugs.

The cost of treating an AIDS patient is also a problem to the orphans. It has been conservatively estimated by Berkley (1992) that between US$150 and US$1,700 is spent in the public and private clinics per patient, and US$15 per day for health care is spent. Some patients have sold their properties such as land and cows to pay for treatment, so that, by the time of death, even the rich patients have spent a lot of their riches on treatment and very little is left for the care of orphans.

In the past, orphans in Africa were absorbed by the extended family system without much trouble. Because of the recent increase in numbers and lack of external support, the extended family can no longer cope with the problem.

Reports by the discussion groups that the government and organizations are unable to assist foster families, and that in some cases they discriminate against them, are disappointing. At this stage of the problem it is important that government and non-government organizations consider offering incentives to families that foster orphans, which would greatly strengthen the extended family system. If the government and these organizations could pay school fees and provide clothing and food subsidies to all orphans irrespective of their backgrounds, it would greatly encourage the relatives and friends to accommodate the orphans. In addition to this assistance, incentives to foster-parents in the form of school fees and clothing for their own children could motivate more people to accept orphans. This proposal may be considered too expensive at present but it could save much more money later, which will be necessary to deal with the psychological stress of these orphans as adults.

The problem of stigmatization of widows, widowers and orphans should be faced squarely. The widowers and widows who are willing to be tested should be officially encouraged to do so at reputable testing centres. After testing several times for about two years following the death of the spouse, the widows and widowers should be given a certificate showing them to be HIV-negative and their community leaders should be informed. This may assist them to be accepted by the community as harmless and hence able to remarry. Combined with this policy, government and non-government organizations, social
workers, church leaders and counsellors can enlighten the public about the stigmatization of AIDS widows and widowers. The success of this policy would greatly improve the care of orphans.

Stigmatization of orphans can also be tackled by government and other organizations. The orphans can be tested and retested for HIV seropositivity. Those who are negative can then be declared so by the testing centres and distributed by the social workers and relatives to the foster-parents who are more likely to accept them than when they are untested. Those seropositive can be distributed to those willing to care for them in that status until death. Stigmatization apart, the foster families are entitled to know the sero-status of the orphans in order to safeguard themselves against infection.

Another suggestion is for investment in the social work system. At present in Uganda there is a lack of organized social work: a few government departments and organizations employ social workers whose activities are not co-ordinated to maximize the impact of their services to the community. For instance, during the focus group discussions there was no mention of the activities of social workers as a solution to orphans' problems because the respondents were not aware of such services. With the increased seriousness of the orphan problem it is imperative for the government and non-government organizations to set up a strong social service system which would complement and enhance the extended family system's efficiency in handling orphans. Social workers can work with and help extended family members to make the correct decisions on the distribution of orphans to relatives and friends. The expertise of the social workers can be used when inspecting the prospective foster-homes of orphans; then the social workers can follow up the foster-homes and advise members of the family on how to cope with the orphans and their problems. The conditions of the orphans at the foster-homes can be regularly monitored by social workers in conjunction with extended family representatives. In this way, the abuse of these orphans by the foster-families can be detected and dealt with before they become out of control. The social workers can also be an additional source of information to government and courts of law when handling the land question.

References


The condition and care of AIDS victims in Ghana: AIDS sufferers and their relations

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So far substantial effort has been devoted to the basic research necessary for AIDS prevention and rightly too. What to do with the AIDS patients, the ultimate victims of the human immunodeficiency virus (HIV), until very recently, had remained almost exclusively the concern of health workers. Sufferers continue to be 'guinea pigs' in the hands of scientific and medical researchers in their frantic efforts to find a cure for the disease. But the long incubation period of the disease means that, even if all HIV transmission were to halt immediately, the number of AIDS cases would continue to grow during the next decade at an average rate of ten per cent a year (Panos Dossier 1992). That aside, the number of AIDS-related deaths in some places has already reached alarming proportions, and the impact on families is already manifesting itself in many ways: increasing numbers of orphans, broken families, collapsing family enterprises, loss of family income, growing number of child-headed households, etc. (see Barnett and Blaikie 1992).

In economically depressed countries the strain on limited resources has begun to show as inadequate personnel and facilities have to be syphoned off to take care of AIDS patients. The message is quite clear: it is time to look at the other end of the continuum - the AIDS sufferers. It has, thus, become important now to expand discussion of AIDS to include its more general social consequences. In the early years of the epidemic in Africa, Jonathan Mann, the first co-ordinator of WHO's worldwide AIDS program, commented in an interview on German television that African societies had some advantages over Western industrial countries in that AIDS patients would not be isolated, and that their families would look after them. Thus in Africa, the condition of the AIDS sufferer will be better appreciated if it is looked at within the framework of the family.

Until very recently, much of what was known about the consequences of AIDS to the family was largely anecdotal, as very little research had been done on it. One reason for this inattention to the family and household consequences of AIDS might be the presumption that AIDS is first and foremost an individual disease: that is, the chain of HIV exposure, infection, disease, and death is obviously an individual phenomenon (Eberstein et al. 1988).

Eberstein et al. (1988) believe that there are at least three reasons which make the family or household-level observation significant. In the first place, the primary avenues of HIV exposure do occur in a family context: sexual relationship, pregnancy and childbirth, and breastfeeding to some extent. Secondly, the responsibility for care and support, especially in Africa as already mentioned, rests to a greater extent on the family and kin. Finally, in all societies the family or household is the important interface between the individual and the society. For example, if individuals are shunned or ostracized, either socially or economically, the family bears the brunt of the stigma and its consequences.

Traditionally, illness and health have been held to be a moral and social, rather than an individual and private, affair. This is because it is believed that a person falls ill because of sins of commission or omission against the gods and the ancestral spirits who are believed to
have a direct link with the living, that is the whole society. Often the breach of taboos affecting the gods and spirits is believed to lead to severe mystical penalties with repercussions on the family and the general society. The healing of the sick, therefore, makes use of ritual support involving a healer and some relatives of the sick person designated by the patient's family head.

Lloyd (1988) has conceptualized that the discovery of a person's HIV status or diagnosis of AIDS has profound and disruptive effects upon other family members and their capacity for problem solving. He believes this disruption, while expressed differently, occurs in all cultures. Lloyd maintains that the extent and duration of family disruption, among other things, are influenced by attitudes about HIV and AIDS. Everywhere HIV infection and AIDS have been associated with shame and stigma. Shame, which is described as a powerful emotion, is seen as a central aspect of disruption experienced by both the HIV-infected person and members of his or her family (Lloyd 1988).

More than any other disease, AIDS has the potential to undermine both the social and economic fabric of communities because its victims are those in the economically-active age group and because its spread depends on the way individuals relate to each other. In Africa, including Ghana, AIDS is transmitted heterosexually which may involve spouses or potential spouses. It is estimated that about five-sixths of all seropositive females in the world are to be found in Africa south of the Sahara. In Ghana seven out of every ten AIDS sufferers are females. Another feature of the disease in sub-Saharan Africa is the high rate of infection in pregnant women. The implications for perinatal infection and elevated infant mortality could have a devastating impact on the fabric of society. A traditional Ghanaian belief sees the woman as the pivot of the family and hence it is said that the death of one's mother is the demise of one's family. This notion may derive from the multiple roles of women in the society and family: as health care providers, educators, wives, mothers and income providers. It may thus be aptly said that the AIDS epidemic in Ghana, and indeed the whole of Africa, is very much a family matter.

The few studies that have been done on the impact of AIDS show that the disease has the potential to affect adversely entire communities by threatening their collective abilities to cope. Social systems which are extremely important in maintaining the normality of day-to-day life for most African people are being challenged, stressed and possibly changed by the epidemic. Reports on some communities in Uganda say that if there is no one to look after a man's children after his death,

women who have severed relationship with the deceased man, either through desertion or divorce, may now reappear on his death to look after his children from later relationships (Barnett and Blaikie 1992).

In badly affected areas of Uganda three-day wakes are giving way to shorter funeral ceremonies. Some of the social networks which are active in contributing to the funeral expenses of relatives and neighbours, helping pay for health care, taking on work on neighbour's fields, caring for the sick and looking after orphaned children are losing some of their capacity to absorb the demands imposed by AIDS. Such developments certainly will have powerful influence on the society's attitudes and perceptions about the disease and in turn either reinforce existing stigmas or generate new ones.

Other studies have observed that AIDS patients are cared for by their families with the greater majority of the burden borne by women, wives, mothers, sisters, daughters, aunts and grandmothers (McGrath et al. n.d.; Ankrah et al. 1992:113). AIDS tends to weaken relationships with non-relatives. The family turns in on itself as neighbours reduce contact with its members because of the shame attached to the disease. Other inconclusive evidence
also shows that AIDS has a major effect on the farming household economy and more generally on household incomes.

Within the constraints of grossly inadequate data some estimates have been made of the most immediate financial impact of the pandemic on health budgets. In 1990, the cost of treatment for the global total of people with AIDS - some 200,000 to 300,000 patients - was estimated at US$2.6 billion to $3.5 billion. While 84 per cent of the expenditure was accounted for by industrial countries, only two per cent of spending was in Africa which had 50 per cent of all patients with AIDS (Cameron and Tarantola 1992). The low expenditure figure for treatment in Africa is not surprising given that many countries in the continent spend an average of US$5 or less per person per year on medical care. The result is that many countries are under severe strain in trying to cope with the disease (Merritt, Lyerly and Thomas 1988) and that explains why families are shouldering much of the burden. There is also a psychological side to it, for hospitals in Africa face more than financial strain. The strain on staff of helping people die with dignity (if possible), instead of curing them, can be enormous. Given the vulnerability of most household economies in Ghana, which is a reflection of the national economy, the actual and potential socio-economic effects of AIDS require careful monitoring if some of the severe downstream effects are to be mitigated or avoided.

Since the first case of AIDS was diagnosed in Ghana in March 1986, the number of cases has been increasing at a remarkable rate. By July 1991, 4,824 HIV seropositive patients had been diagnosed in the country, of whom 2,525 were AIDS patients. By 31 December 1992 a cumulative total of 10,285 cases had been officially reported, rising to over 12,000 by July 1993. As elsewhere in Africa, there is underdiagnosis, under-reporting and incomplete recording of AIDS cases: the current level of recording is estimated at 40 per cent. The complete absence of data on AIDS-related mortality makes it impossible to arrive at quantitative measures of the impact of the disease. However, field observations indicate that the death of people with AIDS-like symptoms is becoming widespread. A more prudent approach is to get an impression of the situation now before it reaches a crisis point. The report that follows is a small beginning in this direction. The aim of the study is to look at the way some of the households in Ghana that are currently caring for AIDS sufferers are coping with the situation, and how this affects the social, economic and physical condition of the AIDS sufferers.

Methodology

The main source of data for this study was a fairly large survey on the Social Dimensions of AIDS in Ghana, the fieldwork for which was undertaken from 1 to 24 March 1992. As part of the survey, data were collected about AIDS sufferers and their relations. Through regional and district AIDS counsellors and co-ordinators a total of 141 AIDS patients were located and interviewed in eight out of the ten regions of the country. In addition, 122 relatives or carers of the AIDS sufferers were interviewed with a different questionnaire. The idea was to match AIDS sufferers with their relatives and carers, but some of the latter did not agree to be interviewed. The selection of the samples was mainly purposive interviewing of only those who agreed to co-operate. Most of the interviewing was done in the hospitals where the patients went for routine checks, and a few others were interviewed in their homes.

After the main survey it was necessary to go back to the field for clarifications of certain issues because the AIDS epidemic is a new experience and people are still learning how to come to terms with it. The result was a third set of data on the households of AIDS sufferers from a pilot survey conducted in three areas of the country. The areas were Agomanya in the Eastern Region of Ghana, currently one of the areas known to have a very high prevalence
rate of the disease, Tamale in the Northern Region, a very low prevalence area according to the official records, and Accra, the national capital and a converging point for people from all over the country.

The essence of the supplementary survey was to have a better understanding of how households are coping with the presence of a member who has AIDS. The idea was to interview the head of household, or the person caring for the AIDS patient if he or she was different from the head, in the home. In Agomanya this was easy because the Catholic hospital in the town is running a home-based care service for AIDS patients. In Accra, in the absence of a well-established home-based care system, relatives of patients were traced at the hospital where they came with the patients for routine checks and counselling. The situation was a little different in Tamale and its environs. It was not easy locating the patients. The stigma attached to the disease in that part of the country is very strong indeed. The traditional practice of vetting a family to ensure that it has a clean record and that no member has ever had a dangerous disease before allowing a son or daughter to marry into it is still adhered to. As a result, AIDS patients are either taken into hiding or rejected by the family of which they are members. Tracing the AIDS patients to their households, therefore, was extremely difficult. It would have been easier to trace the relatives of patients who came to the hospital but unfortunately these hospitals were not functioning as a result of industrial action by nurses. Nevertheless, the regional AIDS co-ordinator in Tamale used his personal contacts to identify potential respondents. The selection of respondents for interviewing was purposive, depending heavily on AIDS counsellors and co-ordinators in the areas for the necessary contacts. In all, 93 households were interviewed, 19 each in Accra and Agomanya and 55 in Tamale and its environs. More respondents were recorded in Tamale despite the problems mentioned above because the area of coverage was bigger and the interviewing period was longer, three weeks as against one week each in Accra and Agomanya. As part of the survey on the households of AIDS sufferers, structured conversations were held with AIDS counsellors and co-ordinators in two of the areas of study, Agomanya and Tamale. The conversations were taped and later transcribed.

Results

**AIDS sufferers and their relatives: personal characteristics**

About 72 per cent of the patients were females, which compares favourably with the national proportion of 74 per cent of AIDS victims. They were relatively young with 77 per cent in the age range 20-29 years, which may be compared with the national figure of 74 per cent. In contrast, only 34 per cent of the relatives of the sufferers are in that age group. If we take the relatives to represent the non-infected general population then the highly age-selective nature of HIV/AIDS infection comes out clearly.

Only 26 per cent of the AIDS sufferers had no formal education. Females were more likely than males to have no education (32% versus 12.2%). The majority (64%) have basic education, primary and junior secondary school level. By comparison, a little more than half of the sufferers' relatives (50.8%) had had no formal education.

It appears that the AIDS patients are a little better educated than their relatives. Again if we take the relatives to represent the non-infected general population then we may conclude that in Ghana AIDS infects the educated. However, this might not be the case because of the way the respondents were selected. It has been stated that most of the respondents were interviewed as they accompanied their sick relatives to the hospital. It is most probable that the less educated in the families were delegated to accompany their sick relatives because they might be self employed and therefore could afford to stay out of work. About 60 per cent
of the sufferers said they were gainfully employed compared with 91 per cent of their relatives. The work of both categories of respondents was mainly in commerce, farming and crafts.

Both categories of respondents were mainly Christians (77% and 82% for the sufferers and their relatives respectively). A few were Muslims (9% and 6% respectively) and a significant proportion said they had no religion (14% and 7% respectively). About a quarter of the patients were married, 17.7 per cent were divorced and another 11.3 per cent were separated. Only one person mentioned that her marriage broke up because she had AIDS. By comparison, about 60 per cent of the relatives were currently married. Just about 7 per cent had never married. Most of the marriages of both samples were contracted by customary rites with consensual unions making up 12 per cent of the marriages of the sufferers. About 46 per cent of all the ever married sufferers have been married twice or more, the mean number of times married being 1.7. For the relatives, a little less than a third have married twice or more, the mean number of times married being 1.4. That means the AIDS sufferers, although younger, are a little faster at marriage than their older relatives. The reasons given by the AIDS sufferers for the breakup of previous marriages included lack of proper care, husbands' promiscuity, infertility and wives' infidelity. Four of the married men affirmed that their wives also suffer from the disease. Two of these wives live in the same town as the husbands, one lived in another town and one had died. Similarly, two of the married infected women said their co-wives also had the disease.

About 55 per cent of the seropositive respondents were of urban origin. Their geographical spread in the country is very similar to the picture portrayed by the national figures. The largest proportion (32.6 per cent) came from the Eastern Region, followed by the Ashanti Region with 15.6 per cent. Brong-Ahafo and Central Region follow with 13.5 per cent each.

Sources of income and financial support

To some extent, the data underscore the notion that in Africa AIDS is a family matter. HIV/AIDS is known to affect the most economically active population most of whom are their families' breadwinners (Panos Dossier 1992). One immediate impact of the disease is that the victims become financial burdens on their families. The data showed that about 56 per cent of the patients were still depending on their own sources of income. By comparison, 92 per cent of their relatives said they depend on their own sources of income. Most of the rest of the sufferers depend on other members of the family, mainly parents and siblings. Only 5 per cent said they depend on spouses and a few (2%) depend on friends. The two sets of data at least give some idea of the dependency burden on relatives of AIDS sufferers which is a result of the disease.

Despite the evidence of some family support, most of the patients seem to experience some financial crisis. When asked to describe their income, only a quarter said it was at least adequate. The rest described their income as inadequate. In fact, a majority of them (60%) reported that they need to rely on others for additional help. Assistance was mainly in the form of food and general needs as well as the payment of hospital bills.

Knowledge of AIDS and transmission routes

The study sought to know whether the patients had heard of AIDS before their diagnosis. Awareness of the disease was high, with 89 per cent having heard of it as against 87 per cent of their relatives. However, the figures were strikingly lower than that obtained in a recent national KAP survey, 99.4 per cent (McCombie and Anarfi, 1991). The mass media were the most important sources of information (68% for patients and 53% for the relatives). Other
sources were friends, relatives and health workers. The indication is that the educational campaign on the disease has made an impact and must continue.

Knowledge of AIDS transmission was characterized by high recognition of transmission through sex, with 80 per cent of the patients and 76 per cent of their relatives giving this as the response. Many fewer mentioned transmission by blood transfusion and genetic transmission. They tend to have few misconceptions. Coming after their post-diagnosis counselling the level of knowledge of the AIDS patients about the disease is not surprising.

**Post-diagnosis reactions**

Lloyd (1988) has conceptualized that when a person is discovered to have HIV/AIDS, the infected person and family members experience a post-diagnosis process of shock, blow, recoil and recovery. He explained that if the family and the HIV-infected person can pass through all the steps in this process, there are good prospects for mutual support, expression of love and acceptance. Otherwise the family will tend to ignore or reject the infected member. The present study attempted to see where the generality of Ghanaian families with AIDS-afflicted members could be placed on the continuum.

Almost all the patients got to know about their ailment after tests in the hospital where they reported sick. Just about two per cent learnt of their situation after blood donation. In fact most AIDS cases in Ghana are detected symptomatically. The first reactions on hearing that they had the disease were shock (41%), sorrow (33%), fear (8%) and anger (1%). A few (11%) were indifferent.

Hospitals and clinics ranked highest (86.6%) among the first places patients went for treatment on hearing that they had the disease. They are followed by traditional healing (8.5%) and then spiritual or faith healing (1.4%). As the disease persists, patients seem to lose interest in all forms of treatment involving medication. For example, in the subsequent search for cures, preference for hospitals or clinics dropped to 38.3 per cent and that for traditional healing to only 3.5 per cent. Preference for spiritual healing, however, increased dramatically to 9.2 per cent.

This development may not be unconnected with the fatal nature of the disease. Conscious of the fact that death awaits them, patients may want to try that which sees beyond this life. The flight may also be connected with the indignity and frustration of being an AIDS patient within the existing health care system in Ghana.

Once HIV-status is known to a person, he or she must undergo the stress of deciding when or whether to tell the family. The difficulty stems from the feeling of shame as knowledge of HIV-status invariably leads to revelation of behaviours or practices which heretofore were unknown or were denied and not discussed by family members. About a quarter of the patients did not tell anybody after the diagnosis. A little over one-third informed their mothers and another 21 per cent informed siblings. Only seven per cent informed spouses, confirming observations in Eastern and Central Africa that some patients do not inform their spouses (see Barnett and Blaikie 1992). Nonetheless, it is heartwarming to note that the family provides the opportunity for AIDS patients to come out.

**Reactions of others to the patients**

In his concept paper Lloyd (1988) remarks that ‘positive HIV-status and AIDS creates a family disruption which is pervasive and enduring. It is felt at all levels of individual and collective life within the family’ (p.184). The patients were asked about the initial reaction of the various family’ members on hearing of their disease. As expected, most of the relatives were shocked (24%), or sad (23%) when they were told of the disease. A few (7%) were angry but some (6%) did not believe it. The reactions of spouses on hearing of the disease
were interesting. About 31 per cent were just outraged or indifferent. About six per cent of
the respondents could not tell the mood of their spouses. Only 30.8 per cent could say
specifically that their spouses were sympathetic.

Similar reactions were exhibited by fathers. However, the proportion that was
sympathetic went up to 39 per cent, 14.8 per cent were outraged and 5.4 per cent were
unsympathetic. Most mothers were quite sympathetic (74%) which underscores their natural
role as care providers. Nonetheless, the proportion of mothers who were outraged (20%) was
quite significant. Such is the threat AIDS poses to the hitherto closely knit African family
system. Cracks seem to be appearing in the fabric.

The reactions of brothers and sisters were quite reassuring. About 48 per cent and 62 per
cent respectively were sympathetic and 23 per cent and 6.2 per cent in the same order were
indifferent. But siblings can afford to be sympathetic or indifferent. Society does not expect
them to shoulder fully the responsibility for caring for a sick relative, particularly if parents
are around. They always come in as extra hands. Other relatives and friends were more
sympathetic than otherwise. Patients could not easily assess the reaction of neighbours and
the community and most of them answered 'no idea'. This may be explained by the fact that
AIDS patients have very little interaction with non-family members of the community.

When respondents were asked about the current reaction of family members to the
patients' predicament interesting changes were observed. It seems the initial negative reaction
to the news of the diagnosis wanes as the disease progresses. This is demonstrated by the
increased proportion of the categories of family members who were sympathetic to the
patients at the time of the interview. For example, the proportion of sympathetic spouses had
increased to 50 per cent and that of mothers to 89 per cent. The wasting nature of the disease
could have a powerful influence on people's emotions just as the effects of wars and famine
have. Also, the traditional belief in the link between the living and the spirits of the dead
could compel some people to be sympathetic to critically ill relatives. People do not want to
incur the wrath of a dying person fearing that the spirit of the deceased would take revenge.

The care and condition of patients

The care of the patients rests almost solely with blood relatives, mainly parents, siblings and
children. The responses of the relatives of AIDS sufferers to the question 'Why are you the
person looking after the sick relative?' show that they see it as an obligation. Some of them
said they were looking after their sick relatives because they are parents, family heads or
husbands, or because there is no one to look after the sick ones. This stresses the fact that
African societies see the sickness of a relative as a family matter. Only 9.2 per cent were
being cared for by their spouses, while 11 per cent were taking care of themselves. A few
were in the care of some religious organizations and hospitals. Some Catholic hospitals in the
country have in place some home-based care programs, which involve home visits in the
towns and their surrounding villages by health workers and some church people. Patients and
their relatives are counselled during such visits and they are given supplies of drugs and other
essential items.

The majority of the AIDS patients (80%) affirmed that they are satisfied with the type of
care being given. It involved general care which included administration of medication,
physical and social support and financial assistance. When asked to state whether or not they
expected any other things 39 per cent answered 'nothing'. In terms of their main reaction to
the situation in which they found themselves, some said that it was the pain and sickness
which dominated their life, others reported that it was their shame and regret and still others
referred mostly to their boredom at being largely confined. However, when asked about their
greatest problem, the majority pointed to lack or insufficiency of medicines to cure them, to
reduce their symptoms or to make life more comfortable; and the need for balanced diet.
The 'no expectation' response may be a sign of hopelessness that brings to the fore the observation by Katoff and Ince that

Before very recently most people who received the AIDS diagnosis felt that life was over. That there would be no more opportunities; no more career; no more chance for love. Many felt as if they were already dead, emotionally if not physically (Katoff and Ince 1991:544).

Coping with the AIDS afflicted

Provision of health care

The day-to-day care of the patients at home is the sole responsibility of the members of the family, mainly parents, siblings, children, uncles and aunts. Only eight wives are taking care of their sick husbands. Interestingly, no husband is taking care of a sick wife. Painfully, most of the households showed many reservations in the care of their sick relatives. For example, a young woman aged 20 years had been abandoned by the whole family but her mother. She had her own drinking cup, plates, bucket for washing and other things. She relieved herself in a receptacle in her room partly because she was too sick to move and partly because she was not welcome at the public toilet in the village (see Awusabo-Asare and Agyeman 1992). In another case, the patient had been locked in her room and food was passed to her under the door.

Most of the households provide medical treatment for their sick relatives, 13 per cent give both medical and herbal treatment, four per cent give only herbal treatment and only one receives spiritual healing. However, most of the patients were not in the hospital at the time for various reasons including the strike by nurses and what the respondents termed embarrassment to the family.

The AIDS patient in the household

Households did everything to stand up to the strain of having an AIDS sufferer among them. In fact the majority of the households (53%) said the sickness of their relative had not had any effect on the household structure. Nevertheless, there was often suspicion of contamination and fear of using the same eating vessels. In the northern part of the country some patients were shut away in the room because of the feeling of shame and embarrassment. In this area some patients in hospital, mostly women, have been abandoned by their relatives. About 13 per cent of the households mentioned that their households have been disorganized and another five per cent said they have been reduced in number. The concern of most of the AIDS-afflicted households was that they get very little or no help from the state and the sick have become a burden on the families.

Reporting to the hospital

Some of the patients report to the hospital alone but many go with their relatives. They often go with persistent headache, coughs and diarrhoea which do not respond to treatment. In the Northern Region, those who go to the hospital alone are those whose relatives already suspect that they are suffering from the disease and, therefore, do not want to associate with them. They are normally at the terminal stage of the illness. In Agomanya patients do not often come alone. There is, however, the practice of leaving the patient alone for a while after some time as the relatives go to look for money with which to cater for them.
Abandonment

In the Agomanya hospital there have been two cases of abandonment so far. They involved women about the age of 30 years. In the North there are a few patients who have been neglected by relatives, some even to the point of refusing them shelter. Some of these ended in the hospital and became the hospital's responsibility. In this hospital about five per cent of AIDS patients are abandoned cases. They are often those whose moral behaviour, in the eyes of their families, is questionable. Their relatives feel they are a disgrace to the family. All the abandoned cases in the Tamale hospital so far have been women.

With no money coming from the AIDS Control Programme, abandoned cases become a financial burden to the hospital. As their diseases are not curable they are treated symptomatically. Now that Ghanaian hospitals are operating the cash-and-carry system it is sometimes difficult to get the routine drugs for the patients. More often than not 'these people are almost dying so we just leave them to die though we know we should be doing better than we are doing', reported an informant.

Handling the sick in the hospital

AIDS patients are given treatment according to the symptoms they present in addition to counselling. In the northern part of the country the hospital feeds the patients because they need a balanced diet. In the handling of the patients the hospitals encounter some problems, some relative to the patients themselves. Most accept the fact that they have the disease but some do not and often attribute it to evil spirits. For such people counselling becomes a problem and they are often difficult to handle. Other problems include lack of financial support, the social stigma attached to the disease (people do not want to associate with them; they are often deserted and that alone kills them fast), and denial by relatives of their wards having AIDS.

The Catholic hospital at Agomanya gets some assistance from the National Catholic Secretariat and other foreign agencies associated with the church. The government hospital in Tamale gets no assistance from anywhere. It is the Planned Parenthood Association of Ghana that helps with information, education and communication (IEC) programs.

In Agomanya the average number of beds occupied by AIDS patients at a time is about three per week out of a total of about 40 beds. In Tamale the rate is about four beds per week out of 100-odd beds. In the former, protective items like gloves, boots, etc. are provided to health workers who handle AIDS patients. There are none in the latter, a much bigger government hospital. Both places lack transport.

The average cost of treating an AIDS patient is around 50,000 cedis (about US$100), more than twice the monthly salary of the average Ghanaian at the time of the survey. The ratio of the cost of treating an AIDS patient to other outpatients is about 5 to 1. The treatment cost covers drugs, facilities used and food. The relatives of those who are not abandoned pay for these charges and the patients who can afford it pay for themselves. In Agomanya patients with full-blown AIDS are treated free of charge and the cost of treatment for HIV patients is subsidized. In the government hospital in Tamale if the patient cannot pay he or she is kept in the hospital and is given whatever the hospital can afford which is often not enough.

Conclusions and policy implications

One advantage Ghana has over most of its West African neighbours is that it took an early start in the control of AIDS by coming to accept it as a major health hazard. Now there is evidence that the level of awareness of the danger posed by the disease has gone up, thanks to the educational campaigns embarked upon by the AIDS control program. The disease itself
has now become firmly established in the country and the rate of spread is increasing remarkably. AIDS sufferers are now visible in some communities and AIDS-related deaths are becoming widespread.

The first people to suffer the impact of the disease are the members of the families of AIDS patients. In the absence of adequate health care facilities families are doing well to cope with their afflicted members. However, there is evidence that some families are experiencing financial crisis as a result of trying to cope with the disease. This, and the strong stigma attached to the disease, are putting a strain on the families and the hitherto close-knit family system is showing signs of cracks to the detriment of the AIDS sufferers.

For a developing country like Ghana this brings out the argument of whether government, in addition to the preventative activities they have rightly embarked upon, should take up or subsidize curative care as well. Although the economic justification for private market curative services appears much stronger, the generally low incomes in the country may make the catastrophic care associated with a disease like AIDS unaffordable to many households. If patients are made to suffer much indignity as a result of neglect by families and the government some HIV-positive people may be forced to go underground and that will endanger the prevention drive. Government must, therefore, subsidize the curative care of AIDS patients. That will give it the power to decide on resource allocation, level of service, and virtually all other aspects of decision-making in health care supply. This will remove any differential in the cost of treatment that may exist between the capital city and the rest of the country.

It is now time to take intervention programs beyond mere awareness creation to include mechanisms for coping with the disease within the family and the society at large. There is certainly the need for social counselling and psychic support. Community education is needed to reduce the level of blame and shame. Families must be helped to accept their sick relatives with love and concern instead of the feeling of embarrassment against the suspicion of neighbours. The expectations of the few patients for better medical care and balanced diet means that they desire to live. This brings into focus the need to put in place organizations to provide emotional and practical support to people with AIDS. Such organizations should provide a kind of lifeline, to serve as a means for a person to re-establish the ability to live fully within the limitations of the illness.

Women seem to be affected uniquely by the disease in Ghana. They are not only in the majority at the receiving end, but also they are at the forefront in coping at the household level. They need special attention in every intervention program. If future strategies to cope with the disease are to succeed, women must be involved in their planning, implementation and monitoring. Women's movements have a role to play here.

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Living with AIDS: perceptions, attitudes and post-diagnosis behaviour of HIV/AIDS patients in Ghana

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Abstract

AIDS infection has created a fear of stigmatization, isolation and panic among infected persons. There are, however, few studies that explore the perceptions and attitudes of HIV/AIDS patients in sub-Saharan Africa, partly because of the isolation and withdrawal of patients. Using data from a study on the social dimensions of AIDS infection in Ghana, this paper explores the attitudes and behaviour of patients and their perception of the attitudes of their relations and neighbours towards them. The traditional forms of support for sick persons in Ghana are under strain either due to or independent of HIV infection. In spite of changes, infected persons perceive their female relatives to be more sympathetic than their male relatives. Some patients continue to deny to themselves their HIV status. These findings have implications for programming as the disease enters its second decade.

Evidence from AIDS research in the last decade has reinforced the view that the state of health of any group of people is related to its living conditions, the socio-cultural context in which people are socialized and operate, and the respect for basic rights of the individual. In most parts of the world, the vulnerable in society have been the hardest hit by the AIDS epidemic (Mann 1992; Mann et al. 1994).

With the initial misconceptions and negative reactions to the disease, AIDS patients throughout the world have been blamed, stigmatized, marginalized and isolated (Sabatier 1988). In developing countries, the conditions of HIV/AIDS patients have been further exacerbated by poverty, poor infrastructure and inadequate medical services. There is also a big gap in African countries between public statements about the disease and the reality of programs in place and the living conditions of infected persons. For many of these countries intervention programs are basically concerned with education and information and the targeting of 'high-risk groups'. As the disease diffuses into the general population, the categories of infected people become more diverse and the effect of the disease becomes more complex (WHO 1992, 1994).

While there have been various attempts to measure the economic costs (see for instance, Ainsworth and Over 1992, 1994) and the social implications of the epidemic (Brokensha

* The study on the Social Dimensions of AIDS infection in Ghana was supported by the Swedish Agency for Research and Economic Cooperation with Developing Countries (SAREC). The study also received institutional support from the National Centre for Epidemiology and Population Health of the Australian National University. I am also grateful to the Fulbright Foundation for supporting my sabbatical at Brown University, Providence, USA, in the 1994/95 academic year.
1988; Schoepf 1988; National Research Council 1993; Preston-Whyte 1994), the emotional and other costs of the disease can only be guessed (Shilts 1987; Panos 1992). Quantifying emotional stress from stigma, isolation, blame and self-pity in the individual and the family is difficult since AIDS infection involves some of the most intimate of personal relations. The World Bank in its World Development Report of 1993 introduced the concept of 'Disability-Adjusted Life Years (DALY)' as a measure of the burden of ill-health. Although an interesting concept, it will be difficult to apply to aspects of some diseases. As pointed out by Klauda (1994) '...how many DALYs would be allocated to a person who is stigmatised ... because (s)he has AIDS' (p. 104). And as the disease enters its second decade and more people get infected, there is the need to understand the psycho-social coping mechanisms adopted by HIV seropositive patients. This is important in Ghana where counselling is not well developed or incorporated into the modern health care system (Ego and Moran 1993).

This paper examines the perceptions, attitudes and behaviour of some HIV/AIDS patients interviewed in a study on Social Dimensions of AIDS infection in Ghana. The focus is on the reactions of patients to their situation, their assessment of the care they are receiving, their perception of the attitudes of their relations, neighbours and the community towards them and some of their post-diagnosed sexual behaviour. In general, there are gaps in our knowledge about the perception and post-diagnosed behaviour of patients in West Africa. This is partly due to the fact that it has not been easy for patients to openly discuss their disease. However, we need to understand the strategies adopted by patients as an input into the design of intervention programs for infected persons.

Context

In Ghanaian cosmology health and illness are social as well as medical issues that are of concern to kin members and the community. The physical health of an individual, considered to be a manifestation of spiritual health, is perceived to be linked with the health of the corporate clan. Illness separates an individual from the group while a cure restores a person to physical health and his or her relationship with the group (Appiah-Kubi 1981). As a result of the social meaning of health, it becomes the responsibility of both the immediate family members and the kin group to ensure that an adult member suffering from a life-threatening disease is healed. The family and the corporate clan then function as a social support system for the individual in need. It is important for the welfare of the infected persons to know how well this social support system will continue to function in the face of the changes taking place in Ghana from modernization and other factors and because of AIDS.

The outbreak of a disease whose cause is not immediately known and which has no known cure is given a supernatural explanation. Such diseases may be attributed to an offence against one's own spirit, the gods or ancestral spirits or a spell cast on an individual by an envious relative, neighbour or competitor, for property or in a polygynous marriage (Twumasi 1975; Appiah-Kubi 1981; Schoepf 1988). This view does not exclude biological explanations of ill-health: biological causes are accepted and often herbs or tablets are used to cure a disease. Most often, it is the factors that bring about the biological changes that are given supernatural explanation.

Historically, a number of diseases have been given such an explanation: for instance, towards the end of 1874, the outbreak of smallpox in the Gold Coast (now Ghana) was attributed to the cracking of palm nuts; outbreaks of diseases such as guinea worm, tuberculosis and measles have been similarly explained (Dickson 1969; Twumasi 1975). In

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1 This is not unique to Ghana. It is true of a number of societies in Africa and was also the case in ancient Israel as recorded in the Bible (e.g. Leviticus, 13 and 14).
Ghana at the moment, traditional views coexist with modern ones and people resort to one or the other to explain events, depending upon the circumstances (Kirby 1994).

If a disease is perceived to result from a sin of omission or commission against the gods, ancestral spirits or one's own spirit, the offender when exposed is expected to confess and appease the gods or spirits in order to be restored to good health. The offence if committed in secret may manifest itself in the form of disease in the individual or the community. An act done in secret when exposed through a disease or in any other form, carries with it a sense of shame (Bleek 1981). One of the reactions of relatives when this occurs is to distance themselves from the shame and ridicule brought about by a member of the family or corporate clan. It is within this context that the reaction of some people to HIV infection should be viewed. Such interpretation of disease causation obviously influences perceptions of a particular disease, patients suffering from it and the behaviour of infected persons.

**Interviewing AIDS patients**

In 1992, a study was conducted in Ghana on the social dimensions of HIV/AIDS infection (Awusabo-Asare and Anarfi 1995). Among the objectives were to study the demographic and social-economic background of HIV/AIDS patients and their relatives, to assess the attitudes of diagnosed persons to their situation and to examine some of the coping mechanisms adopted by the patients.

AIDS patients and their relatives in eight out of the ten administrative regions in the country were interviewed over a period of four weeks by trained interviewers. Two of the regions, Upper East and Upper West, were left out partly because there were few officially reported AIDS cases and partly because of problems of cost and supervision. These are the two regions in the extreme north of Ghana and are poorly linked with the rest of the country. There was one interviewer per region except in the Eastern region where two interviewers were used: one for the Manya Krobo district and the other for the rest of the region. Each interviewer was allocated a minimum number of patients and their relatives on the basis of officially reported cases from the regions and from a reconnaissance survey.

Researching AIDS infection is not like any ordinary phenomenon in demography. Even at the best of times demographic data are affected by distortions and misinformation (Bleek 1981, 1987); AIDS is a disease whose sufferers have been stigmatized and blamed for the outbreak and spread of the disease (Sabatier 1988; Safo 1993). Therefore, patients who agree to be interviewed could be considered as those motivated enough to share their experiences with others. A related issue in AIDS research is ensuring confidentiality. The medical history of any patient is between the patient and the medical officer; if a patient decides to share that with another person, what transpires is expected to be only between the persons involved. This is important under the circumstances where people are stigmatized and isolated. It has an ethical dimension as well, especially if respondents confide in the researcher that they are putting other people at risk through their activities (see Gray, Lyons and Merton 1995). Thus, in dealing with AIDS patients it is not possible to obtain a 'representative sample' as used in population studies. The sample is self-selective and biased.

Locating patients was a further consideration since it was not easy identifying and approaching individuals for interview. Through consultations with regional AIDS counsellors and medical officers of health in the selected regions and the district medical officers of health of some districts it became clear that some patients were willing to discuss their conditions with other people, provided confidentiality could be assured. Thus, appointments for interviews were made through the counsellors and those who accepted our request to be interviewed were listed and contacted. In the case of some AIDS patients permission was also sought from their families.
Table 1
Socio-demographic background of patients

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<td>Farmers/fishermen</td>
<td>22.5</td>
<td>5.0</td>
<td>9.9</td>
</tr>
<tr>
<td>Transport</td>
<td>5.0</td>
<td>0.0</td>
<td>1.4</td>
</tr>
<tr>
<td>Crafts and production</td>
<td>12.5</td>
<td>5.9</td>
<td>7.8</td>
</tr>
<tr>
<td>Service</td>
<td>2.5</td>
<td>7.9</td>
<td>6.4</td>
</tr>
<tr>
<td>No response</td>
<td>30.0</td>
<td>45.5</td>
<td>41.1</td>
</tr>
</tbody>
</table>

Table Continued

Patients and relatives were interviewed at a health facility, at an appointed place or in their homes in the areas where there was home-based counselling. During the fieldwork, some regional counsellors were given a crash course on the interviewing schedule when it was realized that some of the patients and their relations were prepared to talk to the counsellors instead of our interviewers. In some cases people who initially agreed to be interviewed cancelled the appointment. The respondents were, therefore, patients and relations who accepting being interviewed. These constraints need to be borne in mind; see also Anarfi and Awusabo-Asare (1993); Awusabo-Asare and Agyeman (1993); Caldwell, Orubuloye and Caldwell (1994). This paper is about the AIDS/HIV seropositive patients who were interviewed.

Socio-demographic background of seropositive patients

In all 141 seropositive patients were interviewed (Table 1) with a sex ratio of 40 males to 100 females, similar to the ratio of officially reported cases in Ghana. Over 75 per cent of the respondents were aged between 20 and 39 years, a pattern also similar to that found among diagnosed persons (Ghana Ministry of Health 1992). The median age for the
Table 1 Continued
Socio-demographic background of patients

<table>
<thead>
<tr>
<th>Demographic characteristics</th>
<th>Males</th>
<th>Females</th>
<th>Both sexes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethnic group (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Twi</td>
<td>10.0</td>
<td>10.9</td>
<td>10.6</td>
</tr>
<tr>
<td>Fante</td>
<td>12.5</td>
<td>11.9</td>
<td>12.1</td>
</tr>
<tr>
<td>Other Akan</td>
<td>37.5</td>
<td>17.8</td>
<td>23.4</td>
</tr>
<tr>
<td>Ga-Adangbe</td>
<td>20.0</td>
<td>36.6</td>
<td>31.9</td>
</tr>
<tr>
<td>Ewe</td>
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<td>6.9</td>
<td>8.5</td>
</tr>
<tr>
<td>Mole-Dagbani</td>
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<td>6.9</td>
<td>5.7</td>
</tr>
<tr>
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<td>0.7</td>
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<tr>
<td>Religion (%)</td>
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<tr>
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<td>14.2</td>
</tr>
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<td>Catholic</td>
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<td>16.3</td>
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<td>Protestant</td>
<td>27.5</td>
<td>21.8</td>
<td>23.4</td>
</tr>
<tr>
<td>Other Christian</td>
<td>42.5</td>
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<td>36.9</td>
</tr>
<tr>
<td>Muslim</td>
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<td>11.9</td>
<td>8.5</td>
</tr>
<tr>
<td>Traditional</td>
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<td>1.0</td>
<td>0.7</td>
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<tr>
<td>Marital status (%)</td>
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<td></td>
</tr>
<tr>
<td>Single</td>
<td>40.0</td>
<td>38.6</td>
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<tr>
<td>Married</td>
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<td>Separated</td>
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<td>Divorced</td>
<td>7.5</td>
<td>21.8</td>
<td>17.7</td>
</tr>
<tr>
<td>Widowed</td>
<td>7.5</td>
<td>5.0</td>
<td>5.7</td>
</tr>
<tr>
<td>TOTAL (%)</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td>NUMBER</td>
<td>40</td>
<td>101</td>
<td>141</td>
</tr>
<tr>
<td>Number of times married (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>44.0</td>
<td>58.6</td>
<td>54.0</td>
</tr>
<tr>
<td>2</td>
<td>44.0</td>
<td>35.5</td>
<td>37.9</td>
</tr>
<tr>
<td>3</td>
<td>8.0</td>
<td>6.4</td>
<td>6.9</td>
</tr>
<tr>
<td>4 or more</td>
<td>4.0</td>
<td>0.0</td>
<td>1.2</td>
</tr>
<tr>
<td>TOTAL (%)</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td>NUMBER</td>
<td>25</td>
<td>62</td>
<td>87</td>
</tr>
</tbody>
</table>

respondents was 29.8 years, but 31.1 years for the males and 25.1 years for the females. As observed among diagnosed persons in Ghana, infected females are on average younger than the males, indicating earlier sexual experience for females than males.

Ninety-five per cent of those interviewed lived in urban and large urban areas although 45 per cent reported being born in rural areas. This may be due to the fact that most of the patients were interviewed at health facilities located in towns. The majority of the respondents were Akan (44 per cent) and Ga-Adangbe (32 per cent). The Ga-Adangbe, the ethnic group with Ghana's highest reported incidence of AIDS at that time, was deliberately over-sampled; the Akan as the largest single ethnic group in the country are found in five of the eight regions surveyed.

Nearly half of the respondents had completed ten years of basic education (middle/JSS); 19 per cent had primary school education, and 26 per cent had no formal education. In general the few males had higher formal education than the females. Over 40 per cent reported being unemployed at the time of the survey; some of the respondents were not physically capable of undertaking any economic activity at this time. Among those economically active, the majority were in low-level professional and clerical occupations; however, there were more males in the sub-professional category than females. The pattern of
previous occupation was not markedly different from that of current occupation (not indicated). Over three-fourths of the respondents gave their religion as Christianity, eight per cent reported Islam and only one person reported traditional religion. It is possible that those who reported ‘no religion’ are adherents of traditional religion.

Only a quarter of the respondents were married (Table 1). The rest were either never married, divorced, separated or widowed. One woman gave her AIDS infection as the reason for her divorce. The same number of men were in their first and second marriages, while there were more women in their first than in second marriages. One man had married four times and eight of the women were in polygynous marriages.

The background variables indicate that the disease now affects people in all socio-demographic and economic backgrounds in Ghana. Unfortunately, such detailed data on the background of HIV seropositive patients are not routinely collected in Ghana for inferences to be made about infected persons, but this type of information is useful for planning and the design of intervention programs.

Responses of diagnosed persons

The hysteria surrounding AIDS infection and its associated stigmatization has created a sense of panic and fear of discrimination, resulting in some infected persons denying their HIV seropositive status or refusing to inform other people. For a number of reasons, including denial, some patients do not seek expert medical advice until they are already very sick. In Ghana, most of the diagnosed cases are symptomatic ones in which the medical officers confirm their worst fears, although there are a few who become aware of their HIV status under different circumstances.

All the respondents found out about their seropositive status at a health facility when they were diagnosed or counselled, donated blood, or deduced it from the nature of questions they were asked at the centre. However, all the females reported learning their status from counsellors or medical officers. Three of the males were informed when they donated blood (Table 2). Because of the publicity given to AIDS in the mass media, it seems that people have a fairly good idea about the disease (McCombie and Anarfi 1992), hence their ability to infer their status from the questions asked.

Table 2
Source of information about serostatus

<table>
<thead>
<tr>
<th>Source</th>
<th>Males %</th>
<th>Females %</th>
<th>Both sexes %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Told at hospital</td>
<td>67.5</td>
<td>83.2</td>
<td>78.7</td>
</tr>
<tr>
<td>Counsellor</td>
<td>22.5</td>
<td>16.8</td>
<td>18.4</td>
</tr>
<tr>
<td>When donated blood</td>
<td>7.5</td>
<td>0.0</td>
<td>2.1</td>
</tr>
<tr>
<td>Questioning at hospital</td>
<td>2.5</td>
<td>0.0</td>
<td>0.7</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Another aspect of AIDS infection is the negative reactions that have built up about the disease, partly because of scapegoating and witch hunting (Schoepf et al. 1988). Although the fear of disease and death is not unique to AIDS (Kubler-Ross 1970), the reactions to it seem to manifest themselves particularly strongly. Of the 137 respondents who reported their reaction to their serostatus, 86 per cent (118) said they were shocked, afraid, angry and sad; 12 per cent reported being indifferent (Table 3). In terms of proportions more females were shocked and sad than males. These reactions may be related to some of the popular views
about the disease, such as it is a disease which affects 'immoral' people, and to the fact that it has no cure (Awusabo-Asare and Anarfi 1995). As one patient said, 'If you are informed that you have AIDS it means you have been given your death warrant'. Such negative views about the disease were repeated by a number of patients.

A feature of the disease which was observed was the attempt by some of the patients to keep their HIV-seropositive status to themselves. Schoepf (1988) reported on a physician in Zaire who kept his HIV status from his wife and continued to have sexual relations with her; she learnt about his HIV infection only after his death. At the time of the survey, 26 per cent of the respondents had not informed anybody about their HIV seropositive status. Those who had informed somebody were more likely to inform their mother first (49 per cent), followed by brother (15.4 per cent), sister (12.5 per cent) and spouse (9.6 per cent). The spouse was the first to be informed by only 27 per cent of those who were married. The observed situation among married persons is consistent with other observations on couple interaction and communication in Ghana on social issues such as family planning (Ghana 1989; Oheneba-Sakyi et al. forthcoming). Members of the natal lineage and corporate clan are expected to support the individual in times of illness: a spouse is not a member of the natal lineage and therefore may not necessarily be the person who will be informed first. That a quarter had not informed anybody is an aspect of the disease in Ghana which needs to be addressed with proper counselling (Ego and Moran 1993). Such people are likely to put others at risk either deliberately or unintentionally.

Table 3
Reaction to information about serostatus

<table>
<thead>
<tr>
<th>Reaction</th>
<th>Males %</th>
<th>Females %</th>
<th>Both sexes %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shocked</td>
<td>32.5</td>
<td>44.6</td>
<td>41.1</td>
</tr>
<tr>
<td>Sad</td>
<td>22.5</td>
<td>25.7</td>
<td>24.8</td>
</tr>
<tr>
<td>Indifferent</td>
<td>17.5</td>
<td>8.9</td>
<td>11.3</td>
</tr>
<tr>
<td>Sorry</td>
<td>7.5</td>
<td>7.9</td>
<td>7.8</td>
</tr>
<tr>
<td>Afraid</td>
<td>10.0</td>
<td>6.9</td>
<td>7.8</td>
</tr>
<tr>
<td>Angry</td>
<td>0.0</td>
<td>2.0</td>
<td>1.4</td>
</tr>
<tr>
<td>Did not believe</td>
<td>2.5</td>
<td>0.0</td>
<td>0.7</td>
</tr>
<tr>
<td>Other</td>
<td>2.5</td>
<td>2.0</td>
<td>2.1</td>
</tr>
<tr>
<td>Not reported</td>
<td>5.0</td>
<td>2.0</td>
<td>2.8</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Respondent's perception of the reaction of relatives

The choice of a person to confide in with such delicate information as HIV infection is likely to be influenced by the patient's perception of the reaction of the recipient to the information. All things being equal, people are more likely to inform those they think will be sympathetic but may also keep the information to themselves. Table 4 shows the reactions of various relations, friends, neighbours and the community as reported by the patient, when they first heard of the serostatus of the patient and at the time of the survey. They show some of the familial and community dynamics which influence the decision to inform another person and the choice of that person.

In general, the respondents perceived their female relations – mothers and sisters – to be more sympathetic than fathers and brothers. Fewer males were perceived to be sympathetic at the initial stages. The few married persons among them did not consider their partners to be sympathetic towards them at the initial period. However, at the time of the survey the
reported attitudes of relatives had improved, as indicated by increases in the proportion of family members reportedly sympathetic. It is possible that with time some relatives were prepared to accept the situation and assist the patient, or the respondents did not want to appear ungrateful, or owing to their condition some of them could not assess the reactions of people around them. It appears some of the patients and their relations had gone through what Lloyd (1988, quoted in Anarfi 1994) describes as the post-diagnosis process of shock, blow, recoil and recovery. Those patients who had been confined could not have assessed the reactions of some of their relatives towards them. Some of the issues are indicated in four case studies reported opposite (Ahensa 1993).

**Case 1** A young woman aged 23 years was being cared for by her mother and her six-year old daughter at home. She had been abandoned by her husband and her father did not want to have anything to do with her. She lived in a small room and had her own household items such as plates and drinking cups which she used alone. Her daughter was responsible for her hygiene.

**Case 2** A young woman in her early 30s returned to her village from Côte d'Ivoire very sick. At the district hospital she was diagnosed HIV seropositive. She lives in her village with other family members. Only her mother knew what she was suffering from. Although aware of her HIV seropositive status, she wanted to get married.

**Case 3** A young man who had returned from studies in Europe was diagnosed HIV seropositive. When he was informed of it he worked out an arrangement with the hospital authorities to allow him to stay at the hospital, as he puts it, 'till he dies'.

**Case 4** At one of the district hospitals, a female patient brought by her relatives for an AIDS-related disease, was still there two weeks after she had been treated and discharged. In spite of repeated messages to her relations nobody had come to pick her up.

These case studies illustrate some of the problems HIV patients in Ghana are going through. From some, their HIV serostatus has had to be kept secret from the rest of the family for a variety of reasons. Afraid of stigmatization and isolation, some have kept away from family members (Case 3). The social 'safety net' once offered by the corporate clan to its members appears to be undergoing changes; it does not seem to provide the individual with the protection and support it once gave. This may be because AIDS, as a disease with no known cure, is interpreted as a curse or punishment for disobedience: such a situation brought shame not only to the individual, but also to the corporate clan (Bleek 1981). Thus, some kin members may withdraw physically or emotionally from the patient because they do not want to be associated with the shame brought by a relative. There may also be a general decline in the traditional social support system arising from the unintended effects of improvement in education, industrialization, migration and urbanization which the AIDS infection has only exposed and exacerbated (WHO 1992). These factors need to be disentangled.

The patients' perception of their condition was explored further by asking them to evaluate the care they were receiving (Table 5). About 80 per cent of the respondents (higher proportion of females than males) were satisfied with the care being provided. However, a quarter of the males, compared to only six per cent of the females, were dissatisfied with the care. The expectations of the respondents reveal a range of negative feelings and frustrations. Thirty-nine per cent indicated that they did not want anything, while about 25 per cent had given up hope (up to God/don't know and wishing to die). We observed that some of the patients were in desperate conditions: poor and isolated. Emotionally, some had given up hope and were, as they themselves put it, 'waiting to die'. Others, abandoned and with no regular source of income, depended on charity and on the health facilities they were visiting for treatment for support in such diverse areas as drugs, food and money for transport (Ahensa 1993).
### First reactions of others when they became aware of patients' serostatus (%)

<table>
<thead>
<tr>
<th></th>
<th>Sympathetic</th>
<th>Unsympathetic</th>
<th>Outraged</th>
<th>Indifferent</th>
<th>No idea</th>
<th>Total</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse</td>
<td>38.5</td>
<td>7.7</td>
<td>15.4</td>
<td>7.7</td>
<td>30.8</td>
<td>100.0</td>
<td>26</td>
</tr>
<tr>
<td>Father</td>
<td>38.9</td>
<td>5.6</td>
<td>14.8</td>
<td>14.8</td>
<td>25.9</td>
<td>100.0</td>
<td>54</td>
</tr>
<tr>
<td>Brother</td>
<td>47.5</td>
<td>4.9</td>
<td>9.8</td>
<td>23.0</td>
<td>14.8</td>
<td>100.0</td>
<td>61</td>
</tr>
<tr>
<td>Mother</td>
<td>73.6</td>
<td>1.1</td>
<td>19.5</td>
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<td>5.7</td>
<td>100.0</td>
<td>87</td>
</tr>
<tr>
<td>Sister</td>
<td>61.5</td>
<td>4.6</td>
<td>15.4</td>
<td>6.2</td>
<td>12.3</td>
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<td>65</td>
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<tr>
<td>Children</td>
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<td>5.3</td>
<td>10.5</td>
<td>57.9</td>
<td>100.0</td>
<td>38</td>
</tr>
<tr>
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<td>4.9</td>
<td>0.0</td>
<td>7.3</td>
<td>56.1</td>
<td>100.0</td>
<td>41</td>
</tr>
<tr>
<td>Friends (O.sex)</td>
<td>15.4</td>
<td>5.1</td>
<td>5.1</td>
<td>10.3</td>
<td>64.1</td>
<td>100.0</td>
<td>39</td>
</tr>
<tr>
<td>Other Relative</td>
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<td>2.4</td>
<td>2.4</td>
<td>11.9</td>
<td>78.5</td>
<td>100.0</td>
<td>42</td>
</tr>
<tr>
<td>Neighbours</td>
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<td>2.5</td>
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<td>0.0</td>
<td>90.0</td>
<td>100.0</td>
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<td>0.0</td>
<td>86.7</td>
<td>100.0</td>
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</table>

### Reaction at time of interview (%)

<table>
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<tr>
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<th>Sympathetic</th>
<th>Unsympathetic</th>
<th>Outraged</th>
<th>Indifferent</th>
<th>No idea</th>
<th>Total</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse</td>
<td>50.0</td>
<td>10.0</td>
<td>3.3</td>
<td>10.0</td>
<td>26.7</td>
<td>100.0</td>
<td>30</td>
</tr>
<tr>
<td>Father</td>
<td>53.6</td>
<td>7.1</td>
<td>3.6</td>
<td>14.3</td>
<td>21.4</td>
<td>100.0</td>
<td>56</td>
</tr>
<tr>
<td>Brother</td>
<td>66.7</td>
<td>3.3</td>
<td>3.3</td>
<td>13.3</td>
<td>13.3</td>
<td>100.0</td>
<td>60</td>
</tr>
<tr>
<td>Mother</td>
<td>89.3</td>
<td>1.2</td>
<td>1.2</td>
<td>1.2</td>
<td>7.1</td>
<td>100.0</td>
<td>84</td>
</tr>
<tr>
<td>Sister</td>
<td>79.7</td>
<td>6.3</td>
<td>0.0</td>
<td>3.1</td>
<td>10.9</td>
<td>100.0</td>
<td>64</td>
</tr>
<tr>
<td>Children</td>
<td>27.0</td>
<td>0.0</td>
<td>0.0</td>
<td>13.1</td>
<td>59.5</td>
<td>100.0</td>
<td>37</td>
</tr>
<tr>
<td>Friends (S.sex)</td>
<td>31.7</td>
<td>4.9</td>
<td>0.0</td>
<td>7.3</td>
<td>56.1</td>
<td>100.0</td>
<td>41</td>
</tr>
<tr>
<td>Friends (O.sex)</td>
<td>21.4</td>
<td>4.8</td>
<td>4.8</td>
<td>11.9</td>
<td>57.1</td>
<td>100.0</td>
<td>42</td>
</tr>
<tr>
<td>Other relative</td>
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<td>4.8</td>
<td>2.4</td>
<td>7.1</td>
<td>80.9</td>
<td>100.0</td>
<td>42</td>
</tr>
<tr>
<td>Neighbours</td>
<td>5.0</td>
<td>2.5</td>
<td>0.0</td>
<td>5.0</td>
<td>87.5</td>
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<td>40</td>
</tr>
<tr>
<td>Community</td>
<td>6.4</td>
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<td>0.0</td>
<td>6.4</td>
<td>87.2</td>
<td>100.0</td>
<td>31</td>
</tr>
</tbody>
</table>

Note: S. Sex = Same sex; O.Sex = Opposite sex
Table 5
Level of satisfaction with and expectation of care (%)

<table>
<thead>
<tr>
<th></th>
<th>Males</th>
<th>Females</th>
<th>Both sexes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Satisfaction with care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>62.5</td>
<td>87.1</td>
<td>80.1</td>
</tr>
<tr>
<td>No</td>
<td>25.0</td>
<td>5.9</td>
<td>11.3</td>
</tr>
<tr>
<td>Not reported</td>
<td>12.5</td>
<td>6.9</td>
<td>8.5</td>
</tr>
<tr>
<td><strong>Expectation of care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nothing</td>
<td>25.0</td>
<td>44.6</td>
<td>39.0</td>
</tr>
<tr>
<td>Proper medical care</td>
<td>22.5</td>
<td>17.8</td>
<td>19.1</td>
</tr>
<tr>
<td>Balanced diet</td>
<td>0.0</td>
<td>2.0</td>
<td>1.4</td>
</tr>
<tr>
<td>Death</td>
<td>7.5</td>
<td>7.9</td>
<td>7.8</td>
</tr>
<tr>
<td>Up to God/don't know</td>
<td>17.5</td>
<td>17.8</td>
<td>17.7</td>
</tr>
<tr>
<td>Other</td>
<td>15.0</td>
<td>7.9</td>
<td>9.9</td>
</tr>
<tr>
<td>Not stated</td>
<td>12.5</td>
<td>2.0</td>
<td>5.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Sexual behaviour of patients

Of considerable importance for limiting the spread of the disease is the nature of post-diagnosed sexual behaviour of seropositive patients. This is the period when infected persons need counselling, not only to keep themselves fit but also to avoid further transmission of the disease through sex or other means. In a country where counselling of patients is not well developed (Ego and Moran 1993), knowing the attitudes and behaviour of diagnosed patients towards their condition and to others is important for the development of intervention programs and to assist the patients to lead healthier lives.

The sexual behaviour of HIV-seropositive patients was explored, beginning with issues on sexual behaviour in couples when a partner is infected and patients’ sexual behaviour after infection. To the question whether a person had the right to refuse sex with his or her partner who was known to be HIV-seropositive, 82 per cent reported that the person had the right to refuse. Seventeen respondents (12 females and 5 males) felt that the partner did not have the right to refuse, and their reasons were that the two people involved were married or partners, or the partner could have been infected already anyway, or they could use condoms (Table 6). When asked about their own behaviour, 15 (10 males and 5 females) of the respondents said that they had had sexual relations with their partners since they were diagnosed HIV-positive. Of the number ever having sex with partners, nine (4 males and 5 females) reported protecting themselves and their partners by either using condoms (8) or avoiding penetration (1), but six, all males, did not protect themselves or their partners. Three out of the six reported that they did not protect themselves because they did not believe that they had contracted HIV.

Ten of the respondents had sexual relations with people other than their regular partners, four of them with only one person, three with two people each, and three with three, four and eight persons respectively. The people involved were casual partners (3), stranger (1), prostitute (1) and girl or boy friend (5). The reasons for doing so were desire for sex (6), need for money (2) and disbelief of being infected (1).

Denial, as depicted in the behaviour of those who reported that they did not believe that they were HIV-seropositive, is part of the syndrome associated with the disease. Mensa-
Bonsu (1993) has defined denial syndrome to be among other things, 'a firm refusal to accept a certain state of affairs as real' (p.13). Their denial and unprotected sex had put some people at risk of infection, with some of them reportedly involved in sex for money. Thus, some of the infected persons had knowingly been involved in sex for financial reasons in a situation where condoms are rarely used. Some of the infected persons are people who were involved in the sex trade in the first place for financial reasons (Adomako 1991; Anarfi 1993). As the epidemic gains ground, the public health establishment and the government will have to face these realities and assess some of the economic, social and emotional consequences of the disease.

Table 6
Sexual rights of infected person and actual sexual behaviour since diagnosis (%)

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has one the right to refuse sex with infected partner?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Responding 'No'</td>
<td>8.9</td>
<td>15.0</td>
<td>8.4</td>
</tr>
<tr>
<td>Should one refuse sex with infected partner?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Responding 'No'</td>
<td>12.5</td>
<td>11.9</td>
<td>12.1</td>
</tr>
<tr>
<td>Ever had sex with partner since knowing seropositive status?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Responding 'Yes'</td>
<td>9.9</td>
<td>12.5</td>
<td>10.6</td>
</tr>
<tr>
<td>Ever had sex with regular partner and another person?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Responding 'Yes'</td>
<td>7.5</td>
<td>3.0</td>
<td>4.2</td>
</tr>
</tbody>
</table>

Discussion and conclusion

AIDS is not the leading cause of ill-health or of death in Ghana at the moment (Ghana, Ministry of Health 1992). However, the nature of the disease is such that it has ramifications beyond mere infection. For instance, as a disease transmitted through heterosexual contact, there is potential conflict between reproductive interests of individuals or groups and public health concerns. In areas where there is a demand for high fertility and the level of HIV infection is high, some individuals are likely to be put at risk in an effort to achieve their reproductive goals. AIDS as a disease affecting young adults has the potential of creating an orphan generation. Furthermore, in the last two decades individuals and groups in a number of sub-Saharan African countries have become vulnerable to infection because of poor health services and facilities, and deteriorating environmental and social-economic conditions. These and other factors have contributed to give AIDS a high profile in international circles (WHO 1994).

Research on AIDS touches on some of the intimate issues in human life such as people's sexual behaviour, an area difficult to research (Schoepf 1988; Caldwell et al. 1994). Responses on such issues can rarely be cross-checked since they do not lend themselves to observation or some other forms of research strategy. However, the results from this research indicate that it is possible to obtain some information on sexual behaviour as it relates to the transmission of diseases. The respondents appeared to be open about some of their sexual experiences; perhaps the interviewers served as sympathetic ears to some of the patients.

However, ascertaining the reliability and validity of information obtained goes beyond a single cross-sectional study (Dare and Cleland 1994); this is an issue which has to be considered in any research on sexual behaviour. Experience from the survey suggests that a number of approaches will have to be adopted to collect information on individuals and groups, particularly data from patients and their relations who face stigmatization and discrimination. For instance, our knowledge on the coping strategies adopted by patients and their relatives, particularly those directly responsible for the physical care, is at best scanty;
understanding this aspect calls for long-term data collection on patients and their relations. Among the strategies that can be adopted to collect data are counselling sessions and intensive observation: counselling will help to catalogue some of the inner feelings of patients and their relatives, issues which are not well documented and are difficult to obtain in interviewing sessions; and through intensive observation detailed information can be collected about the daily activities of patients.

African societies have been portrayed as community-based and providing support for their members: as indicated by Goody (1969), 'Family responsibility (in Africa) has not diminished to the point that national welfare agencies have constantly to step in' (p.85). One of the areas known to have strong familial support is health. However, the available evidence suggests that this 'idealized past' is under strain, either independent of or as a result of HIV/AIDS infection. That sick family members are ostracized is contrary to expectation, creating conditions of despair and hopelessness. In a country where there is no intensive care for AIDS patients at hospitals and home care is provided by family members, the few patients who are abandoned face problems. Currently, only a few mission-run hospitals and clinics provide support services for families caring for their relations at home; some were even under strain from underfunding (Awusabo-Asare 1994). Although counselling is available in government hospitals for patients, there is not enough and some patients do not attend these sessions for a number of reasons, including the inability of some of them to afford the cost, that they do not want people to know they are suffering from AIDS for fear of stigmatization, or they are too weak to move on their own. At some of these fixed locations the staff were few, over-stretched and without adequate logistic support (Ghana, Ministry of Health 1992). The evidence suggests that there should be a well-thought out program of support for HIV/AIDS patient in their homes: this is important because in the event of case overload the present facilities at our hospitals and clinics will not be able to cope with inpatient care. While the numbers are small, structures should be put in place to promote and support home-based care. More importantly, given the nature of the disease, home-based care is going to be the norm and so we should start planning for it now. Ghana can learn from the alternative approaches adopted in Uganda and Zambia (Masheija et al. 1993; Foster 1993, both quoted in Ainsworth and Over 1994).

There are also hidden costs of AIDS which are not immediately apparent. An example is the plight of the six-year old girl in case 1 described above. Given the situation, it is likely that she will not be sent to school. Her mother needs her services since there is no adequate support for her, but this is also the time when she should be in school to prepare for her future. Some of these issues will have to be brought out into the open for resolution.

At a wider level, however, the search for solutions will have to be more than targeting individuals or high-risk groups for intervention programs. The fight to reduce the spread of HIV infection is likely to be successful if there is a general policy of reducing both individual and collective vulnerability. Some of the people suffering from AIDS in Ghana now are people who took risks during the period when the economy of the country had virtually collapsed (Alderman 1994). For instance, the economic hardships led to large-scale migration of Ghanaians to neighbouring countries where some of them, especially the females, entered the sex trade: some of these people returned as AIDS sufferers in the mid-1980s (Adomako 1991; Anarfi 1993). This is a challenge not only for the governments of sub-Saharan African countries but also for the international community. AIDS has implications beyond the borders of one country.
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AIDS and the Ghana legal system: absolute ignorance or denial syndrome?

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The emergence of the Human Immuno-deficiency Virus (HIV) and its end-stage Acquired Immune Deficiency Syndrome (AIDS) has opened a new chapter in world affairs. The nature of the infection, and the modes of transmission, are giving birth to a new culture in all spheres of life. No longer are issues pertaining to human sexuality considered unworthy of mention in decent society, and no longer is an individual's sexual lifestyle a private matter. No longer are children to be kept ignorant of sexual matters as a means of offering moral protection to them. Quite to the contrary, moral protection, at the present time, lies in openness about human sexuality and the levels of responsibility that should accompany the individual's sexual self-expression. The school curriculum now contains information about AIDS as well as the use of condoms for prevention. Contraceptives are advertised openly and even on prime-time television. Partners in relationships are keeping a lookout for evidence of infidelity out of fear of what such infidelity could mean to their own lives. Suddenly, individuals in Ghana are willing to stand up and identify themselves as sufferers from a dreadful disease knowing full well the implications of such publicity (see Mirror 9 October 1993:1). All these changes in attitudes began to occur within a period of eight years since the first official sufferers of the disease were discovered in this country. Indeed, it is no exaggeration to characterize it as a social revolution.

With all revolutions comes the realization that institutions and rules based upon tenets that are no longer valid must give way to new ones that are required to handle the emergent problems of the day. Thus, a social revolution such as has been described, has brought with it a need to re-examine the social institutions, in order to develop a response to the emerging concerns. Just as the bubonic plague in twelfth-century Europe wrought such social changes that social ideas and institutions had to be refashioned, so it is that the current medical emergency of AIDS may assume the proportions of a social emergency and so require responses that may fundamentally change our attitudes in all of life.

The social institutions that have to be looked at include the legal system of Ghana. For these purposes, 'Legal System' refers to the whole range of activities beginning with law-making, through the judicial system, to the institutions responsible for the execution of the laws (Dias 1985: 60-62). All these institutions together are responsible for the social function of regulating behaviour and are therefore all the subject of this discussion. A consideration of the pertinent issues would reveal that all these different sectors of our national life, subsumed under the expression 'legal system' have to develop an adequate response to new challenges engendered by this social revolution or risk being marginalized in current efforts to fight the disease AIDS.

In order to assess what the appropriate response ought to be, it is necessary to look at the responses so far, to determine what more needs to be done, or done differently. However, the question 'What is the response of the legal system in Ghana to this onslaught by an incurable disease?' elicits no response other than the exchange of baffled looks. It appears that at the
current time, the response is one of total silence. The legal system is operating as if there were no new issues to which it ought to address itself. Is this attitude born out of ignorance of the social consequences of the disease, or the belief that stoically denying the existence of this disease in our country will make the issues disappear? Many other countries, even in the West African sub-region, have enacted legislation on various aspects as far-flung as changing the health requirements for immigrants, surveillance on sufferers from HIV, and even quarantining them (Tomasevski et al. 1992). Whatever the individual merits of the various pieces of legislation, there is at least an indication, in those countries, that something happened in the decade of the 1980s which required a response of sorts from the legal system. Not so with Ghana, which has taken no discernible steps, in any direction, despite the frightening statistics emerging from the medical experts who have been charged with the monitoring and control of AIDS.

The aim of this paper then, is to expose some of the more obvious issues that require responsive action on the part of the legal system. The experiences of other countries are cited and relied upon to show what directions the law could take in developing these responses. At the same time, the problems inherent in some of the modalities adopted by other countries are highlighted, so that efforts can be made to avoid those pitfalls when we finally come round to tackling the legal issues thrown up by the advent of this disease.

General issues

The infection

The condition of HIV infection and its final product, the disease AIDS, presents problems that are altogether new in the world of epidemics. Variously described as 'epidemic' or 'pandemic', AIDS has characteristics that make the challenge of its control a serious one for any legal system. But first, the incidence. The HIV infection which results in AIDS is a condition that is now recognized as having the notable features of suppressing the immune system of a sufferer. This suppression permits the onset of opportunistic diseases leading eventually to death (see Begg 1989:2). It is insidious in nature and an infected person can remain healthy for years. Its progress has now been recognized as consisting of four main stages (Kirby 1993:356):

1. Acute initial infection during which many people suffer a viral illness with fever. During this period, however, any tests would show negative results.
2. Asymptomatic infection, when infected people are healthy but would test positive for antibodies. This interval is of uncertain duration. Estimates have varied from five years to upwards of ten years. Recent research shows that even when exposed to the risk to the same extent, some people do not contract the virus.
3. Persistent Generalized Lymphadenopathy. This stage is characterized by night sweats, weight loss and enlarged lymph nodes.
4. Full-blown AIDS resulting in death, often from opportunistic disease. During the whole of this period however, the virus can be passed on to others, even though the sufferer may show no outward signs of illness.

This disease is thus one which can lie hidden in an individual for years, without any obvious signs of illness unlike the other epidemics that have afflicted the world in the past.

1 The list of countries with AIDS legislation at the end of 1990 included the following in West Africa: Liberia, Niger, Togo, Guinea, Mali, Senegal, Guinea-Bissau, Chad.

2 In 1986, two cases of the disease were reported. This number had grown to 11,872 by September 1993.
The manner in which the disease manifests itself is not the only problem with serious implications for the world in general. Another serious problem is that, unfortunately, despite heavy investment in research, there is as yet no recognized cure.

**Modes of transmission**

The modes of transmission have also now been determined to be specific excluding accidental contacts, and other unintentional modes of communication. The specific modes of transmission are sexual contact; contact with infected blood through contaminated equipment or transfusion of blood; and perinatal transmission, that is, from infected mother to baby during childbirth.

**The social epidemic ‘AFRAIDS’**

The three factors outlined above—the nature of the disease, incurability and its modes of transmission—have determined social attitudes to the disease. These attitudes have been characterized as another epidemic dubbed ‘AFRAIDS’. Thus any discussion of the social dimensions of the disease must recognize that there are in fact two epidemics: the first epidemic is a medical one and the second a social one; but the social one is dictating the pace and spread of the medical one. The major problem for us in Ghana is that whilst the medical experts are grappling with the medical epidemic as well as trying to manage the non-medical problems of the infected, the social epidemic is spreading unchecked. The profound way in which the second epidemic can affect the life of the ordinary citizen and thereby frustrate the efforts of the medical experts is the major reason why, among other institutions, the legal system should concern itself with the social epidemic and in that wise assist the efforts of those tackling the medical epidemic. The danger posed to the enjoyment of the individual’s civil rights, the opportunities offered for the exploitation of the infected and affected, as well as the possibility of affecting time-hallowed ethical rules of all the major professions, call for the Law’s intervention.

The need for Law to intervene would be served by an examination of the nature of the second epidemic. There are good reasons for the emergence of the social epidemic ‘AFRAIDS’. The most potent of them is that HIV infection means eventual death, preceded by a period of prolonged misery and suffering. Human beings react instinctively to the prospect of death despite the certainty of it as an event for all mortals. Thus any condition which means certain death for the individual is unlikely to be courted by the average person. Although every human being expects to die some day, the fact that the day is not known does not torture all of one’s waking moments. This disease, however, puts one in a position where one is forced to confront the certainty of death and to await the event in misery and physical torture. This psychological torture is more than ordinary human endurance can contemplate. The other consideration is the knowledge that contracting the disease carries a social stigma of immorality which would be hard to explain away. For these reasons, the disease AIDS strikes terror in everybody’s heart. The terror in turn produces all manner of irrational actions:

AIDS... is spreading inexorably... stamping with terror the honest faces of rational people, church-going people, charitable people who would give their bank rolls - their lives even - to help victims of flood or fire, but who turn their backs on neighbours with [the disease] (Waltzer 1990)

It is indeed ironical that people who would be willing to risk their lives saving others would shun those with the disease because of the risk of catching the disease, and consequent death. One would have thought that the truism observed by the sages in pidgin English that...
‘All die be close eye’ (i.e. death is death however caused) would hold sway. Not so with death through AIDS. This attitude has serious consequences for the whole society, and is thus the modern issue with which the society must grapple.

A second reason why this AFRAIDS epidemic is rising is the mode of transmission of the disease AIDS, as well as the tag of immorality associated with it. Apart from those acquiring it at birth or through blood transfusions — and it is acknowledged that they are generally few in number — the other modes involve sexual activity, heterosexual or homosexual, or drug addiction. These two latter modes thus have associations of immorality or at least suggestions of loose and licentious living. Despite the fact that there is evidence that even one sexual encounter is enough to cause an infection, the tag of moral depravity persists. This perception is not helped by the kind of messages that are being propagated on the electronic media. Thus, to the fear of certain death is added the stigma of immorality. This stigma aggravates the agony of the sufferer, and also increases the level of abhorrence of non-sufferers towards those who suffer it. No one escapes from the stigma of immorality. Even babies born with AIDS do not escape the stigma since the suggestion of an immoral ancestry serves to justify the rejection of them by the generality of ‘decent’ society.

The third and by far the most potent factor in the rise of AFRAIDS is the absence of a cure for AIDS. Unlike other diseases that cause death but which are curable, such as cholera, AIDS has to be avoided altogether if one is to escape its effects. Had a cure been already found, the sheer terror with which AIDS is perceived would be considerably lessened although people would not be the more anxious to contract it. As matters stand at the moment, the greater the distance between an individual and potential sources of infection, the higher the possibility of being spared the burden of the disease. All these factors have ensured that the strident calls for protection against sufferers have been induced by sheer panic, and often not very well-considered measures in those countries where some action has been taken.

Emergent issues

The preceding discussion has shown that there are several problems that must be confronted with some urgency. What then are the issues at stake? First, the spread of the diseases must be controlled; secondly the sufferers must be cared for; and thirdly, they must be protected by the law against abuses from those who would rather despatch them than suffer the possibility of their spreading the disease. These three objectives are linked, for the ability to control the disease depends upon identifying those capable of spreading it. This also would determine those in need of the arrangements for care that have to be put in place. These two objectives in turn would be attainable only if there were very little to be suffered legally, socially and economically, by a person so identified. Thus the policies to protect sufferers and provide for their care are directly linked to the success of any control measures that would be adopted.

Issues of control

The absence of a cure has ensured that the need to contain the spread of the disease has become paramount. This paramount need has in other countries, particularly in the industrialized West, spawned various public health measures as well as other pieces of legislation, such as immigration requirements, which are expected to assist in containing the spread. In the anxiety to respond to public calls for action, governments have lost sight of the purpose for such legislation, with disastrous results. Efforts to stem the spread of this disease have resulted in the adoption of measures that have driven carriers and other sufferers underground. It is now generally admitted that with increased inability to own up to infection comes an increased risk of transmission. People who know of the dangers to themselves arising from characterization as AIDS sufferers are unlikely to assume that burden. Many
countries now require compulsory testing of select groups only, such as prostitutes, drug addicts or immigrants, who are considered to be an obvious risk owing to their lifestyle or place of origin. Those countries which tried compulsory testing, have abandoned it because it is expensive. Further evidence has also shown that it was of doubtful utility anyway. Cuba is now the only country to maintain compulsory testing for all.

Among the control measures being adopted in some countries is the revision of quarantine regulations to include AIDS sufferers, as well as a resort to the criminal law by the criminalization of certain activities, including conduct deemed risky as being conducive to the spread of the disease. In New South Wales, there is even criminal liability for failing to inform a sexual partner of one's infected state (Kirby 1993:361).

Although resorting to the criminal law as an instrument of disease control has dubious legal antecedents, this has not deterred those who wish to use it. Even for novel situations, old rules are being re-examined, stretched and re-interpreted to fit the new problems. For instance, traditionally in Anglo-American criminal jurisprudence, body parts have not been considered as 'weapons' for the purposes of considering whether an attack is a common assault or an aggravated assault resulting in grievous bodily harm. The reason for this is to be found in the philosophical notion that a weapon is an implement external to the person of an individual, which is carried for the purpose of causing harm. Since the emergence of the disease AIDS, however, several courts in the United States have had occasion to pronounce on the issue. Some have restated the principle that teeth, even the teeth of an infected person which are used for the purpose of causing injury, cannot be regarded as an 'offensive weapon'. Others are not sure, and believe that juries should, on a case-by-case basis, determine whether the body part is used as an offensive weapon (see Tomasevski et al. 1992).

There are compelling arguments on both sides. Those who choose to maintain the old rule have voted on the side of certainty, but are there not other considerations such as the deadly nature of the virus for which reason an infected person would attempt to use it in a fight against an opponent through a bite? This is not to say that the position of the other group is more defensible because there is also virtue in certainty in the administration of the criminal law. Their attitude indicates by implication that the intention with which the teeth are used is the determinant of whether or not they are an 'offensive weapon'. Surely this throws the law into some disarray? How do police officers figure out what charge to prefer when a particular part of the body has been used to cause injury? The big question here, however, is why well-worn norms are being suddenly questioned and re-defined. The answer is 'AFRAIDS'.

Another way in which the criminal law is being pressed into service is the introduction of specific legislation criminalizing certain kinds of conduct which were not criminal before. The view that the intentional spread of disease, or risky conduct that encourages the spread of dangerous diseases, ought to be criminalized, has found favour in some jurisdictions in the United States. This view has fairly respectable common-law antecedents, and is thus not a new phenomenon. In R. v. Vantandillo, the court found criminal, the carrying of a child with smallpox along a public street, thus exposing other persons to the danger of infection.

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3 Cuba is reported to have isolated all known infected persons in a special camp with excellent facilities. This is just a euphemism for quarantine.

4 This is a misdemeanour and therefore makes one liable to a maximum term of imprisonment of three years. See section 296(4) of Criminal Procedure Code.

5 A first-degree felony carrying a maximum term of life imprisonment. See section 296(1) of Act 30.


7 4 M & S 73; 105 ER 762

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However, this view was discarded in *Queen v. Clarence* where the majority of judges did not consider it proper for the spread of an infection to be held criminal. This was a case in which a man who knew he had gonorrhoea had sexual intercourse with his wife and infected her. In the words of Judge Stephen, 'Not only is there no general principle which makes the communication of infection criminal, but such authority as exists is opposed to such a doctrine in relation to any disease'\(^8\) (p.39). One of the dissenting judges in that case indicated that he did not fully appreciate the difficulties raised by his colleagues because in appropriate cases there would be need for the law to respond to deliberate acts calculated to spread a disease. He indicated that he could conceive of 'a state of things in which a kiss or shake of the hand given by a diseased person maliciously with a view to communicate his disorder might well form the subject of criminal proceedings'. The minority view in this case is now being resurrected and relied upon as the direction in which the criminal law must move in the face of HIV/AIDS.

The attraction of this attitude at the present time is exemplified by the decisions of American Military Courts in two cases. In both these cases involving military personnel, the accused persons who were AIDS patients were convicted of aggravated assault. Their convictions were based on the fact that although they had been informed of their disease, its mode of spread, etc., they had gone ahead to engage in unprotected sexual intercourse without informing their partners of their condition\(^9\). For such risky behaviour, the court found them guilty of conduct likely to result in death or bodily harm. It is clear that the only reason their acts were considered worthy of punishment was the introduction of a new and fearful element: the spread of HIV.

Does Ghana want to take a like position?

### Classification

There are other difficulties with the disease which, though medical in nature, carry serious legal implications. This is the problem of classification. AIDS is variously classified as 'contagious', 'sexually transmitted' and sometimes 'infectious' or 'communicable'. With the various classifications in the different countries, AIDS is transformed from one phenomenon into another as it moves from jurisdiction to jurisdiction. This is because all these classificatory words carry various connotations. For instance a sufferer from an infectious disease is subject to quarantine for the duration of the disease\(^11\), but someone with a disease classified as 'a sexually transmitted disease' is not. The issue of classification thus has serious implications for any country's ability to adopt effective control measures to fight this disease.

The classification as an 'infectious' or 'contagious' disease carries its own problems. Such classification makes a person subject to quarantine regulations for the duration of the disease for purposes of treatment. The difficulty here is that the non-availability of a cure for AIDS renders difficult attempts to put any sufferer into quarantine, since this is likely to lead to a detention for the rest of the person's natural life. This is a serious consideration all on its own, but that is not the biggest of the problems with quarantine. The real issues are the following: what is the use in quarantining AIDS sufferers when there are other infected but healthy-looking persons, in the nature of carriers, who are equally, or perhaps even more, dangerous to the uninfected? How can all infected persons be found out without compulsory testing of

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\(^8\) *Queen v. Clarence* (1888) 22 QBD 23.

\(^9\) *Queen v. Clarence* (1888: 52). See also (Bronitt 1994).


\(^11\) See Quarantine Ordinance, Cap. 95.
all the citizens? With what frequency would such mass testing be done in order to isolate those who might be infected after the mass testing? Can any country afford the expense of such testing with the frequency that would make the policy effective? These and other such questions render the prospect of quarantine an exercise in futility.

A classification as a sexually transmitted disease (STD) does not create an easier route for those charged with working out a solution since it implies that persons with whom the sufferer has had sexual contact must be traced. Such tracing is embarrassing to the infected as well as affecting the privacy of every person in that category. Persons so traced would, particularly those testing negative, be unlikely to keep their experiences to themselves. The classification of AIDS as an STD also affects the confidentiality of the medical personnel. If they are required by law to trace the sexual contacts of the sufferer, then they cannot guarantee confidentiality to the person now diagnosed to be infected. Without absolute confidentiality, persons having reason to suspect that they are infected would do their best to avoid consulting qualified medical personnel.

The Ghanaian situation

The Ghana legal system seems to have closed its eyes to many of the issues discussed earlier. Except in medical circles, the import of this new disease, which threatens the very fabric of society, is receiving no serious attention. Indeed, a look at the statute books would seem to indicate that either the public health regime established in colonial times for disease control still works perfectly, or else the prevention and control of diseases is not a matter of priority now in spite of the Primary Health Care program. It is unclear whether ignorance is the culprit, or whether denial or plain apathy is responsible for this state of affairs. Why would a legal system pretend that its guidance is not required on a major social issue such as this one? The exponential nature of the growth of this problem would be indicative of the problems that are being shored up for the future if no reaction is forthcoming from the legal system. Ghana's problems began in 1986 when the first two cases of HIV were recorded here. In under eight years, by September 1993, 11,872 cases had been reported. Judging by the number of people without access to hospitals, this figure is by no means an accurate indication of the size of the problem. Certainly those people who never reported to a health facility and have died in the villages, do not feature in these statistics. From these figures, it is clear that the attitude affecting the legal system has grave import for everyone in the country: the infected, the affected and non-infected people.

In 1990, the Secretary for Health of Ghana issued a policy statement on the testing of international travellers for the virus (Sarpong 1990). The statement was to the effect that the government wholly supported the WHO stand on the testing of international travellers because such testing was of doubtful utility, and very expensive.

The fact that an incoming traveller carries a certificate of freedom from HIV infection does not mean he is not carrying the virus. In the first place the certificate may be false. Secondly tests to determine HIV infection are not 100% specific and thus a negative result may be a false negative. Thirdly the timing of the test in relation to the date of travel is important in determining whether infected persons are detected or not. The longer the period between the test and the date of travel the greater the chance that the traveller might have become infected between test and travel (Sarpong 1990).

Although the reasons given were unconvincing, that represented the position of Ghana on the point. If this matter had been discussed by the generality of the population, it is unlikely that they would have adopted such a light-hearted attitude to the value of testing on the sole ground of the presence already of the disease in the country. The question here is this: if the
countries with better health-care systems and better facilities for the sick are still testing international travellers, why is a poor country like ours convinced that international travellers pose no risk to Ghanaians?

What public health laws exist at the current time, and how may they be pressed into service for the control of this new disease? The three most prominent statutes are the Mosquitoes Ordinance, Quarantine Ordinance and Infectious Diseases Ordinance. The Infectious Diseases ordinance lists as infectious the following diseases: 'plague, cholera, small-pox, yellow fever and any disease of an infectious or contagious nature which the Minister may declare in manner hereinafter provided' (Section 2, Cap. 78). It is those infected by these diseases who are subject to quarantine under the Quarantine Ordinance. Thus, where a disease cannot be classified as either infectious or contagious, it is not covered by the Ordinance at all. Regulations on quarantine are intended to prevent the spread of disease by isolating those who have contracted it. This is, however, done for the purposes of treatment. It is thus clear that neither of these pieces of legislation is any use in the current situation.

At the level of constitutional provisions, may recourse be had to the provisions of the general police power of the State?12 This power includes the authority to regulate public health and welfare of the community for the purposes of protecting society from the harm any individual may cause, and preventing individuals from inflicting harm on themselves (Werdel 1990). The State can thus adopt measures that would achieve protection by compelling its citizens to conduct themselves in a prescribed manner. A consideration of the provisions on the police power of the State reveals that quarantine, and restriction of movement for reasons of public health are the measures mentioned for the purposes of the control of infectious diseases13. However, for the reasons already outlined above, the provision on quarantine cannot be usefully pressed into service, neither can the clause on restriction of movement14. The reason for this is obvious: restricting the movement of HIV and AIDS sufferers without more, would be pointless as the kind of activities that can spread the virus are not necessarily curbed by restriction of movement of particular individuals. Therefore new measures are required to deal with this problem.

One of the most serious problems in this area is the problem of individual attitudes and how they threaten individual liberty. The reason for such an assertion is that in a study on attitudes to the disease, 87.5 per cent of the sample, who happened to be nurses, were of the opinion that HIV and AIDS sufferers should be quarantined (Walker 1990). This opinion was held despite evidence that the condition was known to be incurable. In other words, the people were advocating a detention for life for HIV carriers and AIDS sufferers. This attitude is not restricted to the nurses in the sample. In January 1992, a District Magistrate in Accra denied bail to prostitutes brought before him for soliciting (West Africa Magazine 27 January - 3 February 1992). According to the report, his reason for doing so was that he required them to submit to an AIDS test before granting bail. There are many interesting questions on this issue. What was the real purpose in such a requirement? Could the magistrate have ordered their detention indefinitely if the tests had revealed that they were HIV-positive? Is the absence of disease now a requirement for bail? Do the courts have a residual power to protect the public against persons with dangerous diseases? Such instances merely serve to illustrate

12 This is a reference to the ability of the State to compel its citizens to adopt certain modes of behaviour even against their will, e.g. citizens are compelled to stay alive, by the prohibition of suicide; women who get pregnant are compelled to carry the pregnancy to term, by the prohibition of abortion.

13 Article 14(1)(d) and Article 21(4)(c) of 1992 Constitution.

14 This omnibus exemption clause upholds the lawfulness of 'the imposition of restrictions that are reasonably required in the interest of defence, public safety, public health [emphasis mine] ..., on the movement of residence within Ghana of any persons generally or any class of persons ...'
the dangers in relying on knee-jerk reactions at a time when everybody in the society feels threatened.

Attitudes that are even more alarming were revealed in a recent study by Adjei, Owusu and Ablordey (1993). The study, which was based in the Ashanti and Northern regions, and which used the Focus Group Discussion method, showed that a large number of members of focus groups were of the opinion that persons diagnosed as infected should be surreptitiously injected with poison by the doctors so that they would not be able to spread the disease (Adjei et al. 1993:46). Some members opined that if a sibling contracted the disease, they would find a way of killing the person to save the family from disgrace (p.103). Is no one worried that the Ghanaian extended family whose virtues are much touted may now be the cover for murder as a result of this disease?

It is against this background that the absence of visible action on the legislative front gives cause for concern. In July 1993 amendments to the Criminal Code were debated in Parliament. These amendments related to sexual offences and the penalties attached. This was the most obvious occasion for some action to have been initiated on the issue of AIDS since the emergence of AIDS has increased the dangers to which victims of sexual assault are exposed. Unfortunately, AIDS did not feature in the discussion of these offences with the result that despite the alarming statistics of the increase in HIV-positives and AIDS, no consideration was given to these increased dangers. Was this again a classic act of denial, or mere ignorance of the pervasive nature of the disease?

Although Parliament has since this occasion requested, and received, a briefing from the Minister for Health on the disease, action is yet to come out of those sessions. This observation notwithstanding, it is of some moment that the Members of Parliament have exhibited a desire to be properly informed on the subject. It is certainly a welcome first step that would decrease the possibility of policies being adopted because of AFRAIDS. As has been pointed out, there is a danger that policies that may be adopted would not be even adequate responses to the problem. The danger is greatly increased when as a result of AFRAIDS, policies are adopted for the purpose of subjecting sufferers to oppressive measures, such as the confinement of the infected. A proper appreciation of the issues at stake is therefore the \textit{sine qua non} of the formulation of proper policies. As Kirby (1989) pointed out, 'Good laws and policies arise out of good understanding of the relevant scientific data. They do not arise of guesswork, idiosyncratic decisions still less from prejudice, fear and loathing' (p.47). This observation still does not obviate the necessity that action must proceed beyond this first step, and quickly.

What are some of the questions to which the legislature ought to address itself? These fall into different categories. Some are regulatory in nature, and others are in respect of protection for the infected. For the criminal law, some of the issues are the following: ought there to be criminal liability for the intentional spread of the disease through indiscriminate sexual activity? What about intentionally donating blood knowing one's HIV-positive status? These questions are not idle queries. In a recent incident, a man who had been diagnosed HIV-positive at Cape Coast travelled to Saltpond to donate blood. He was found out only because one doctor's suspicions were aroused as to why a voluntary blood donor would move away to donate blood. How many such incidents have occurred without detection? If it has happened once, it can happen again. Should there be increased penalties for infected persons who commit sexual offences? What should be the criminal liability of third parties who intentionally or negligently pass on contaminated blood to patients in a hospital or other health facility? This is not a far-fetched possibility. In a study carried out in Berekum-Jaman District on the HIV seroprevalence among certain groups of the population, as many as nine per cent were found among 261 blood donors in 1990 (Sardick 1992). In 1993, the average for such donors in the Western Region was a frightening 28.9 per cent (Baka 1993). Other
questions are: should there be criminal liability for persons who engage in reckless conduct likely to spread the disease, such as by the use of unsterilized instruments in the course of their occupations, for example herbalists, traditional birth attendants, wanzams and barbers? Should 'soliciting for immoral purposes' remain a crime when the AIDS Control Programme is targeting prostitutes as a means of reducing the spread of the disease? Should a seropositive status be a defence for euthanasia, or attempted suicide?

Even health-care workers cannot be trusted to look out for the welfare of the public. The recent case in France involving doctors in the blood transfusion service is instructive on this score. Those doctors were found to have knowingly kept hundreds of litres of contaminated blood in hospital stocks, and given them out for transfusion. Therefore the possibility of health-care workers intentionally or negligently allowing such a situation to occur, is a real one. Similarly, there are people who would rather avoid the expense of procuring sterilized equipment for their occupations by re-using syringes or other equipment, than operate in the manner that would protect the public. The dangers posed by AIDS are such that the criminal sanction should be invoked to the end that it might deter potential violators.

Apart from the criminal law, there is need for the development of a regulatory framework to tackle the issues arising from this epidemic. One of the more pressing issues is the ethics of curative measures. Every so often, the media feature a herbalist who claims to have treated and cured a number of people with AIDS. No one considers this to be human testing of drugs, but are the people involved not being used as guinea pigs for the testing of all manner of herbal preparations? Why should the efficacy of a drug be proved only by its effect on human beings? Is that not the role of guinea pigs and other laboratory animals? Could any pharmaceutical company adopt such methods without a hue and cry from national and international organizations? Yet we suffer this exploitation of the desperate by the opportunists to continue.

Other regulatory measures are also required to resolve the issues such as the following: should hospitals and other health facilities not have a statutory duty to ensure that the appropriate safety regulations are followed by their staff, as well as the correct reporting procedures? Ought there not to be anti-discrimination measures for the protection of the infected? In a number of studies, between 74 per cent and 80 per cent of the sample of respondents indicated that they would not eat with an AIDS patient (Walker 1990; Amofa 1992). Indeed the higher figure is from a sample of nurses. Would such people as represented by the sample attend to a medical emergency involving a known AIDS sufferer? Would they willingly rent out accommodation to such people, or keep them as tenants if they were landlords? What about the 70.7 per cent of the sample who indicated that they would not like to work next to someone with AIDS? Would such people employ people with AIDS? Would they calmly accept a decision by their common employer to continue to employ such a person? Would they tolerate such a person as the teacher of their children? Or a doctor to whom they must go for treatment? If they were lawyers would they represent such a client? What about their families? In Kenya, a female teacher who refused to divorce her infected husband was dismissed because parents would not let her teach their children when this fact became known (Muriithi 1993). People cannot be compelled to relate to the infected in the privacy of their homes, but should such attitudes be encouraged where facilities provided by the State with public funds are concerned? We may vigorously deny that there are such problems in this country, but merely pretending that there would be no such problems in the immediate future will not make the issues disappear. On the contrary, such an attitude is likely to cause untold hardship to the sufferers who do not need any external force to increase their misery, and who need all the protection that any country can offer to its citizens.

There are other issues pertaining to individual lifestyles; this is because certain lifestyles are known to be risky. The issues then are: should there not be legislation aimed at backing
the educational measures being adopted, in order to enforce the observance of some preventive measures? In colonial days, the Mosquitoes Ordinance, 1911 (Cap. 75) was enacted to enforce sanitation measures that would assist in the eradication of malaria. In the same manner that the this ordinance made it an offence to create conditions that would promote the growth of mosquito larvae, ought certain lifestyles to be controlled by legislation? Would such an intrusion into our bedrooms be acceptable to the citizens of this country? The answers to these questions involve choices which have to be made at one time or the other. Why can we not start discussions now?

Reinforcing ethical rules on confidentiality would also require examination. The issue of confidentiality is directly related to the effectiveness of the control measures. Without adequate assurance of confidentiality, few would seek medical assistance in recognized health facilities. Yet there are grave challenges to these time-honoured principles. What is the real substance of this duty of confidentiality that doctors owe to their patients? When has it been broken? Where an infected person refuses to share that information with the spouse or spouses, what should be the doctor’s duty? Should the person’s spouse be informed anyway? Are the parents and other close relatives of an infected person entitled to be informed of the condition? What about employers who are contemplating investment in training for an employee? Must school authorities be told of a child’s condition? In a country where the extended family system ensures that many people feel an affinity towards very many others, keeping professional confidences about a disease of this nature requires almost superhuman effort. Should that effort be required of all health personnel? These are questions not admitting of easy answers. Yet, it may be that in giving attention to them lies the possibility that solutions adopted would bring sufferers out of hiding and into official statistics. The contrary position would only exacerbate the situation and frustrate attempts at increasing protection. Can the legal system continue to maintain a stoic silence on these issues?

Which way forward?

As a matter of urgency, the problem of AIDS should cease being treated as a medical emergency. At the very least, it must be recognized that a multidisciplinary approach is the only hope for the future. Establishing public health agencies to monitor the spread and educate the public are useful starting points, but they risk being ineffective if action does not proceed beyond those points. The aid of the law must be sought in establishing a regime and adopting mechanisms for control. Legislation can be of assistance, but only if formulated from an informed base.

In order to do so effectively, the government must set up a committee to produce a Working Document for legislative action on AIDS. Such a starting point would have two advantages: it would provide a scientific approach to the issue and thus lower the emotional temperature of the discussions that would follow; secondly, it would put together a team of multidisciplinary professionals whose interaction would serve to adequately cater for the interests of the various disciplines. Currently, the medical personnel are setting up systems aimed at monitoring and controlling the epidemic; these include home-based care. Whilst they are so engaged, sociologists note that the extended family that may be expected to take care of a sick member, is not what it used to be. Therefore it may not be a good idea to design a health system based upon the participation of the extended family. Lawyers are likely to worry more about the rights of their clients and other human rights issues. Other social scientists are interested in the effect of this new phenomenon on the social scene and want to be a part of the solution. Putting such disparate elements together would produce a response which would be a more efficacious assault on the disease.

Recommendations on legislation should approach the issue from the standpoint of protection for the sufferer. At the present time, the stigma of infection is a potent ally to the
spread of the disease. The uninfected can take care of themselves by rejecting and isolating the infected. These methods however only serve to provide incentives for going underground so as not to increase the burden of one’s infected status. It is for this reason that solutions should aim at reducing the social burden of the disease so as to encourage people to seek medical assistance. Once afflicted, there is no hope of cure. Therefore for those already afflicted, there is no incentive to make public their condition since they stand to gain no personal benefit. If they are being called upon to assist the society by protecting the health of others, then at a minimum, there must be legal guarantees that would assure them of the protective arm of the law. As matters stand at the moment, we require a kamikaze mentality in all infected people. Thus, our success in controlling the disease is bound to be limited by the human instinct for self-preservation.

Conclusion

In this paper, an effort has been made to demonstrate the fact that the absence of AIDS-related activity on the legal front is itself a disease. The extent of the problem is such that neither ignorance, feigned or genuine, nor denial that there is a problem requiring action, is of any use in the battle against the disease AIDS. Public health has ceased to be of legislative interest for too long a time and this does not augur well for the health of the country. The AIDS issue goes beyond a public health problem and that fact must be appreciated by all. The nature of the disease, its mode of spread, and the age-groups most at risk compel the conclusion that we continue at our peril to treat HIV/AIDS issues as a mere problem of public health. Indeed, uncontrolled, it would strike at the very heart of the Economic Recovery Programme. Where will be the able-bodied of the society if within the next decade, effective measures are not adopted to stem the tide of HIV infection? How effective can the control measures be if the legal system continues to manifest the symptoms of the Absolute Ignorance or Denial Syndrome? This is a matter that should concern all of us. As John Donne wrote, ‘Any man’s death diminishes me, because I am involved in Mankind; and therefore never send to know for whom the bell tolls; it tolls for thee’.

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Sexual behaviour in India with risk of HIV/AIDS transmission

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The estimate of cumulative HIV-positive persons in India by the end of 1994 ranges from 900,000 to 1.9 million. The corresponding figures projected for 2000 are 2.1 million to 6.7 million. The estimate of cumulative AIDS cases in India by 2000 ranges from 500,000 to 1.2 million. These figures indicate the magnitude of the problems India is going to face in the near future because of the AIDS pandemic.

Although at the initial stage of the spread of HIV/AIDS in the USA and a few other Western countries, male homosexual relations and sharing of equipment by intravenous drug users were the principal modes of HIV transmission, by now the predominant mode of transmission in all countries is heterosexual relations. In India this has always been the case. It is estimated that in India about three-fourths of HIV transmission occurs through heterosexual relations and the rest occurs mainly through transfusion of infected blood and sharing of infected equipment. The role of male heterosexual relations in HIV transmission in India cannot, however, be ruled out, although evidence of such transmission so far is rare.

The risk of transmission of HIV and other sexually transmitted diseases is higher in sexual relationships with multiple partners and without the use of condoms. Premarital sex often involves multiple partners, and extramarital sex, by definition, implies multi-partner relationships. The following categories of people are likely participants, voluntary or non-voluntary, in multi-partner sexual relationships: female prostitutes and their customers, male homosexuals, hijras and male prostitutes. Avoidance of multi-partner sexual relationships, use of condoms and sexual abstinence are usually advocated for prevention of spread of HIV and other sexually transmitted diseases. This paper provides salient findings from the empirical studies made so far in India along with the historical contexts of the topics mentioned above.

Premarital sex

Surveys of adult students of schools and colleges in contemporary India indicate that although premarital sexual experience among them is not as common as in Western countries, it is not as rare as perceived widely. For example, there is no evidence in India yet of premarital sexual experience among students as rampant as that found in the 1991 US National Survey of Family Growth: 76 per cent of young men and 66 per cent of young women in the USA had experienced sexual intercourse by their final year of high school (Laumen et al. 1994: 324). But the estimates of 25 per cent of male students in a Delhi school (Sehgal, Sharma and Bhattacharya 1992) and 28 per cent of male college students in Hyderabad (Goparaju 1994) reporting premarital sexual experience signal an urgent need for appropriate sex education in Indian schools and colleges.

There is very little information on the female sexual partners of unmarried male students. Neighbours, relatives, prostitutes, friends and fiancees have been mentioned as partners in a
few studies. There is an indication that the premarital sexual partner of a male student is often a married woman who may be a relative or neighbour. For example, one-half of all the first sexual partners of 72 college students in Hyderabad were married women older than themselves and a large majority of the partners were relatives. This is somewhat expected because of the higher value placed on the premarital chastity of Indian women than that of men and because most Indian girls are still married at an early age. Some findings indicate that a sizable proportion of unmarried students visit prostitutes. For example, a survey conducted in a red-light area of Calcutta found that eight per cent of the customers of prostitutes were students (Biswas 1994) and another survey in a Bombay red-light area found the corresponding figure as high as 30 per cent (Gilada 1994).

Findings from the responses of middle and upper class men and women to the questionnaires published in Debonair and Savvy — two expensive Indian magazines — indicate a very permissive attitude and behaviour regarding premarital sex among them, almost similar to that among their counterparts in Western countries (Savara and Sridhar 1992, 1993). But a methodologically more rigorous study among these classes in Calcutta, Delhi and Madras found a significantly less permissive attitude and behaviour (Basu 1994). In this 1993 study 17 per cent of male respondents aged 21 - 45 years and eight per cent of female respondents reported experience of premarital sex. However, these figures are also considerably higher than those commonly perceived.

Studies among the urban lower classes show a wide variation in premarital sexual experience. The percentages reporting such experience among 264 blue-collar workers, 258 migrant workers and 139 loom workers in four towns of Maharashtra were 25.4, 32.2 and 12.2 respectively (Savara and Sridhar 1994). The prevalence of premarital relations among sexually transmitted disease (STD) patients is high. In a study of 300 men in Lucknow diagnosed to have STDs, 81 per cent reported having had premarital sexual experience, most of them with prostitutes (Narayan 1984). A strong association of HIV infection with multipartner sexual relations is exemplified by the findings of a study of 115 professional blood donors in Delhi among whom 15 were HIV-positive (Chattopadhyay et al. 1991). All these 15 were unmarried and had multiple sexual partners, mostly prostitutes. Out of 100 HIV-negative donors only nine had multiple sex partners.

No quantitative estimate of the practice of premarital sex is available for any rural community of India, but casual reports indicate that it is not uncommon, particularly for unmarried men. An in-depth study of 72 male college students in Hyderabad revealed that among those who had a rural upbringing, the proportion having premarital sexual experience was higher (46%) than among those who had an urban upbringing (17%).

Anthropological studies in India have provided very little information on the sexual attitudes and behaviour of communities studied. Remarkable exceptions are those conducted by Elwin (1947, 1979) whose popular treatises on a few Indian tribes in central India during the 1930s and 1940s give detailed descriptions of sexual activity among them. For example, his description of institutionalized premarital relationships among the Muria Gonds indicate that almost all adolescent boys and girls of that tribe had premarital sexual relations in village dormitories known as ghotul, where all of them usually spent their nights. Elwin, however, observed the gradual erosion of the ghotul institution due to Hindu intrusion of the Muria territory. Another tribe known as the Santal living mostly in Bihar and Orissa, for whom reasonably good descriptions of premarital sex were recorded in the 1930s and 1940s, is also reported to have a permissive attitude towards premarital sex (Biswas 1956; Mukherjea 1962). But almost no information is available on the contemporary situation among any of the tribal groups.
Extramarital sex

The ideal for a Hindu woman to remain loyal to her husband under all circumstances — patibrata — has mostly retained its social force in contemporary India. As in the case of premarital sex, the violation of marital fidelity is more punishable for women than for men. Women often are bound by their helpless situation to accept their husbands’ deviations from marital fidelity in order to stay in a married state. Despite these ideals and situational constraints, references to extramarital relationships are not uncommon in Indian literature but empirical studies regarding their prevalence and attitudes towards them are rare.

A study conducted among middle-class working women in Delhi metropolis in the 1950s and 1960s shows that attitudes towards extramarital relationships underwent identifiable changes towards permissiveness within a single decade, although different norms of sexual morality for married men and women were still maintained (Kapur 1973).

A few recent studies, varying considerably in quality, in various urban communities of India, show a wide variation in the practice of extramarital relationships. A study among the educated middle class in Calcutta, Delhi and Madras found that the proportion with experience of extramarital sex was nine per cent among men and less than three per cent among women (Basu 1994). Another study in four towns of Maharashtra found that the corresponding proportion was seven per cent in the middle-class group and varied from one to twelve per cent in the lower-class group (Savara and Sridhar 1994). No generalization is possible from these findings but they indicate not only that extramarital relationships are less frequent in India than in Western countries but also that these are not altogether absent as claimed by some staunch believers in the Indian tradition of strict marital fidelity.

Prostitutes

There is a widespread belief in India that prostitutes are primarily responsible for the origin and spread of AIDS and it can be mostly controlled by testing all of them for HIV and isolating those who are found positive. This belief is partly based on the highly publicized initial detection of HIV infection among a few prostitutes in Madras in 1986 and also on subsequent publicity about the phenomenal rise of HIV infection among prostitutes in the red-light areas of Bombay and other cities. It reflects a lack of knowledge about the complex nature of both prostitution and the spread of HIV infection in India.

History in India

Prostitution as a profession has a long history in India. A whole chapter is devoted to it in Kautilya’s Arthashastra written circa 300 BC and Vatsayana’s Kama Sutra written between the first and fourth centuries AD. The devadasi (handmaiden of god) system of dedicating unmarried young girls to gods in Hindu temples, which often made them objects of sexual pleasure of temple priests and pilgrims, was an established custom in India by 300 AD (Basham 1959). There are reasonably good records of prostitution in large Indian cities during the eighteenth and the first half of the nineteenth centuries of British rule; prostitution was not considered as degrading a profession in that period as it was from the second half of the nineteenth century. A Calcutta Corporation publication of 1806 reports that there were 2,540 women in 593 brothels in 82 streets of Calcutta and that tax-payers of about six per cent of Calcutta’s property were prostitutes (Ghosh and Das 1990).
Current situation

Because of the clandestine nature of the sex industry and also because of the wide varieties and geographical distribution of prostitutes, it is impossible to have an accurate estimate of their number in contemporary India. Some guesses are, however, available. Gilada’s (1985) estimates of 100,000 in Bombay, 100,000 in Calcutta, 40,000 in Delhi, 40,000 in Pune and 13,000 in Nagpur are considered overestimates by some critics and underestimates by others.

Empirical data on the way of life and sexual practices of prostitutes in contemporary India are scarce. The advent of AIDS has generated a few empirical studies along with intervention programs in red-light areas of a few large cities. The findings of these studies corroborate the common knowledge that prostitutes, in general, lead a poor standard of life in dilapidated and unhygienic environments (Gilada n.d.; Ghosh and Das 1994). A major portion of what their clients pay is shared by pimps, landlords, madams, financiers and policemen. They do not get nutritionally adequate food and they are exploited by local traders who sell them essential goods. Because of strong prejudice against them they cannot take advantage of the government health facilities and have to depend mostly on local quacks who charge them exorbitantly for treatment and medicines. A large proportion of them suffer intermittently from various kinds of STDs. Most of them are forced to enter this occupation because of adverse circumstances.

Many prostitutes send a part of their income to their families. A survey conducted in a red-light area of Calcutta in 1987 found that 59 per cent of prostitutes were abandoned by their husbands and that many of them originating in Murshidabad district, where young women in many poor families are expected to go into prostitution, remit a substantial amount of money (Rs 475 per month, on the average) to their families (Ghosh and Das 1990).

A few well-designed and well-executed intervention programs by non-government and government agencies in a few red-light areas have started showing signs of increased use of condoms and reduced prevalence of STDs among prostitutes (Jana et al. 1994). One key factor in these successes is the use of trained prostitutes living in the project areas as peer-group educators in raising AIDS awareness among prostitutes and motivating them to use condoms. Training was given to selected prostitutes without any charge and after the completion of training they were given some compensation and allowed to continue their occupation.

It has been reported that even when health education programs succeed in motivating the prostitutes to use condoms, their customers, who usually have higher bargaining power, are often reluctant to use condoms. The processes by which the prostitutes succeeded in making them use condoms in the above-mentioned programs are not well understood and deserve a high priority on the social research agenda in connection with AIDS.

Devadasi system

Studies of the devadasi system in contemporary India indicate that it still prevails as an institution in some Hindu temples, mostly in Karnataka and Andhra Pradesh. Its operations are, however, clandestine because laws against it have been passed in all states. Gilada and Thakur (1988) report that every year about 10,000 young girls of poor families are dedicated as devadasis to the goddess Yallama in a small temple of northern Karnataka. They speculate that most prostitutes in the border districts of Maharashtra and Karnataka are devadasis.
Call-girls

Prostitutes who are known as call-girls are usually more educated and attractive than those living in brothels and are often engaged in some other occupation. They earn higher incomes and have some freedom in choosing their clients who mostly belong to the middle and upper classes. In a study of 150 call-girls, 20 clients and ten madams in Delhi, Bombay and Calcutta in the 1970s, Kapur (1978) found that the earning of call-girls ranged from Rs. 50 to 100 per hour and Rs. 400 to 10,000 per night. Eighty per cent of their clients were married. Many of them had suffered from STDs at one time or other and had experience of induced abortion but in general, they tried to take good care of their health by visiting physicians whenever necessary. Many of them wanted their clients to use condoms but most clients did not comply. A high proportion of their clients preferred oral sex to vaginal intercourse. In a subsequent study of nine call-girls in Delhi in 1993 Kapur (1993) found that some of them belonging to the upper middle class were aware of AIDS and rejected clients who refused to use condoms.

Clients of prostitutes

A few hundred thousand men have sexual relations with prostitutes every day in India but very little is known about their socio-economic characteristics, ways of life and sexual preferences. It is not possible to implement effective intervention programs among them without such information. Insights derived by health practitioners and social workers from the experience of working in red-light areas suggest that the following categories of men are frequent visitors to prostitutes: low-level workers in the manufacturing and transport industries; other workers living away from their families for a length of time; traders and customers in transitory markets; visitors to fairs, festivals and pilgrim centres; defence personnel living away from families; students; pimps and others who have some control over prostitutes; traders and service providers in red-light areas; and professional blood donors.

As in many other countries, Indian truck drivers and their helpers who spend the major part of the year on or near highways are generally known to visit many prostitutes during their stopovers. In-depth interviews with 79 truck drivers and 21 helpers in a check-post near Calcutta in 1993 showed that a majority of them reported visits to between three and seven prostitutes in a week and that the number visited by each trucker ranged from 50 to 100 in a year (Rao et al. 1994). Also, most of them reported never having used any condoms. Blood tests in a sample of truckers in the same place in 1993-1994 showed that 5.6 per cent of them were already HIV-positive. These facts point to the urgent need for adequate intervention programs among truckers and other frequent clients of prostitutes.

Legal provisions

Legislation passed in India regarding prostitution in 1956 and 1986 did not have the objective of abolishing prostitutes and prostitution; the stated objectives of the legislation were ‘suppression’ and ‘prevention’ of prostitution. The 1956 Act (SITA) assumed that prostitution was a ‘necessary evil’ and prohibited a prostitute from soliciting clients in public places and forced her to work in certain areas known as red-light areas, thereby exposing her to exploitation by pimps and others. Though the SITA did not aim to punish prostitutes unless they solicited, it gave enough powers to police and other government agencies to terrorize, harass and financially exploit a prostitute. The 1986 Act (IPTA) provides marginal benefits to prostitutes by prohibiting male police officers from searching them unless accompanied by two female police officers; and also by seeking to draw women away from
prostitution through rehabilitation in Protective Homes. However, a recent review of the conditions in a well-known Protective Home in Delhi indicates little success in meaningful rehabilitation of its inmates (Agnes 1992).

Legislation regarding AIDS was introduced in the Rajya Sabha in 1989 which gave some government agencies sweeping powers to infringe the liberties of certain categories of people, but, owing to strong opposition by a few activist groups, it was withdrawn in 1992. A subcommittee of the National AIDS Control Organization is currently considering various issues related to HIV/AIDS with a view to making recommendations regarding its social, ethical and legal aspects.

**Homosexuality**

**Problem of identification**

Homosexuality can be described as the orientation and inclination of a person to have sexual relations with a person of his or her own sex. It is difficult, however, to identify a person as a homosexual, heterosexual or bisexual because the behavioural expression of the sexual inclination of a person may take a multitude of forms and may change in their life cycle. This is why in their analysis of sexual behaviour data of white males and females in the USA, Kinsey et al. (1948, 1953) developed a six-point scale to identify a person’s position in the heterosexual-homosexual scale from his or her history of sexual behaviour. Because of the lack of any such behavioural survey data, such identification is not possible for the Indian population. In India people are commonly identified as homosexuals if they have experienced as adults any kind of explicit sexual act with any person of their own sex.

**Male homosexuality and AIDS**

The clustering of AIDS cases among male homosexuals in the initial phase of the HIV epidemic in the USA and a few other Western countries led to a misleading notion that the disease afflicted only ‘reckless’ male homosexuals and it was often referred to as the ‘gay plague’ or ‘gay cancer’, ‘gay’ being the current vogue word for homosexuals. Recent studies have shown that HIV is spreading everywhere more through heterosexual relations than through any other mode of transmission. It is, however, true that the risk of HIV infection is greater for persons who practise anal intercourse and this type of intercourse is more common between homosexual partners than between heterosexual partners.

**Prevalence in Western countries**

More surveys of sexual behaviour have been conducted in the USA than in any other country. The survey conducted by Kinsey et al. (1948, 1953) among 4275 white males (15-55 years) during 1938-1947 is perhaps more widely cited than any other in sexual literature. It found that four per cent had overt homosexual experience (to the point of orgasm) during their adult life, eight per cent were homosexual for at least three years during their adult life, and 37 per cent had at least one overt homosexual experience to orgasm as an adult. Surveys conducted in the USA in recent years with more sophisticated methodology show a lower prevalence of homosexual behaviour. For example, surveys conducted during 1970-1990 found that only five to seven per cent of males had had at least one overt homosexual experience as an adult (Rogers and Turner 1991). The prevalence of homosexual behaviour in France and Great Britain in 1990-1991 is somewhat similar to that in contemporary USA (ACSF 1992; Johnson et al. 1994).
Historical evidence in India

Vatsayana’s Kama Sutra (written between the first and the fourth century AD) refers to the practice of eunuchs and male servants giving oral sex to their male patrons and masters respectively. Some erotic sculptures of mediaeval Hindu temples depict lesbian acts. The Muslim rulers in India are reported to have maintained harems of young boys. During the British rule sodomy (anal intercourse) was made illegal under section 377 of the Indian Penal Code enacted in 1861: this legislation is still in force. Indian homosexual activists think that because of this legal provision, male homosexuals are often subjected to undue harassment and blackmail (ABVA 1991).

Current situation in India

Very little is known about the practice of homosexuality in contemporary India. According to Ashok Row-Kavi (1993), a self-acclaimed homosexual activist, the number of exclusively or predominantly homosexual men in India may be over 50 million. His estimate is based, however, on the assumption that the prevalence of homosexual behaviour is not less than what Kinsey et al. found for white American males in 1938-1947. But recent surveys, as shown above, have shown that Kinsey et al. overestimated the number of homosexuals in the USA.

Since the advent of AIDS in India, homosexuality is often discussed in popular newspapers and magazines but information provided is almost always anecdotal. Only one survey of 1200 self-identified homosexual men of South Asian origin living in South Asian countries (mostly in India) and in Western countries (mostly in the UK), admittedly not a representative sample, provides some quantitative information on various aspects of the respondents’ sexual behaviour (Khan 1994). A vast majority of them were married and living with their wives, reflecting the cultural situation in South Asian countries which obliges all men and women to marry members of the opposite sex, whatever may be their sexual orientation. Only five per cent of South Asian homosexuals living in their own countries reported that their family members accepted their sexual identity; 12 per cent of those living in Western countries did so. The most common locations of the first homosexual experience in both regions were parks and toilets. Relatives, mostly male cousins and uncles, were the second most common category of first homosexual partner, strangers being the most common category. Mutual masturbation was mentioned as the most common type of homosexual act.

Strong prejudices against homosexuality in India, enhanced by the popular misconception that it is at least partly responsible for the spread of HIV/AIDS in India, and the awareness among some Indian homosexual activists that the government should not continue to ignore homosexuals’ needs in its AIDS prevention programs, prompted them to organize homosexuals in formal groups for social and political purposes. A few newsletters and magazines—Bombay Dost being one of the well-known newsletters—have been trying to establish local networks of such groups and provide information of special concern to homosexuals. Bombay Dost makes special efforts to popularize the use of condoms among homosexuals. The Government of India has already recognized the need for intervention programs among homosexuals and has taken the initiative to collect information necessary for the purpose.

Hijras and male prostitutes

A culturally identifiable group known by the Urdu term hijra in most parts of India and other terms in the southern states of India, deserves special attention in HIV/AIDS intervention programs because many members of this group are known to depend at least partly for their
livelihood on working as male prostitutes. Most *hijras* are castrated males and dress as females. A few are hermaphrodites, that is, born with ambiguously male-like genitals.

**Ways of life**

Traditionally, *hijras* earn their livelihood by receiving payment for their musical performance at homes on occasions of male childbirth, weddings and other festivals, as well as by begging. Because of their special identification with the Hindu god Shiva and the mother-goddess Bahuchara Mata, they are believed by many to have the power to confer prosperity and health on newborn babies and newlywed couples and also the power to do harm to them. With the erosion of such beliefs in contemporary India, *hijras* are reported to increasingly engage themselves as male prostitutes.

*Hijras* live in all parts of India but they concentrate more in north Indian cities where they have greater opportunities to earn their living by performing their traditional role as household performers on festive occasions. The total population of *hijras* in India is not known; in censuses many of them report themselves as female. The unofficial estimate of their population in India varies from 50,000 to 500,000.

Some anthropologists and other social scientists have made studies of the social, religious and sexual beliefs and behaviour of some *hijra* communities; the most recent and extensive ones are by the anthropologist Serena Nanda (1986, 1989). The usual working group of *hijras* is a household of five to 15 members organized as a commune. Members from all castes and religions can be initiated into the *hijra* community through a ceremony. After initiation they are expected to adopt the values and organizational principles of the *hijra* community, breach of which leads to punishments of varying degrees. The renunciation of male sexuality through castration is the heart of *hijra* social and religious identity. There are myths and folklore associating Bahuchara Mata, the major object of the *hijra* devotions, with transvestism and transsexuality. The castration operation is usually performed by a *hijra* called a *dai-ma* crudely and under insanitary conditions. It is legally punishable but reported to be performed secretly in large numbers.

**Sexual practices**

Anthropologists who have studied *hijra* communities in various parts of India agree that, in addition to earning their livelihood as performers, most *hijras* in contemporary India engage themselves in sexual activity with men for money or for satisfying their own homosexual desires, as long as they are physically attractive or capable of doing so. There are also nineteenth century reports of kidnapping of small boys by *hijras* for the purpose of sodomy or prostitution. Most *hijras* seem to engage in casual prostitution by offering sexual favours to men in exchange for money. Some others, particularly those with strong feminine identity, are involved in relatively long-term relationships with men who may be known as their ‘husbands’. Having a ‘husband’ in an economically reciprocal and emotionally satisfying relationship is a preferred alternative for those *hijras* who openly engage themselves in sexual relations with men.

Upon formal initiation into the *hijra* community through the ritual of castration, a *hijra* is expected to abstain from sexual relations or to marry because sexual activity is offensive to Bahuchara Mata. According to sexually active *hijras*, many join the community mainly for sexual relations with other men although they are aware that such behaviour lowers their status in the society. Almost nothing is known about the sexual techniques *hijras* practise or are asked to practise when they perform the role of a prostitute. It is very likely that they are often passive partners in anal intercourse without the use of condoms, thus making themselves highly vulnerable to HIV and other STD infections.
Male prostitutes

In addition to a large section of the *hijra* community, there are many full-time or part-time male prostitutes in India. Some of them live in red-light areas of metropolitan cities; many seek male clients by offering massage services in parks, beaches, hotels and houses. Thousands of homeless and poor boys and young men employed in various establishments and firms are compelled to provide sexual services to their male bosses in return for their job security. Young men who work as helpers to highway truck drivers in their long trips provide such services.

Use of condoms

Although the condom was originally devised and used everywhere for protection against sexually transmitted diseases, it has been perceived and used in India during the last few decades mainly as a protective device against unwanted pregnancy. Its use as a method of contraception among reproductive-age couples in India (145 million in 1991) increased from three per cent in 1970 to over five per cent in 1991. The extent of the use of the condom as a contraceptive device varies considerably among states and union territories.

Use among prostitutes and their customers

There is a very low level of use of condoms among female prostitutes in India. Reports of rapid increase of prevalence of HIV-positive cases among prostitutes in red-light areas of Bombay and a few other Indian cities have persuaded non-government and government agencies to start intervention projects in pockets of those areas for motivating prostitutes to use condoms, and distributing condoms free or at subsidized prices. One such project in Calcutta (Jana et al. 1994) and two projects in Bombay (Gopalakrishnan 1992; Gilada 1994) are reported to have achieved reasonable success in increasing the use of condoms and reducing the prevalence of sexually transmitted diseases including HIV infection. As stated earlier, one common factor accounting for the success in these projects is the effective use of selected prostitutes as peer-group educators in project implementation.

The reports of the intervention projects indicate that with the proper approach it is not very difficult to convince the prostitutes of the need to use condoms for protecting themselves from HIV and other sexually transmitted infections. It is also not very difficult to impress upon the pimps, madams, landlords and others involved in the sex industry that keeping prostitutes free from diseases serves their own economic interests. The main problem lies in the persisting unwillingness of the customers to use condoms, and prostitutes’ powerlessness to insist on their use or reject the customers. The literature regarding the increased use of the condom among small groups of prostitutes does not explain how the powerlessness of prostitutes in this respect was overcome, at least to a certain extent. This is an area which deserves high priority in behavioural research regarding HIV/AIDS.

Very little is known about the attitudes and behaviour regarding use of the condom among frequent customers of prostitutes. One such group about which a few small-scale surveys have been made is that of long-distance highway truck drivers and their helpers. The level of condom use in almost all the samples surveyed is reported to be low but there are indications that well-designed intervention programs involving both education and distribution of condoms can increase the use of condoms significantly among truck drivers and their helpers (Rao et al. 1994; ARFI 1994).
Constraints on condom use

Studies during the last few decades have identified a few reasons for limited use of the condom as a family planning device, although it does not have any side effects. The most common complaint of men against it is that it reduces the pleasure of sexual intercourse. People are also generally aware that the condom does not give full protection against pregnancy and sexually transmitted disease. The loss of its effectiveness in giving protection may be due to its inherent quality or its faulty use or storage. The powerlessness of women to make their sexual partners use condoms, if the latter are unwilling to do so, is also an important constraint on the use of the condom. The apparent link of the condom with the penis and sexual intercourse makes any reference to it culturally sensitive and often a forbidden topic for open discussion. Other constraints on the use of the condom are ethno-physiological misconceptions about it (e.g., it can remain hidden in women’s body), its past association with prostitutes (for protection against STDs), and vaginal pain and irritation when prostitutes entertain too many customers in a short span of time.

The rapid spread of HIV/AIDS in India demands introduction of adequate programs to minimize the constraints on the use of condoms as far as possible. Some of them are: production of thin, robust and well-lubricated condoms in air-tight and attractive packages; distribution of condoms through channels which make them easily accessible to people vulnerable to sexually transmitted diseases including AIDS; enhancing men’s motivation to use condoms through mass media, entertainment programs, group discussions, interpersonal communication and by emphasizing the pleasure aspect of using condoms; further experimentation in the distribution of condoms through vending machines installed in public places frequently visited by groups vulnerable to HIV/AIDS.

Sexual abstinence

One important way to avoid infection from sexually transmitted diseases including HIV/AIDS is to abstain partly or fully from sex. The biological drive for sex is almost universal in human beings but it is not necessary for the survival of a person, as food is.

Virtue in Hindu culture

In Hindu culture and religious scriptures abstinence from sex is considered a virtue. Although Hindu epics enjoin husbands and wives to have sexual intercourse for begetting children at specific periods of women’s menstrual cycles, over-indulgence in sexual relations even between husband and wife is considered to be a sin and is believed to cause serious illness. Sublimating sexuality into spirituality though sexual abstinence has always influenced Hindu thoughts and actions. Many people in contemporary India, both rural and urban, believe in the theory of sublimation in some form or other. In its most popular and simple version, semen is believed to be a source of physical and spiritual strength and should be conserved by men as far as possible. Food is supposed to be converted into semen by successive transformations through blood, fat, bone and marrow. Advocacy of the sublimation theory and virtue of sexual abstinence by Indian national leaders such as Mahatma Gandhi has reinforced the existing folk traditions and religious beliefs in this respect (Kakar 1989).
Implications for sex education

In some Western religions the virtue of abstinence from sex is recognized but Western psychologists and sexologists generally consider prolonged abstinence from sex as detrimental to mental and physical health (Robinson 1924; Biegel 1961). Freud (1924) thought of sexual abstinence as the source of various illnesses and at the same time, ‘abstinence’, he believed, was ‘hardly thinkable for young artists because sexual experiences act as a stimulant to artistic activity’.

In contrast, Indian literature contains hardly any reference to the negative effect of sexual abstinence on the human body and mind. Despite the widespread intrusion of sexually explicitly scenes and themes in the Indian entertainment and advertisement industries, the virtue of sexual abstinence among both men and women and anxiety over loss of semen on the part of men still dominate Indian minds. So emphasizing abstinence from sex as a way of protection from AIDS and other sexually transmitted diseases in sex education programs is a more viable option in India than in Western countries.

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