

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

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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 risks¹ 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

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-Osaghae, Department of Sociology and Anthropology, University of Benin; Benin, Francisca Isi Omorodion, Department of Sociology and Anthropology, University of Benin; Lagos (1992), Felicia Oyekanmi, 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.

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