

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 Research¹. 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 Ghana².

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).

¹ Much of the research of this program is reported in a volume of collected papers, Orubuloye et al. 1994.

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

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 gonorrhoea. 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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