THE PSYCHO-SOCIAL DIMENSION OF SEXUALLY TRANSMITTED DISEASES: A STUDY IN AHMADU BELLO UNIVERSITY TEACHING HOSPITAL, ZARIA

BY

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DEDICATION

This study is dedicated to Bisoye, Bukky and Bankole

DECLARATION

I hereby declare that this thesis is my own work and that it has not been submitted in any form for another degree or Diploma in any other institution. Information and excerpts from published and unpublished work of others have been acknowledged in the text.

BERNADETTE EKWUTOSINNABUGWU-OTESANYA

CERTIFICATION

This Thesis entitled the Psycho-social Dimension of sexually transmitted diseases: A study in Ahmadu Bello University Teaching Hospital Zaria, by Bernadette Ekwutosi Nnabugwu-Otesanya meets the regulation governing the award of M.Sc sociology of Ahmadu Bello University, Zaria and is approved for its contribution to knowledge and literary presentation.

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ABBREVIATIONS

STD	Sexually Transmitted Disease
STC	Special Treatment Clinic
[illegible]1	Syphilis
[illegible]	Gonorrhoea
AIDS	Acquired Immun. Deficiency Syndrome

ABSTRACT

The study examined the socio-demographic characteristics of patients that attended the sexually transmitted disease clinic (SID) otherwise known as special treatment clinic of the Ahmadu Bello University Teaching Hospital, Zaria. It also examined the types of diseases and history of such diseases in this society.

The source of data were hospital records of nine hundred and sixty one patients, studied for the period of June 1986 to hay 1987. Out of this total, a sample of one hundred was subjected to a more detailed personal interview using a questionnaire method within four weeks of April/ May 1987 to elicit such psycho-social factors like stigmai pattern of utilization of treatment which could not immediately be identified in the hospital records.

Findings showed that in the total sample (961) there was disease in females under 5 years old 2,81. Those of ages 20 - 24 years had the highest representation (27.06%) males and (5.52%) females. The oldest age of respondents was 55 years with 8% representation. Most patients (60.35%) were single, 34.55% were students and (13.01%) were civil servants. The two main religions, Christianity and islam, were represented with 30.9% moslems and 58.90% christians recorded.

enorrhoea was the most common disease with 43% reported cases in the clinic. Males (82.83%) attended the clinic more than females (17.l4%); females were found to be sex contapts.

The 100 respondents revealed polygamy among 3.9% of the married. There was a great use of traditional medicine and self medications before attending the clinic. There was also evidence of. previous exposure to disease among 61% of respondents. Patients perception of disease guided their reaction to it. Secrecy, sexual exposure even with disease, extended family system (especially for the under 5 years) were identified as factors in the spread and therefore, difficult in the control of control of sexually transmitted disease.

Emphasis on prevention using social medicine, which takes cognizance of the diverse culture and norms of society is recommended. Health education with emphasis on sex education and persuasion based on the knowledge of cause and pattern of distribution of disease is also recommended especially for the single.

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CHAPTER ONE

INTRODUCTION

1.1 Research Problem

Sexually Transmitted Diseases (Venereal Diseases) are social diseases found in all societies. In the Nigerian society they are referred to as chewo mata in Hausa, in Ibo as Nsi Wanyi and in Yoruba as Atosi Abo. It is interesting to note that all those concepts in the three main Nigerian languages associate 'woman' as the originator of sexually transmitted diseases.

These perceptions do have their own implications, which we shall explore later in the study. It is now commonly acknowledged that there is increasing incidence of venereal disease, due to a number of social, economic and political factors. It becomes an urgent public health problem almost everywhere constituting a challenge to the social and medical services. It is aggravated by increased mobility of people due to improved transport system with a consequent temporary or a more permanent separation of families. Further, increased stress and strain associated with development and industrialization has led individuals to find certain forms of out-let and easy availability of prostitutes or other sex

partners have encouraged these diseases. Venereal disease belongs to a category of diseases and disabilities that is highly stigmatised. By this we mean that the sufferers are ostracized, gossipped about, morally censured, regarded as infectious and a host of other negative responses. This has led to improper and sometimes incomplete treatment of sexually transmitted diseases, making its sufferers a risk factor in society.

This fact is evident based on the researcher's experience as a research assistant to a study group that investigated the pattern of drug use in Zaria. The group found that most pharmacy and chemist shops are run by untrained personnels, and where there is a trained one, he or she plays the role of a doctor. The commonest ailments treated in these shops are venereal diseases and treatment is based on trial and error method of all kinds of antibiotics. On the part of patients, it is obvious that majority of them have more confidence in these treatments after frequent use of these drugs and a supposed cure.

Some, however, indicate their unwillingness to go to the hospital for the fear of exposure to stigma. They believe that all they get from the hospital are prescriptions which reverts them to the chemist shop.

Six to ten O'clock in the evenings were the periods most of such patients patronized the chemist shops with the hope that fewer people would identify them.

In the process of contact tracing it was discovered that there was an indiscriminate use of antibiotics among prostitutes. Four categories of prostitutes were identified in this society. These are: those that live in the big hotels and pay as much as ₦5 daily for accommodation; those that live in their houses but go to the small bars in the evenings to solicit for customers. The third category are those that live in the traditional homes and engage in petty trading or hair plaiting during the day in the 'Azare' or common living room and in the process solicit for customers who now come from about 7 p.m. to pay and take their turns. The last group identified were the very young girls about 14-17 years old who stay by the rail lines in Samaru from about 8 p.m. They claim they are students in secondary schools and they pay for their tuition through prostitution and enjoy other facilities such as attending film shows with their customers whom they may never have met before.

All these groups claim their customers come from all walks of life. In fact through observation this was found to be true. They are all aware of the existence of sexually tran mitted diseases, but say they take antibiotic capsules as prophylactic. They seem to know the names of almost all antibiotics available in the rug markets today. A discussion on the possibili ty of using other preventive measures like condom (durex), a rubber sheath used by the males which functions as a protector from venereal disease and contraceptive device, was objected to. Th yreported that their custom rejected the use of condoms because they preferred by these prostitute a direct body contact. Signi ficant also is the belief/ that condoms can tear in the pro ess of coitus and would necessitate the pieces gets into the women's womb which then/ surgery a process which th y did not want to experi nce. They also refused the idea of coming to the clinic on a regular basis. They would prefer the team to visit them in their brothels due to the feeling of shame and labelling. Some, however, had no objection but their number was very insignific nt.

In an effort to minimise this stigma, various individuals have resorted to different forms of denials through their different perception of the

disease. Some, guided by superstitions like witchcraft, have failed to accept the cause and therefore treatment of the disease, hence there is difficulty in its prevention and control.

Nigeria as a third world country is said to be over-populated, hence the ideas of controlling birth become necessary, yet there is an increase in sexually transmitted diseases which is medically known to be complicated with loss of libido, strictures, pelvic infectious disease (PID), infertility and associated deformities of the children (general paralysis of the insane, blindness etc.) born by untreated venereal disease patients, drastically reducing the population and increasing the number of infactile deformities as is seen in syphilis or neonatal gonorrhoea (Ophthalmic Neonatarium). It is in recognition of these diseases that Nigerian Government, like most governments of the world inspite of their inability to provide free health services for all their citizen due to their poor economy, has created a unit for sexually transmitted diseases in all the teaching hospitals and directed that sufferers of the disease be treated free in such units. Considering that such hospitals are few in the country and are located

only in the urban areas, it becomes necessary to look into the social dimensions of the disease with a view to assessing the socio-cultural factors that has led to the increase in the disease despite the strong moral codes guiding the different religious groups in the country regarding sexual activities and to suggest what factors whould be encouraged or discouraged in our day-to-day life to minimise or completely control sexually transmitted diseases.

Medical concern so far has been on curative measures with emphasis on improved diagnostic and chemotherapic measures. Little or nothing has been done on social dimensions of these diseases. Nigerian scholars like Sogbetun (1977) Osoba, (1981), Bello (1978) and Alli (1981) have contributed immensely to the study of these diseases but as can be expected by their profession as medical doctors they lay emphasis on the medical frame work or model.

1.2 Research Objectives

The Research has three objectives:

(a) To determine the social and demographic characteristics of patients with sexually transmitted disease.

(b) To find out the types of diseases and history of these diseases.

(c) To find out people's perception of the disease and the social consequences resulting from their disease.

CHAPTER TWO

LITERATURE REVIEW

2.1 Theoretical Review: Social Medicine

This review of literature is mainly concerned with the theoretical orientation of medical care, its basis, merits, demerits and some empirical studies done emphasising the role of socio-economic and cultural factors in perception, prevention, treatment and control of diseases in general and sexually transmitted diseases in particular, are mentioned.

The role of socio-cultural factors in disease/illness and treatment has since been recognised by the founder of modern medicine himself Hippocrates who in his study of man and his illness, took into consideration the climate he lived in, the food he ate, the water he drank, his general environment although significantly omitted such factors as man's occupation, believes and values. It is in recognition of the socio-cultural factor in disease that advocates of social medicine like Alwyn Smith (1968: 210) suggests that the need for social medicine arose with the changing situations in the world. Smith asserts that many diseases are socially important, may be difficult to prevent and yet easy to treat; thus he sees the distinction between health and disease as being essentially arbitrary

and resting mainly on a consensus of what is acceptable; levels of unacceptability to him may vary between populations as well as among different individuals within a population. The particular concern of social medicine with diseases is in the understanding of studies on the population distribution of the relevant attributes and their associated variables. Smith sees the problem of disease definition as dependent on factors associated with definable groups within populations as being relevant to social medicine. Based on the World Health Organisation definition of health as the total physical mental and social well-being of the individual rather than absence of disease. He thinks health is not a clearly definable condition independent of its social economic and historical context. To him, the reintegration of social science in general with the biological sciences that study the ecology of species, the source of their variations and the determinants of their survival is the most important contribution of social medicine to medical care in general. In his words, "Sociology and demography have much more in common with general biology than has much of modern medical sciences whose affinities are often more with physics, chemistry and engineering. One would not wish to despise such affinities but only regret

that they have often led to the loss of older valuable medical tradition "(Smith 1968: 213-214).

Other writers like Armstrong David (1980) analyse how differences in perception of what is disease and health is seen in doctors/patient relationship. He thinks patients claim to be ill, doctors decide whether they have a disease or not. Yet, although doctors rarely have any problem in describing the characteristics of specific diseases, there does seem to be some difficulty in defininining what disease actually is. He thinks the concept of disease places its basis firmly on the patient and makes it synonymous with the lay concept of illness. To him this is unsatisfactory because it ignores three factors:

(a) The claim of the medical profession to an exclusive skill in identifying disease quite independent of wnether the patient feels ill or not.

(b) The objective status usually afforded disease as against the more subjective experience of the patient.

(c) The existence of pre-symptomatic diseases which do not immediately cause disease (Armstrong 1980: 3).

He says that although most diseases do have a biological base, it is not sufficient to explain the nature of disease itself. He looks into such social factors as cultural factors. He particularly compares Japan and United States of America which are both affluent societies with equivalent health status; in Japan cancer of upper gastro-intestinal tract disorder are more common while in the United States breast cancer is more common. He looks at other factors like the economy as relevant to disease. He compares the western countries with the third world, and looks at some other subcultural factors as poor housing, nutrition, hygiene as relevant. Most importantly is his stresses on family factors (way of life) as an important factor in the existence of disease.

This brings us to the social background of modern medicine and germ theory of disease. Modern medicine is the aftermath of the industrial revolution at the end of the eighteenth and beginning of the nineteenth centuries which, with the expansion of the use of machinery and large scale factory production, was accompanied by infectious diseases becoming more prevalent in the rapidly growing and insanitary towns.

At the beginning, environmentalists regarded sanitation as the solution to all health problems. They were critical of the orthodox physicians who could offer only an irrational system of therapeutics. It is with the origin of the germ theory of Pasteur (1822-95) and other scientists like Kochs (1843-1910), Ehrlichs, Flemings that the idea of an agent causing factor in disease became prominent. Flemings' accidental discovery of penicilline made the idea of introduction of drug as a killing agent of the germ causing agent of disease a more acceptable therapeutic measure. But the present awareness of penicilline resistant germs and its explanations as being due to an elimination of the sensitive germ and presence of penicilline producing neissieria gonorrhoea (PPNG) raises other questions.

Critics of the germ theory point to the fact that disease was thought to depend upon the number and virulence of the germs which invaded the body. If the conditions of the body such as temperature or its chemical state were favourable to them, germs the germs would flourish and overwhelm the body. The body at this stage was looked upon as a pleasure vehicle for the germs making it possible for all efforts consequently directed towards either avoiding contact with the germs or altering

the state of the body to discourage the growth of the germs. Later the recognition that the body could be resistant to germs producing various theories of immunity. The reasons, according to these critics for these differences, were generally neglected They argue that immunity is not a fixed thing. It changes with the individuals and with communities. They therefore advocate for a better knowledge of how individuals living under different conditions acquire varying degrees of immunity and what conditions of living favour the growth and virulence of germs. They also point to the importance of social classes in the existence of the germ agent.

Critics of germ theory looking at the works of Virchow (1821-1902) on the structure and function of the cells of the body and recognising that many diseases were not associated with germs, led to ideas like that of Leffs (1953) analysing primitive medicine and its associated man's ignorance of natural laws, its basis on religious beliefs, rational medicine of the Egyptian era, the Greek medicine, which all had two main schools of thought, the practical and the philosophical, came to the conclusion that "The theory and practice of medicine are conditioned historically. All medical theories bear the stamp of the period in which they

were formulated and tested in practice. Each generation adds something to medical theory. Man's knowledge of the structure and function of his body and the effects of his environment, preserve health and conquer disease". (Leff 195?: 42-43). As society progresses medical theories are judged not as much on how far they improve the health of whole populations as on how far they can cure established diseases. Today social medicine best reflects our present period in history and mode of living in society and therefore, gives us the best opportunities for raising health standards and advancing the theory and practice of medicine. Leff / also discusses utterances of doctors like Professor Ryle's in 1947 agreeing with the view of social medicine and apologising to his colleagues in the New York Academy of Medicine by quoting him as saying that "Some of my friends have rebuked me for leaving the clinical fold. I reply in effect that I have merely taken the necessary steps to enlarge my field of vision and increase my opportunities for aetiological study. My / allegiance to human medicine is not quite / discouraging. I wish I could convey to them and to you some of the sense of stimulation and rejuvenation that my close association with statistics and medical social workers and with men and women in the public health and industrial

health services has brought to me" (Leff 1953: 17.)

Other critics like Kunsladdler (1980) criticises the fact that medical ethics have neglected cultural differences and pluralism which exists in healing systems, and continued introducing western medical innovations into non western societies.

Models of Treatment

The medical model of treatment has its basis on the germ theory. It acknowledges the presence of the agent causing disease and all efforts of treatment are geared towards removing the agent causing disease. These take the form of chemotherapy and surgery and is presently used by modern medical practitioner.

The psychosocial model, while acknowledging the presence of agents causing diseases, looks at the social economic and psychological factors that may be responsible for the state referred to as illness. It takes cognizance of the different cultural settings, genetic conditions, perceptions of diseases and illness, illness behaviours of the different ethnic groups, the attitude of individuals or groups to conditions of illness not being in

isolation. The individual and his immediate environment is considered more than the disease factor in curing illness. They use such methods as psychoanalysis counselling, change of attitude as means of treatment prevention and control of disease. Persuasion rather than chemotherapy is the major method of treatment based on the influence of social medicine. Tucket (1976: 168) work done by scholars like Borwiski in 1952 suggesting that the ethnic origin of an individual influences his perception and interpretation of symptoms. In his study with Americans of Italian origin and Americans of Jewish origin, it was observed that Americans of Italian origin were concerned mainly with the immediate pain experienced while Jewish Americans focussed upon the symptomatic meaning of pain and its significance for their health and Welfare. Tucket (1976: 168) also discusses Zola's work in 1966,which further confirms the above study, through Zolas' study of Americans seeking medical aid in a study of Italian Irish and Anglo Saxon Americans. The Italian Americans would be most concerned about symptoms that interferred with social and personal relationships such as (their relationship to boyfriend/girldfriend). Irish Americans needed

someone else to approve their actions while Anglo Saxon Americans saw a doctor only when the symptoms was considered to be interferring with their work or physical activity. Tucket (1976) also talks about Saunder's (1954) description of the differences in attitudes and responses to symptoms that exist among Anglo and Spanish speaking persons in the American South West. Whereas the Anglos preferred modern medical science and hospitalization for many symptoms, the Spanish speaking people relied on folk medicine and family care and support. As a result, Spanish people people had lower rates of medical care utilization than did the Anglos.

Tucket (1976) suggests that it is possible to have a disease yet not feel ill. It is also the case that people who notice symptoms of diseases and or fell ill may or may not seek medical aid. It is in recognition of this that advocates of social medicine claim that it is not all that we give drugs in the hospitals that are sick and that it is not all that we see in hospitals that are the only sick persons within the society.

Godkin and Rice (1981) in a clinical data pertaining to 21,000 patients and four family health centres shows the possible relationship between stress and physically manifested illnesses. Statistical tests

revealed a significantly higher age sex standardized prevalence rate of somatic complaints (e.g abdominal pain, lower back pain, hypertension, venerophobia etc.) in patients with 1 of 4 selected indicators of psycho-social stress (anxiety, depression, couple conflict, child abuse/neglect) compared with the patient population which was not diagnosed as stressed. The findings lend further support to the mounting evidence that psyche-social stress is a contributive factor in a wide variety of physical complaints encountered by primary care physicians on perception of illness. Sawyer and Harris (1968) talks about 'Tohaleisia' where syphilis (Yeke-yeke) or Ndabu-wan), swelling of the genitals in men or (Konde Wopoi) which causes inability of a man and woman to separate after sexual intercourse as believed to be a curse on the individual rather than by sexual intercourse. This brings us to the factors that may inhibit or present physical symptoms and guide the patients either to come to hospital for treatment or to look for other sources like spiritual healing, traditional healing etc. or prefer to hide his or her symptoms. And possibly increasing mortality rate. Stigma and labelling are highlighted here.

According to Erving Goffman (1961) stigma as a word originated from the Greeks. To them it refers to bodily signs designed to expose something unusual and bad about moral status of the signifier e.g. sign on the body identifying the bearer of such sign as a slave, a criminal or a traitor. Later in Christian times, disgrace rather than bodily evidence was prominent. To Goffman it is the societies that established the means of categorising persons, as deviants of a type that is stigmatised. Such categorised individuals have attributes that make them different from others in the category. In stigmatised conditions the individual is reduced in our minds from a whole and usual person to a tainted, discounted one, to an attribute that is deeply discrediting. Goffman talks about three different types of stigma.

(a) Various physical deformities

(b) Inferences from a known record e.g. mental disorder, imprisonment, addiction, alcoholism, homosexuality, unemployment, sucidal attempt and radical behaviour which results in blemishes of individual character perceived as weak will, domineering and unnatural passions, treacherous and rigid belief and dishonesty.

(c) Shame arising from individual perception of one's attributes as being defiling thing to possess and one he can readily see himself as not possessing. (Goffman 1963: 4).

According to Goffman the special situation of the stigmatised is that society feels he is a member of the wider group, which means he is a normal human being but that he is also different to some degree and that this difference which is derived from society can not be denied. To him for a difference to matter, it must be conceptualized collectively by the society as a whole. In sexually transmitted diseases, therefore, the individual is faced with shame and feeling of guilt, this guided by his cultural setting determines how he perceives and reacts to his condition.

Labelling is another factor that influences perceptions of disease both by the patient and the doctor. This refers to such attributes as associating individuals or groups with specific conditions or behaviour. The idea of labelling is shown more in deviant conditions like crime etc. but certain sexual problems like syphilis causing general paralysis of the insane until recently were labelled as mental illness and were treated in psychiatric hospitals instead of sexually transmitted

disease clinics. Kenneth & Jones (1975: 86) talk about the labelling perceptive as something socially problematic which exists in the eyes of the beholder and the society. According to this view social problems and deviants are defined by society's reaction to what it presumes to be violation of expectations e.g. by labelling someone as a homosexual or pervert or an alcoholic we go a longer way towards making a deviant out of him. This brings us to the idea of deviant in the medical setting; as relevant to sexual behaviour which is my point of concentration in this study.

The sociological study of sexual behaviour differs from both the biological and psychological approach in the way that assumptions are made as to its origin and also to the unit of analysis used for study. While biology might be tempted to think of origins or aetiology in terms of organic and genetic, sociology thinks more on behaviourial and developmental aspects stressing such themes as socialization, interpersonal aspects like stress on the situational factor. In cases of deviance, biology would use as the unit of analysis the diseased organ or sick person (and medicine is heavily dependent on biology) while sociology would use the act, behaviour of the deviant person, categories of deviance as the unit of analysis requiring

attention.

According to Kenneth and Jones (1975) sociological study of deviant's behaviour in sexual life falls into three categories firstly ecology and styles of sex as a physical act, secondly the normative implications of the physical act and how it relates to the individuals, and thirdly the frequencies and techniques of sexual behaviour which vary widely among individuals according to variables like social class, ethnic group, levels of education, age and sex categories.

A survey of over two hundred societies on a cross cultural basis showed that heterosexual behaviour is almost universally favoured but that as many societies condemned homosexual behaviours as condoned it. Among the Siwans of Africa a male who indulges exclusively in heterosexual behaviour is singled out as peculiar. During male purberty rites among the Arandas of Australia and Keraki of New Guinea, homosexuality plays an important part. Nearly every male in Afghanistan is homosexual until he marries. In contrast to this, and for no reason, nearly all societies strongly disapprove of masturbation. Bestiality is acceptable among the Eskimos, joked about among the Tswana of Africa and

strongly disapproved of by the Hotentots of South Africa (Kenneth & Jones 1975: 88).

Kenneth and Jones also report of Kinsley's research on sexual behaviour in the human male and females based on 12,000 american males and 8,000 females. Masturbatory behaviour was practised by 93% of males and 62% of females and is more common among the better educated urban dwellers and less common among devoutly religious believers. Males worry and experience guilt feelings while females do not appear to do so. Extra marital sexual relationships were allegedly experienced by 50% of males and 26% of females by the age of 40. Males felt more strongly about such relationship if experienced by their wives, and 51% thought such behaviour sufficient grounds for divorce as compared with only 27% of females. Such behaviour did not appear to vary much with social class differences although devout females appeared more inhibited than those who were not devout. In this study also homosexual behaviour was experienced by 50% of males and 28% of female by the time they reached the age of 45, and was found to increase with the level of education for both sexes and especially among single females. Sexual contact with animals was experienced by 8% of males and 3.6% of females

by the time they reached 21 years primarily by those living in rural areas. Although after 21 years this decreased almost-to zero in males and 50% in females (mostly unmarried).

Talking about deviant behaviour functionalist theorists like Talcot Parsons, Mechanic and Freidson see illness as a deviant social role, disfunctional both for individual and society because it prevents the individual from performing his role. That in the presence of illness the patient takes up a sick role which makes him not responsible for his state makes it mandatory for the individual to be relieved of normal responsibilities as long as his condition exists and makes it mandatory on him to seek therapeutic help. Critics of this paradigm have had a critical look at other factors like stratification determining what duties or rights individuals have to their health. They argue that the establishment of the sick role is a form of labelling and that it makes the sick dependent on people who are not sick. They argue that Parson gives the institution of medicine a social control function which is not necessary. Whether sexually transmitted diseases fall into these roles is a matter of personal judgement but the present directive from the Federal Ministry of Health that sexual

transmitted disease patients should be treated free of charge acknowledges Parsonian model of sick role.

2.2 Empirical Review

Sexually Transmitted Diseases

Venereal disease refers to all conditions got through the process of love making. The word venereal is coined from the Goddess of love venus. This included such conditions as may be got through kissing, close body contact and sexual interaction. It is in realisation of the fact that not all venereal diseases are got through love making that we now specify such conditions that are sexually transmitted. For the purpose of this study the word venereal will be interchangeably used with sexually transmitted. (Leff (1953: 232) sees venereal disease as ranking with tuberculosis as a leading social disease; he suggests that their incidence is susceptible to changes in the living conditions of the people and further observes that the influence of such social factors as war, political upheavals, disruption of family life, general losing of moral restraints, the prevalence of undernourishment (which is a spur to prostitution and poverty), as associating factors in the incidence of sexually transmitted diseases. He highlights the effects

of venereal disease as the leading cause of disability in the army in the first world war. He points to the extent of promiscuity during the second world war as another factor. Promiscuity is revealed through Bethel's (1941) report of one brothel in the Military Zone of Germany where over a quarter of a million soldiers visited a thirty six-roomed brothel in a period of eight months and on an average each prostitute received about thirty clients a day. There were large increases in the incidence of venereal disease in all countries of Europe during the second world war particularly in France, Norway, Denmark and Germany. The increase was from three to nine times and all the achievements of twenty years of venereal diseases control were practically wiped out. The United States third army command reported a monthly average rate for gonorrhoea of 10.6 per 1,000 for white soldiers and 83.7 per 1,000 for Black. The incidence of gonorrhoea as compared with syphilis was 7.1 to one for whites and 3.6 to one for Blacks. The incidence of venereal disease increased as the war progressed and it rose by another 37 percent in the last year of the war as compared with the previous years.

The death rate from syphilis is declining in the U.S. owing, in part, to improved methods of treatment with antibiotics. However, the death rate

in 1944 (11.3 per 100,000 of the population) was still more than the recorded deaths from poliomylitis, rheumatic fever, malaria, diphtheria acute bacterial miningitis, typhoid, paratyphoid pertusis, scarlet fever, puerperal septicaemia and dysentry all combined. Over 400,000 persons in America become infected with syphilis every year. At least one adult in ten has had the disease and one in five of all the deaths due to organic heart disease are caused by syphilis. Also there were 14,000 infantile infections and 6,000 psychiatric hospital admissions were due to syphilis among Americans in 1949 despite the decline in the incidence of venereal diseases after the end of the war. The United States Public Health Services estimates that about 675,000 are infected with gonorrhoea each year, a ratio of 5 persons per 1,000 of the population. There was also a marked increase in venereal diseases in Germany attributed to the behaviour of soldiers of occupation. Climatic factors were also highlighted in United States where 90 per 10,000 of the population were observed to have venereal disease in summer of 1946. The number doubled in the British and French zones to reach rates of up to 32 per 10,000. The most marked and speedy decline took place in the Russian zone where the respective rates for gonorrhoea and syphilis in Saxony in March 1947 were 10.7 and 11.4 per 10,000.

In Russia the notification of venereal diseases, sources of infection and contacts have been made compulsory. The rise in the incidence of venereal diseases continued into 1947 in the British zone with an average increase of 30 percent for syphilis for the whole zone and an even higher increase in the Ruhr where social conditions were particularly bad. In Africa Alli (1981) reports gonorrhoea per 100,000 population. In Kampala, (Uganda) 1 in 10 and Nairobi in Kenya 7 in 100.

On the issue of social values and culture having relationship with disease Hossain (1971),in a study of male Pakistani immigrants attending venereal disease clinics in Great Britain,noted that inspite of increased mobility in the world resulting in greater social instability which predisposes individuals to venereal disease, the rigid social system of the Pakistani guides their social life as they leave their country to other countries to work.

In the 3rd world,however, the actual degree of venereal disease infection is not known as pointed out by Sogbetun et al (1977) due to economic factors and lack of modern diagnostic facilities and medical manpower. Sogbetun sees Ibadan as a society as permissive as any other in the Western world and

points out that despite the acceptance of polygamy, casual sexual relationships are not uncommon in both sexes with attendant risk of infection. He reports Willcoxs work of 1946 where an incidence of gonorrhoea of 600 per 1,000 among Nigerian troops were recorded, he also talks about World Health Organisation (WHO) expert committee on gonococal infection in 1963 reporting an infection rate of 7 per 100 among the adult population of Lagos, Osoba, (1972) in this same study reported a gonococcal infection rate of 15.8% and 17.6% respectively among prostitutes and female hospital patients in Ibadan. He found that 33% of 442 males complaining of urethral discharge had gonorrhoea amongst patients seen at the patient clinic. Also Alli (1981) discusses a voluntary screening study done on some male post college students in Zaria 2% (10 out of 546) were identified as asymptomatic carriers of neissiare gonorrhoea.

Alli (1972) also reports a selected study of hospital patients (Ibadan UCH special treatment clinic) 1.3% with 5 or more gonorrhoea episodes develop bilateral epididymitis. Eighty percent of urologists practice in all teaching hospitals are taken by urethral strictures and management of reproductive failure due to sexually transmitted diseases (STDs). In females salpingitis and pelvic inflamatory diseases

(PID) are frequently seen post gonorrhoae which results in tubal occlusion and infertility. But the role of such factors as cultural perception and subsequent reaction was seen in Kenya where most patients due to the shame would rather go to chemist or be treated by street peddlers, medical auxiliaries, nurses or doctors at primary health centres. Only a few attended a specialised clinic for venereal diseases.

To conclude, the need for social medicine in combination with what we know today as modern medicine can not be emphasised further although Catterall et al (1983) did not find any influence of social factors in the distribution of veneral diseases except for gonorrhoea. He said that occurrence rates of overall sexually transmitted diseases had no aetiologically relevant to social class occupation, non sexual social contact, drug abuse or aggressive attitudes and behaviour. Hussain's (1971) work points to the fact that although promiscuity makes sexual behaviour a more casual thing among every age and socio-economic group, increased mobility of people with consequent stress, breaking of family ties, resulting in greater social instability, and easy availability of prositutes with subsequent increase in sexually transmitted disease. Social values of a rigid social system makes promiscuity uncommon in a group like Pakistani with lesser number of venereal

diseases due to such controls as illegitimacy which is virtually unknown, capital punishment for sex relations outside wedlook as prescribed by Koran.

Arthur (1953) in a survey of African marriages and family life noted certain patterns of controls of sexual relations that may encourage or discourage venereal disease. Among the Nupe of Nigeria for instance extra marital affairs was dealt with not by legal measures but either by a religious sacrifice or by husband beating up the other man stripping and drawing him of his clothes and drew him to the street naked. Among the Katab group of Nigeria it was regarded as a moral offence entailing trouble not merely on the households of those concerned but also to the entire town and a sacrifice was needed to wipe it out. Before going to war for instance any man going to war but guilty of adultery had to make a confession and be purified. Author however, thinks that prostitution is long established as an institution, and a means of escape for women married against their will among Hausas. H. Sawyer and Harris (1968: 72) talk about the Sierraleonean (tohaleisia) as having the power to cause one to have syphilis i.e. Yeke ye'ke' or Ndabu wan swelling of the genitals of men or konde wopoi which causes inability of a man and woman to separate

after sexual intercourse and all treatment to the above is aimed at revoking the curse.

On the question of stigma for sexually transmitted diseases, it is in recognition of the presence of stigma that a clinic for sexually transmitted diseases is referred to as a special treatment clinic. Syphilis, gonorrhoea or chanchroid are referred to as A_1 B_1 C_1 respectively all in an effort to minimise this stigma. Writers like Kinsey as discussed by Kenneth and Jones (1973: 92) have pointed out that to label one as deviant, in this case sexual deviant was not proper since known or defined deviation is only a small proportion of the total number of instances of deviant behaviour in the community. He particularly points to homosexuals as sexual deviants and argues that only a proportion of boys who may have engaged in homosexual experience at some point in their lives actually become homosexuals.

Murphy et al (1981: 265) in a study of rural dwellers and health care in Northern Nigeria found that the majority of villagers had no ready access to orthodox health care facilities and where such services existed, villagers used both orthodox and traditional systems. She also observed that socio-cultural traditions and lack of education affected adversely women's propensity to utilise obstetric care. This study aims at just doing this for sexually transmitted diseases in Africa.

Considering the present cost and availability of orthodox medical services and its cultural acceptance in a developing country like ours and the fact that social medicine is presently being used in mental hospitals, it becomes necessary to research into all aspects of social cultural relevance to health and illness with a view to emphasising the positive and demphasising the negative, to be able to achieve health for all by the year 2,000.

Sexually Transmitted Diseases in Nigeria

The relationship between venereal diseases and infertility had been pointed out by Onifade and Osoba (1975) in a study of 151 patients who were complaining of infertility in the gynaecological clinics at the University College Hospital Ibadan. They assert that about 60% of the primary and secondary infertilities are due to venereal diseases, the authors stress that there are considerable reservoir of gonococol infection among the female population in Ibadan.

Osoba and Onifade (1973) in another study of 208 pregnant women randomly selected in University College Hospital Ibadan found out that 3.3% had gonorrhoea, 20.6% had trichomonas vaginalis. Emmanuel (1979) in a study of 105 paediatric gynaecological cases in Lagos between 1963-1973 recorded 15 cases of vulva vaginitis of which two were due to gonorrhoea. Chukwdebelu (1975) in discusing pelvic infections disease (PID) saw it as a complication of criminal abortion, puerperal sepsis and spontaneous abortion. He made very little mention of the effects of venereal disease to pelvic infections disease. But Arya et al (1980) suggested correlation between fertility, pelvic infections disease and venereal disease based on his study of two districts Teso and Ankole of Uganda.

In Zaria, however, Bello (1983) found out that the attendance to the clinic was at a ratio of 6:1 male female attendance and that most women were referred from the gynaecological section following history of discharges. On the males he noted that 70% have prostitutes as source of infection. He pointed to some factors like religion, ignorance, poverty and the issue of quacks as things that inhibit all control measures. On contact tracing, he noted the inadequacy

in information dissemination, poor communication system, poor street numbering and the purdah as factors that make control through contact tracing impossible.

Other writers like Schram (1971) talks about previous treatment given to syphilis in Nigeria as white paste roast, chameleon, gun powder, gin, grain powder and in fusions of bark of trees.

Considering the above literature therefore, sexually transmitted diseases could be said to be a world wide disease as old as man. Efforts had been made to control these diseases by certain restrictions in the pattern of sexual life of individuals. This preventive measures as practised for example in Russia is aimed at eliminating the complications of STD with particular mention of the associated infertility problem.

CHAPTER THREE

METHODOLOGY

3.1 Research Unit

This study was conducted in Ahmadu Bello University Teaching Hospital in Zaria for the following reasons. Firstly, the researcher works as a contact tracer in the sexually transmitted disease clinic referred to as a Special Treatment Clinic of the Hospital. This job involves tracing the orign of new patients' diseases and having opportunity to interview them in an effort to reveal such delicate and private factors that may be responsible for their presence in the clinic, including pattern of their sexual life, and educating them about the disease which are confirmed by the doctor through their investigations. Secondly, her previous training and also working in the hospital as a Nigerian Registered Nurse has enabled her to understand better the different types of diseases referred to as venereal or sexually transmitted diseases, their mode of transmission, incubation period and symptoms. The third reason is that the researcher speaks the three main Nigerian languages and English which is the language of most patients who attend the clinic; this gives the patients the trust to confide in her with such information as is relevant to their complete cure.

The fourth reason is that her job involves direct contact with prostitutes in the hospital and in their different enclaves such as their homes, and hotels. This contact is quite important since prostitutes are known to be the major elements of continuity in the sexually transmissible disease circle. Last, but quite significant as well, is the fact that she has been directly involved in a study of the pattern of drug use in Zaria, which involved going to most registered patient medicine and pharmacy stores in Zaria to interview customers and identify how they use antibiotics and to determine the consequent effect of drugs used in the hospitals for the treatment of sexually transmitted diseases.

3.2 Data Collection

Two types of data were used in the study. The first involved data from hospital records of 961 patients that attended clinic within the period of June, 1986 to May, 1987. These records were used to highlight the socio-demographic characteristics of patients and their diseases.

Epidiemiological research involves community based data and records based data. Community based data however, is an elaborate research which is very expensive and takes a longer time. Records based data however, may not always be right

considering the fact that it needs a second person to record information and this may not always be accurate. It is in recognision of this inaccuracy, and the fact that such data are designed for a specific interest and may not be useful for other research situations that the need arose in this research for a second data set consisting of interview schedules of 100 new patients selected from the hospital records within a four week period of April/May, 1987. The reason for the latter sample was to get more relevant data such as the relationship between demographic characteristics and sexually transmitted disease.

Information on history and patients perception of disease were also relevant for determining other people's perceived reactions towards them. About twenty to thirty patients attended the clinic daily, Monday through Friday. These include both new and old patients. New patients were preferred based on the fact that they were most likely to give a better response, considering their anxiety to get well. The old patients on the other hand would not be very cooperative having had some relief following previous clinic treatment.

The interviews were held in a cubicle within the clinic to encourage privacy and free flow of information. All the responses were recorded verbatim in order to avoid omissions. In the case of patients under the age of five, parents were allowed to assist in responding to interviews. The interviews were also interpreted into local languages such as Efik, Ibo, Yoruba, Hausa which the researcher could speak, when English language appeared to be a barrier to communication. The services of the clinic nursing sister and interpreter were used in such languages as Fulani, Kaje and Idoma. Five case-studies following an indepth interview are also presented.

3.3 Problems Encountered During Data Collection

The first problem was the question of getting permission to use the hospital data from the clinic. Although I work with the data, I still needed a formal request from the post-graduate coordinator to the clinic consultant before I undertook the study. There was also the problem of hospital records not containing certain social information which one may consider relevant to the diseases treated in the clinic such as the perceived cause of disease, hence the need to carry out the interview. It is in recognition of this deficiency that a new profile has been designed for the clinic. There was also the problem of omissions as could be seen in the high number of unrecorded information in the data.

The second problem was the interview schedule. Generally, the patients were cooperative but for some who felt that I was probing too much into their personal life, which in most cases they had refused to disclose to the doctor. For example, a question about the identity of the partner, invariably met with hostility. Similarly disclosure of certain demographic characteristics, such as occupation and marital status for example met with characteristic resistance and perhaps deception. Certain patients who claimed to be single were found to be married

as the interview progressed. This, they claimed, they did because they wanted their disease condition kept secret between them and the hospital personnel involved in the treatment. With respect to occupation, many of the patients who were recorded as business men or women could not specify what business they did and in actual fact majority of the women were later found to be prostitutes. Interesingly, it was also discovered that most patients find it difficult to differentiate between girl-friend and boy-friend and a casual pick up liaison. Such differentiation could only be ascertained by me after probing.

Research Location and Area of Study

Zaria is a predominantly Hausa speaking town in the Northern part of Nigeria which, nevertheless, is quite heterogenous in population in terms of religion, ethnic origin and culture. It has a good number of industries among which are the Nigerian Tobacco Company, with many expatriates and Nigerian as its employees, and the Zaria Industries which manufacture tarpaulin, the Comrade Cycle Industry, Groundnut Oil Factory, Nigerian Industrial Development Centre with a training school for craftsmen, and the Leather Research Institute, the oldest in the country.

Zaria also has academic institutions among which is the Ahmadu Bello University, the largest University in Africa South of the Sahara. There is the Nigerian Military School, the only one in the country and located in the Chindit Barracks. The Nigerian Army Depot is also located in the same area with the Military School and comprises of barracks and training units for the Nigerian Army.

Zaria has the only Military Policy Training School and Barracks which are situated in the Bassawa area of the town.

The town has the Nigerian College for Aviation Technology, the only one of its type in the country. There is the Institute for Transport Studies in the town also. Many Primary and Post-primary Institutions exist in Zaria. While some are privately owned, others are owned by the government. They serve the interest of the children and wards of both natives and staff of the many establishments in Zaria.

Another area of Zaria is Wusasa which is a residential area and the seat of Christianity in the North with a Theology College and is the home of a former Head of State of Nigeria. Wusasa has a mission hospital (St. Lukes Hospital) which is owned by the Anglican Mission.

The Indigenous Hausa live in the walled city which has the palace of the Emir of Zaria. There are no hotels or Churches in the City. The city has a homogenous outlook.

There is also the Sabon-Gari area with shopping centres, banks, and a large market. Most non-indegenes live in this area e.g., the traders, craftmen and women. Sabon-Gari can be taken as the commercial centre of Zaria. The largest number of hotels and churches are located there. Most of these hotels harbour the prostitutes. The Ahmadu Bello University Teaching Hospital is in Tudun-Wada area and it caters not only for Zaria citizens but for people from other parts of the North and the South of the country. Impressionistically it caters more for people from the southern part of Nigeria because of its relatively free medical services as compared with other teaching hospitals in the south of the country. Along these are numerous informal sector enterprises.

Hence with its socio-economic set-up and the resultant population Zaria presents itself as an interesting location for the conduct of this study.

3.4 Description of STD in the Study

In this section it may be useful to give a brief description of the STD that are referred to in this study in a way that is intelligible to non-medical specialists.

Syphilis is caused by an organism known as treponema pallidum. It is capable of involving practically every structure of the body in its course. It is characterised by a sore on the sight of infection usually the penis or Labia which may or may not present with pain, this sore usually disappears after some time with or without treatment.

Syphilis is classified into two: the acquired and the congenital as the name goes. The acquired is through sexual contact while the congenital is passed through the mother of the unborn child. Each, however, has three stages namely early infections phase, usually a lesion (sore or chanre) which may or may not be noticed. Secondary stage, covering structures of the body (skin and mucous membrance, subcutaneous tissue). Later the bones, joints and muscles. Tetiary stage or quaternary syphilis affects the heart structures and nerves. The third stage in congenital syphilis is called stigmata. It is the secondary stage, with its associated pains disability that brings patients to seek for treatment.

The incubation period is 10-12 weeks.

Gonorrhoea presents with purulent yellow discharge. It can be passed from an infected mother to child at delivery, where eyes of baby are seen with discharges containing the organism (opthalmianeonatorum). It can lead to blindness in such babies if not quickly treated. In adults, it can lead to urethral strictures in males and pelvic infectious disease in females. The incubation period is 2-10 days. They may however be asymptomatic in which case a scrapping of the meatus in males and the cervix in females may reveal its presence under a microscope.

Candida (Thrush fungus) could be present in mouth, lungs, guts and vagina. It could be carried as a commensal i.e. it does not cause any problems. (Calteral (1971) suggests that gestogesic contraceptive pills can excerbate calteral candidosis. It is present more in the female than in the male; its incubation period is not certain. It is characterised by excessive itching and whitish discharge in the female and urethral iritation in the male.

Trichomonaisis Vaginalis can only be identified under a microscope. It presents as offensive discharges and causing itching in the female and irritation in

the male. Its incubation period is 4 days to 3 weeks.

Herpes Genitalis - is a virus of the herpes virus Type 2. It is sexually transmitted. It presents as rashes on the genitals. Its incubation period is four to five days. Its complications are still births, abortions in early pregnancies or congenital mal-formations. There is no known cure, but paliative treatment are given to increase immunity level by vitamins.

Chancroid 'soft chancre' or ulsus molle is caused by strepto bacillus of Ducrey (Haemophilus ducreyi) - characterised by ulceration at the sites of inoculation usually the penis and the labia. Incubation period is one to five days. Complications include inguinal abcess phimosis, urethral fistula usually mixed with syphilis in which case it is referred to as mixed chancre. Lymphogranuloma venereum or granuloma inguinale all presenting as an open leasure on the genitals.

Most books on venereal diseases are written by the white and all the above diseases are said to be tropical diseases. They claim low incidence among the white and high in negroes. They associate the diseases / with the socially unenlightened and economically unfortunate.

CHAPTER FOUR

FINDINGS: SOCIO DEMOGRAPHIC CHARACTERISTICS OF PATIENTS AND DISEASES

On the basis of hospital records, this chapter describes the socio-demographic characteristics of 961 patients who attended the special treatment clinic otherwise known as the sexually transmitted disease clinic in a period of twelve months, from June, 1986 to May, 1987. However, in order to highlight some problems associated with these records two case studies are also presented.

Table 1

AGE DISTRIBUTION OF PATIENTS BY SEX

AGE GROUP	Male		Female		TOTAL	PERCENTAGE
Under 5	-0%		27	16.4%	27	2.8%
5 - 9	1	0.1%	7	4.2%	8	0.8%
10 - 14	32	4.0%	3	1.8%	35	3.6%
15 - 19	102	12.8%	32	19.4%	134	13.9%
20 - 24	260	32.7%	53	32.1%	313	32.6%
25 - 29	71	8.9%	5	3.0%	76	7.9%
30 - 34	142	17.8%	7	4.2%	149	16.0%
35 - 39	139	14.5%	3	1.8%	142	14.8%
40 - 44	38	4.8%	6	3.6%	44	4.6%
45 - 49	4	0.5%	13	7.9%	17	1.8%
50 - 54	1	0.1%	7	4.2%	8	0.8%
55 - 60	6	0.8%	2	1.2%	8	0.8%
TOTAL	796		165		961	

Out of the 961 patients, majority (82.8 %) were males and the rest (17.2 %) were females. The sample ranged from below 5 years to 6[illegible] years. The highest represented age group was 20-24 years with 32.5 % followed by 30-34 years with 16. 0%.

Looking at the representation by sex, it is seen that 20-24 years has a high representation for both sexes with 32.7 % of the males and 32.1 % of the females while there were more females (7. 9%) than males (0.50%) representation in ages 45-49. However, the trend is reversed in ages 10-14 with more males 4.0 % representation than females with 1.8 %.

The most shocking finding is the presence of children under 10 years, representing 3.6 % of the sample. Majority of these, that is 34 out of the 35 children, were females. This fact leads one to speculate that there is a presence of sexual abuse among children especially young girls which may or may not have been noticed or perhaps regarded as significant by their parents.

Females presented to the clinic as contacts of male patients. This is not surprising because most of these diseases are easily detected by males due to their physiology and anatomy. That is, in men the infection manifests itself quickly within a matter of days

because of the burning sensational difficulty in micturition, obvious purulent discharge and sometimes complete dysuria associated. The anatomy of the females, on the other hand, makes such symptoms difficult to be recognised, except with the aid of a speculum (an instrument used to examine the female cervix). Most female symptoms present at very delayed stages as pelvic infectious disease (PID) which in most cases is latent complication of venereal disease. In females, the infection is thus neither easily detectable nor reported.

A Case Study of 3 Under 10 Year Old Children With Sexually Transmitted Disease

The study was done on a family with three children who were found to have gonorrhoea.

Tayo, a 9 year old boy, was referred from the paediatrics Unit and brought to the Clinic by his mother with a swelling of the penis and a purulent discharge. Pain and dysuria (difficulty with micturition) was the major complaint. On examination, Tayo's discharge was positive for gonorrhoea. The mother was asked to bring all members of her house-hold as was the routine in the clinic. Two sisters of Tayo, aged 8 and 3, were found to be positive for gonorrhoea.

All effort to get a clue to how the children got the disease failed but an intensive interview with the 3 year old girl revealed that her brother Tayo engaged in what she called a type of play, which involved sexual intercourse with her and the eight year old sister.

Master Tayo was a primary five pupil, his eight year old sister was in primary three while the 3 year old stayed at home with the mother who said she is a full time house wife although it was observed that she had a shop situated within their residence.

The mother felt strongly that it must have been poison from a jealous person. She refused to associate the symptioms with coitus and said we should not believe her 3 year old daughter, because she was not sure of her information and therefore asked that we discard such information. The mother claimed she was in the house most of the time and was in a position to observe any actions of her children. The father had similar opinion with their mother. They had tried a traditional medicine.

The nine year old boy said he first had intercourse in school with another girl in his class and later with a girl of about same age who sells groundnut around his house. The eight year old girl denied any sexual relationship. They were, however, all treated and told of its dangers.

This case study illustrates how females come as contacts and also how very young children indulge in sexual relationship and how perception of the parents about disease may be detrimental to the children's cure.

<u>A Case Study Illustrating Age Factor and Role of Extended Family in S.T.D.</u>

Kehinde, a four year old girl, was referred to the clinic from the Paediatrics Unit with vaginal discharge, swelling and a high temperature (102°F). She was found to have gonorrhoea. An interview with her showed that she had coitus

three times with somebody she referred to as 'brother Kayode' whom her mother identified as her husband's 26 year old junior brother who was living with them after being retrenched from his work. (Brother Kayode has since secured a job in Zaria but still lives with Kehinde's family).

Kehinde's mother left her in the care of brother Kayode to go to work on the days her granny took ill. Kayode had threatened to beat Kehinde if she informed anybody. Kehinde's mother was asked to inform her husband about Kayode's sexual molestation and the subsequent venereal disease and to find another accommodation for Kayode in the interest of the little girl.

After two visits, Kehinde was still found to have gonorrhoea. Her mother reported that her husband objected to informing Kayode because he did not believe his daughter knew her contact nor did he believe his brother could be involved in such action. Kehinde's mother had to obey her husband. Although Kehinde's father and uncle were asked to come for advice and treatment for the uncle, her father refused and threatened her mother with divorce.

4.2 Religion

With respect to religion, Table 2 shows that of the total sample, 30.9% were moslems, 58.9% were christians, 4.7% had no specific religion and about 5.4% were not recorded. This patter is maintained in the sex groups with 61.9% male christians and 44.2% female christians. The pattern changes slightly with a higher number of female moslems 43.6% as compared with the male moslems which has 28.3% representation.

TABLE 2

RELIGION OF RESPONDENTS BY SEX

RELIGION	Male		Female		TOTAL	PERCENTAGE
Moslem	225	28.3%	72	43.6%	297	30.9%
Christian	493	61.9%	73	44.2%	566	58.9%
Others	43	5.4%	3	1.8%	46	4.7%
Not recorded	35	4.4%	17	10.3%	52	5.4%
Total	796	100%	165	100%	961	100%

Interestingly, there is a high percentage of christians in a predominatly moslem town. This could be suggestive of a higher reporting among christians possibly due to their exposure to western influence by way of education and occupation. It could, however, be that the moslem religion with respect to matters of sexuality and modesty inhibits reporting or allows for more traditional methods of treatment.

The heterogenous nature of the town may also be responsible for the pattern of representation here.

4.3 Tribe/Language

Majority of the respondents (39.9%) were Hausa/Fulani while 28.6%) were members of other Northern tribes. The area of study being predominantly Hausa may be responsible for this. A very large number (33.4%) were of the Southern tribes. The mobility of these groups may tend to give them more exposure to sexual laxises with high risk of S.T.D.

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TABLE 3

DISTRIBUTION OF ETHNIC GROUPS BY SEX

ETHNIC GROUPS	Male		Female		Total Percentage	
Northern Ethnic Groups	529	66.45%	101	61.2%	630	65.6%
Hausa/Fulani	292	36.7%	63	38.2%	355	39.9%
Southern Zaria	143	18.0%	26	15.8%	169	17.6%
Other Northern Tribes	94	11.8%	12	7.3%	106	11.0%
Southern Ethnic Groups	267					
Yoruba	102	12.8%	7	4.2%	109	11.3%
Ibo	93	11.7%	35	21.2%	128	12.3%
Other Southern Ethnic Groups	72	9.1%	22	13.3	94	9.8%
Total	796	100%	165	99.99%	961	100%

There was a fluctuating trend for the sex representation of the tribes. The Hausa/Fulani still had the highest representation of the females (38.1 %) followed closely by Ibo females (21.2 %). The lowest representation by sex are the Yoruba females with 4.2 % as against 12.8 % of the Yoruba male.

4.4 Marital Status

TABLE 4

MARITAL STATUS OF RESPONDENTS BY SEX

MARITAL STATUS	MALE		FEMALE		TOTAL PERCENTAGE	
Married	286	35.9%	93	56.3%	379	39.4%
Single	510	64.1%	70	42.4%	580	60.3%
Divorced	-(-%)		1	0.6%	1	0.1%
Widowed	-(-%)		1	0.6%	1	0.1%
Total	796	100%	165	100%	961	100%

Table 4 shows that majority of the patients (60.3 %) were single and only 39.4 % were married. However, while the male kept this pattern with 64.1 % of them being single and 35.9 % married, the female majority (56.3 %) were married. This is due to the fact that the females presented as contact of their male partners. The pattern of attendance suggests that unmarried males have a higher incidence of sexually transmitted diseases than the married males because of their exposure to multiple sexual partners.

TABLE 5

OCCUPATION OF RESPONDENTS BY SEX

OCCUPATION	MALE		FEMALE		TOTAL	PERCENTAGE
None	104	13.0%		-.0%	104	10.8%
Not recorded	33	4.2%	2	1.2%	35	3.6%
Child	7	0.9%	27	16.4%	34	3.5%
Student	285	35.8%	47	29.7%	332	34.6%
Farming	107	13.4%	14	8.5%	121	12.6%
Driving	63	7.9%		0.0%	63	6.6%
Business	103	12.9%	6	3.6%	109	11.3%
Civil Servant	96	12.1%	29	17.6%	125	13.0%
Prostitute	-(		15	9.1%	15	1.6%
House-wife	-		23	13.9%	23	2.4%
Total	796	100%	165	100%	961	100%

4.5 Occupation

Considering the occupation of respondents, it is very significant that the highest represented category were students with 34.5 % representation. Zaria having many educational institutions may have been responsible for this. It may, however, be that students are the most widely travelled group and stand a great risk of being infected especially by casual sexual contacts. Student were followed by the Civil Servants with 13.0 % representation.

When we look at the distribution by sex the student occupation still scores highest for both male and female. The females, however, have a higher representation of the civil servant category with 17.6 % as against civil servant males (12.1 %). Farming with 13.4 % representation scores next to students for the males. The business category consists of prostitutes who had earlier designated themselves as business ladies.

Regarding occupation of patients, it is pertinent to mention that most patients do not like to tell what their occupation is, as could be seen in the high number (3.6 %) whose occupation were not revealed and were not recorded.

The case study below illustrates the difficulty in identifying occupation of patients in this sample.

Ngozi, a 32 year old mother of two, who has never been married, presented to the clinic with sexually transmitted disease diagnosed as trachomonais and gonorrhoea, and was requested to bring her male contact. She had registered as trader but a thorough interview with her revealed that although she had a regular sexual partner who maintained her and paid her bills, she regularly took in other sex partners to maintain herself and her two children and in fact did not do anything else for a living. This case study illustrates the difficulty in identifying occupation. In this case, the revelation about her true occupation was only possible when pressed to bring her male sex contacts. Her occupation was validated when she was visited in her two bed room flat.

4.6 Disease Distribution

TABLE 6

DISTRIBUTION OF DISEASE* BY SEX
(HOSPITAL-RECORDS)

DISEASE	MALE		FEMALE		TOTAL PERCENTAGE	
A	24	3.0%	3	1.8%	27	2.8%
B	472	59.4%	76	46.0%	548	57.0%
C	64	8.0%	130	78.8%	194	20.2%
D	161	20.2%	22	13.3%	183	19.0%
More than one type	112	14.0%	13	7.9%	125	13.0%

*14.0% of males and 7.9% females had more than one type of infection at a time.

In the nature of diseases afflicting the respondents in table 6 four major types were identified namely syphilis (subsequently referred to as the 'A group which includes primary, secondary and tertiary syphilis). Secondly the B group which included pre-and post pubertal gonorrhoea.

There was also the C group which includes such diseases as chancroid, lymphograduloma venereum, granuloma inquinare, non-specific genital infections, trichomonaisis candidosis, pubic lice (pediculosis pubis), herpes simplex and genital warts. Finally was the D group which included such conditions as venerophobia and infertility treated in the clinic. It must be mentioned here that these letters attached are internationally accepted and used so as to minimise the stigma attached to the disease and encourage reporting.

There was a significant percentage (57.0 %) of patients with gonorrhoea or B group. This high rate could be due to the short incubation period (3-7 days), the obvious discharges, pain, and discomfort associated with this disease.

Syphilis or A group was suffered by only 2.8 % of the sample which may be related to the fact that it has three months incubation period. Salient is the fact that about 13.0% of the sample had more than one type of

the disease. While g norrhoea was found to be the most common disease suffered by the male 59.40%, the C group or candidias etc. 78.80% was the most common for the females. A very insignificant number of females (1.8%) had syphilis.

In conclusion to this demographic study, the pattern that emerges is that ages 15-24 present more to the clinic, more males came to the clinic than females. The respondents were mostly students and there were more single respondents than married.

CHAPTER FIVE

HISTORY AND PSYCHOLOGICAL ISSUES IN SEXUALLY TRANSMITTED DISEASES

Considering the fact that hospital records did not have information about the history and psychological consequences of sexually transmitted diseases, and in addition to the constraints of the availability of these patients on a regular basis, it became necessary to study a sample of one hundred new patients within a period of four weeks in April and May, 1987.

The sample of 100 patients had 58 males and 42 females. Their ages ranged from below 5 to 55 years, as the highest representation. They were with 15-19 years/43 Moslems, 54 Christians and 3 had no specific religion.

They were 68% Northern respondents as compared to 32% southerners. The Hausa Fulani had the largest single representation in the North (38%) while Ibos were the largest single representation from the south (17%). Their marital status showed 65% as single 33% as married, and 2% as previously married. With respect to type of marriage, 19% were monogamous while 13% were polygamous.

An investigation of respondents' previous exposure to disease was carried out. Table 7 shows that majority of the patients (52%) had previous symptoms before coming to the clinic, while 39% had

had none. The fact that 49% reported infection for more than one occasion points to the complex and recurrent nature of sexually transmitted disease within the sample.

5.1 Previous Exposure to Disease

TABLE 7

PREVIOUS EXPOSURE TO DISEASE

	NUMBER	PERCENTAGE
No response	12	12%
Never had	39	39%
Once	4	4%
Two times	32	32%
Three times	10	10%
Four times	1	1%
Five times	2	2%
Total	100	

Regarding the management of such previous infections, Table 8 shows that patients (87%) utilised a wide range of self-medication including traditional medicine.

TABLE C

PREVIOUS TREATMENT OF DISEASE

TYPE OF TREATMENT	NUMBER	PERCENTAGE
No form of treatment	10	10%
Treated with capsules	72	72%
Treated with traditional medicine	87	87%
Infection from chemist	89	89%
Treatment from other doctors	69	69%
Other hospital workers	2	2%
Special treatment clinic	3	3%

*Many respondents used more than one type of medication so it cannot add to hundred

Only 10%
did not take
Only 10% / any form of treatment for their disease. The rest had utilized other healers. It is significant that only 3% come to the special treatment clinic without having had previous treatment. It is obvious, as can be seen in Table C, that most respondents used a combination of one or two of other methods of treatment.

This alarmingly high rate of self-medication may be due to a number of reasons. In a discussion with respondents it was revealed that many took to self-medication because of ignorance of the existence of the clinic. This may be due to poor publicity. Some believed that they would get better treatment from other

sources besides the clinic. Others said the fear of labelling them as sex deviants made it such that they would, if they had an alternative, not want to be associated with the clinic even where they were aware of its existence.

5.3 Source of Sexual Contact

TABLE 9

SOURCE OF SEXUAL CONTACT FOR S.T.D BY MARITAL STATUS

	Married		Single		Total
Prostitutes	25	75.8%	25	73.3%	50
Casuals	15	45.5%	46	68.7%	61
Girl-friends	12	36.5%	19	28.4%	31
Boy-friends	2	6.1%	19	28.4%	21
Brother	-		4	6.0%	4
Spouse	1	13.0%	-		1
Sister			1	1.5%	1
Unknown			10	18.0%	12

It does not add to 100 because of multiple partners. The source of disease contact as revealed in Table 9 might partly explain the high rate of self-medication in the sample. It is significant to note that most married respondents (75.8%) contacted their disease through prostitutes while 45.5% contracted through casual liaisons. What was obvious was that many respondents had multiple sexual

contacts. The high number of respondents whose source of disease was through prostitutes, (75.8% of the married and 73.3% of the single) is very disturbing and goes further to explain why it has been difficult to control S.T.D.

5.4 Psychological Issues

TABLE 10

PATIENTS PERCEPTION OF NATURE OF DISEASE AND CONSEQUENCES OF STD

PERCEPTION	NUMBER	PERCENTAGE
No response	4	4%
Do not know	20	20%
Malaria/Yellow fever	15	15%
Venereal disease	45	45%
Poisoning	1	1%
Do not think he/she has disease	3	3%
Total	100	

This section deals with patients' perception of the nature, cause and consequences of S.T.D. as shown in Table 10. Most patients (45%) were aware that they had venereal disease while the majority (55%) believed their symptoms were either due to some superstition, malaria or yellow fever. Significant was the 3% that did not think they had any form of

disease. These were the respondents that did not feel any symptoms of disease but were in the clinic as sex contacts of known venereal disease patients.

The education of respondents did have some influence in the ability to correctly diagnose the disease as venereal. Table 11 shows that the higher the educational level, the more the number of respondents who correctly diagnosed their disease as sexually transmitted disease.

TABLE 11

EDUCATIONAL LEVEL AND DISEASE PERCEPTION

Educational Level	No Response	Do not know	Malaria/ Yellow Fever	Venereal Disease	Poisoning	Others	No disease	Total
X	X	X	X	X	X	X	X	X
Koranic/No Education	1	4	11	3	1	4	2	26
Primary	-	4	2	6	-	2	1	15
Secondary	1	6	2	12	-	1	-	22
University	3	5	-	24	-	5	-	37
Total	5	19	15	45	1	12	3	100

While those with no education or koranic education associated symptoms with malaria or yellow fever popularly referred to as (shawtra), one patient believed his disease had to do with poisoning.

On the casual factors of disease, Table 12 shows that about 23% did not know what caused their symptoms; in this group were those who did not know they had venereal disease at all and those that did not believe their symptoms were associated with any form of sexual contact.

TABLE 12

PERCEIVED CAUSE OF DISEASE

	NUMBER	PERCENTAGE
Do not know	23	23%
Toilet and toiletories	13	13%
Superstitution/Allah/ God's will	11	11%
Spouse	1	1%
Sexual contact with spouse prostitute	21	21%
Casual pick up	15	15%
Girl/Boy friend/spouse	25	25%

About 13% thought it was caused through contact with toilet and toiletories and 11% thought it was due to some form of superstitution. Of particular interest, is one respondent that associated the cause of the disease to that of crossing / evil spirit while going to urinate. Surprisingly, out of the thirty four married

patients only one person related the symptoms to sexual contact with spouse while about 52 admitted sexual intercourse with casual pick ups and prostitutes.

Experience of Stigma

Table 13 shows the extent to which respondents disclosed or did not disclose the fact of their disease to significant others. The majority (77) disclosed their disease to relatives (22), healers (25) and and friends (30). The healers consisted of chemists, hospital personnel and traditional medicine men. Sadly, but understandably, of the 33 people who did not disclose their disease to any one, 24 were married. The reasons for the non disclosure of disease to others by married people were mainly due to fear of divorce, separation or labelling.

TABLE 13

DISCLOSURE OF DISEASE TO OTHERS BY SEX AND MARITAL STATUS

Marital Status	Did not inform anybody	Informed Relatives	Informed others, healers	Informed friends
Married male	24	2	13	-
Single Male	3	17	2	16
Married female	3	1	2	2
Single female	2	2	7	12
Widowed and Divorced	1	-	1	-
Total	33	22	25	30

Considering the number that had sexual contact while having the disease, Table 14 reveals that a greater number (48%) had sex while having disease, while 38% did not and 14% could not remember immediately if they had coitus while having the disease.

TABLE 14

SEXUAL INVOLVEMENT SINCE ONSET OF SYMPTOMS BY SEX

	Male	Female	Total
Can not remember	11	3	14
Yes	43	5	48
No	36	2	38

Out of the respondents that had sexual intercourse, 17% were found to be married and 21% were single as shown in Table 15.

TABLE 15

SEXUAL INVOLVEMENT SINCE ONSET OF SYMPTOMS BY MARITAL STATUS AND SEX

Sex	Single	Married	Total
Male	29	14	43
Female	2	3	5
Total	31	17	48

Of interest is the higher percentage (14%) of married men that continued coitus while having the disease. In discussing reasons for their actions regarding sexual involvement while having the disease, they indicated shame, fear of divorce or separation as the major reasons. The influence of stigma on venereal disease can be illustrated further by the following case study.

A Case Study of Effect of Stigma on Health Seeking Behaviour

> Dauda, a 36 year old highly educated man married to a university graduate from royal home. He reported to the clinic with repeated symptoms of gonorrhoea and chancroid. He admitted to continued sexual coitus inspite of infection, but informed his girl friend about his infection. She was treated but not his wife for fear of divorce. He planned a sort of deception

> whereby he would purposely mislead the wife about her inability to conceive so that she would seek medical help and in the course of this, her infection will be discovered and treated.

This is a pathetic case which graphically illustrates the effect of stigma on sexual and marital relationship whereby the man was even willing to go through a tortuous deception rather than disclose the source of infection for fear of being divorced from a royal marriage. This fear of stigma is so much that it becomes a negative saction as could be seen in the relationship between the S.T.D. team and the rest of the hospital staff. Most communication with other members of hospital staff were through the windows or in the clinic, while standing, for fear of contamination because it was a belief that mere sitting on the clinic seat was enough to transmit infection. The position of the clinic was also based on these others' perception. On observation, it was seen that patients who came to the clinic did not always want to be associated with the clinic, hence they would rather go to mix with in-patients' visitors' seat, leaving the S.T.D. clinic seat vacant most of the time. There was always difficulty in getting an interpreter for the clinic. Even where one was assigned, he/she would rather go to help in the out-patients department. The doctors were not excluded. Doctors posted from community

medicine to help in running the clinic declined with very flimsy excuses on many occasions.

The host department (Medical Microbiology) was not left out of the stigma although they should have had a better perception of the clinic. Workers in the clinic were referred to as 'idlers'. The special treatment clinic was deprived of the use of departmental vehicle for contact tracing exercises when there was such need. This was because most patients of the clinic were regarded as sexual deviants and did not deserve any pity.

It can be suggested, therefore, that these informal sanctions and negative reaction about the S.T.D. and its facilities play a big role in in hibiting the reporting of diseases and failure of patients to bring contacts as part of their treatment.

CHAPTER SIX

SUMMARY, DISCUSSION AND RECOMMENDATIONS

In this chapter, a summary of the study is given in the first section, while the second section discusses the major findings. Lastly, we put forward some recommendations which may enhance the health and social policy in Nigeria.

6.1 Summary and Discussion

This study has examined the sicio- demographic characteristics of a sample of hospital records of 961 patients attending the sexually transmitted disease clinic in the period of June 1986 to May 1987.

It revealed that it was the younger age grade 15-24 years who were mostly single and were students or civil servants, that had the highest incidence of venereal disease. There was a sex difference in the pattern of attendance; such that males came to the clinic more than females, and infact most of the females that attended clinic were brought as contacts of male patients. A particular interest here is the female age grades under 5 and 5-9 years which constituted 2.80% of the 961 hospital record sample.

The presence of this age group in the sample suggests a possible existence of child sex abuse within

our society. perpetrated by the elder members of extended family as revealed from the different case studies. This is encouraged by the African traditional extended family system which has shown itself as a disadvantage in this respect, though it serves as a security system.

This social system, although useful, predisposes young children in the homes to sex abuse. Domenico (1982) in looking into the role strain and working mothers in an urban centre in Nigeria also identified that in a traditional setting, 9% of children were left in the charge of house maid or baby-nurse while in todays modern society 41% are left in the care of house maid. That study although meant to look into the mental state of these children could be relevant to our study of sexually transmitted diseases, and the high rate of children presenting with it, when one considers that those seen in the clinic are those that have discharges which were recognised by parents. A greater majority may have been missed out since such cares as bathing the children and washing are done by the house maids.

Looking at the ages that present in the clinic, there is evidence of high rates of pre-marital sex by young people and the associated danger of contracting venereal disease because generally the higher the

age of the individual the less likelihood he would contract venereal disease because he becomes more enlightened about its prevention.

As far as religion is concerned, however, one may want to agree with Hussaini (1971) that religion had some influence in controlling deviant sexual exposures which results in STD's, with the greater number of reported cases being Christians. It could however be argued that this difference may not necessarily be due to the control which religion has on disease rather, that Christianity allows freer heterosexual association and has been more exposed to the secular influence of Western culture.

Considering the marital status of patients there was a high representation of single males. This leads us to speculate that marriage may here stand as a control measure. There are no immediate means of knowing about other control measures, as discussed by Arthus (1953), that applied to the sample but the fear of separation or divorce as discussed by most respondents could be a pointer to the cultural control and negative sanctions to extra marital activities.

Occupationally the most represented categories were those of students, civil servants and prostitutes. Significantly these are the categories most influenced

by circularizing influence of mobility and education. The study has confirmed the general view that prostitutes are the carriers of S.T.D.

Education showed relationship to perception of disease. It was relevant as far as recognising the symptoms of venereal disease. But even then, the category of educated respondents attempted self medication and traditional medicine.

Stigma, as discussed by Goffman, was in this study manifested in respondents' reluctance to disclose their diseases to their spouses, in the high rate of self-medication and patronage to informal sector healers, and attendance at the clinic as a last resort. Stigma could also be seen in the circumspect, almost clandestine interaction which characterised the patients visits to S.T.C, and the reaction of the rest of the hospital staff. This perception and reaction of others may have played a big role in inhibiting reporting and failure of patients to bring contacts as part of their treatment. This also results in the subsequent inability of the society to control sexually transmitted diseases.

Gonorrhoea (B1) was seen to be the commonest disease presented in the clinic. Possibly, as suggested earlier, it may be because of its short

incubation period. Prostitutes and casuals were a point of focus in its spread, and the refusal of their customers or themselves to use durex or condom (as discussed in the introduction) which is known to protect them from the venereal diseases complicates the issue. Their perception of its complications which are not based on any scientific fact is responsible for their unwillingness to use condom. This negative attitude to use of condom has some implication in the prevention and cure of S.T.D.

The respondents' perception had great influence on their self-medication. Most did not think it was a serious disease, hence the frequent continued exposure to sexual activity while still infected.

In this regard, one can discern that this mistaken perception and the attendant sexual behavioural pattern are greatly responsible for the spread of S.T.D.

6.2 Recommendations

Efforts should be made to eliminate mistaken perception, if we are to control these diseases and achieve health for all in the year 2000. Of special mention in this preventive campaign is of course the AIDS disease.

In the light of the high affliction of STD on a large number of young unmarried people, it is pertinent to

recommend the Nation to liberalize its policies with regard to sex education, availability and accessibility of fertility control measures to this segment of the population. Such measures would go a long way in curbing a lot of the negative effects of sexual behaviour chief among which are spread and cure of S.T.D. The effect of stress of unemployment and possible exposure of the youths to sex deviance cannot be over emphasised. This becomes necessary when we think of the number of unemployed in the study.

A more positive approach to viewing prostitutes is advocated, if we consider that this group of professionals are seen here as one of the outlets to sex desire and the consequent spread of venereal disease. Since prostitution is institutionalized it is a near impossibility to attempt to wipe out this profession. Rather, the laws of the land should protect them from being infected by their clients and provide them with medical facilities for frequent examinations considering that feeling of shame and labelling prevent them from attending the regular clinics. One of the ways being for the medical personnel to visit the brothel and their residences as was seen from the discussions.

A further research into the efficacy of drugs used by traditional healers especially for venereal diseases should be encouraged, since the cultural set up recognises them and their use cuts across all

tribes and educational levels as seen in the study. This will go a long way in helping the epidemologist to know if the present disease is new infection or is as a result of an ineffective traditional treatment.

Given the widespread practice of extended family living, in our society, there should be conserted effort to the enlightenment of the people about the possible dangers of child sexual abuse by older relations in some homes with under 10 year old girls.

This campaign should not only involve parents and other adults alone, but also children themselves. These educational efforts would make it easier for parents and children to detect sexual advances and molestation of children, and therefore allow for timely intervention of such dire effects as S.T.D. whenever they may occur. There should also be recreational facilities in offices and residential areas to keep these children out of mischief.

Lastly in consequence to the above discussion, the researcher recognises along the lines of Ryles (1968), the integration of social medicine with other branches of medicine in this society. For social medicine is a preventive approach that takes cognizance of the diverse culture, climate, environment, beliefs and norms of the individual.

Social medicine would be helpful in identifying the socio cultural and psycho social etiology and the epidemiology of these disease conditions and suggest ways of eliminating them.

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QUESTIONNAIRE

Socio-Economic Characteristic of Patient

Age

Sex

Religion Moslem Christian Others

Tribe (language)

Marital status

if married

male: No of wives

No of divorces

Females: Rank in marriage

Siblings:

Education level

literacy in mother tongue

literacy in real English

Occupation, No response /

& salaried selfemployment

Type of disease A B C D E

Patients perception of disease:

what so you think is the disease you have?

How did you get this disease?

How many times have you had this type of illness?

Pattern of sex:

Has this disease in any form affected your sexual relation with your spouse or friend.

In what other way

Pre Hospital History:

What did you do when you first noticed the sign of disease. Who advised you to come to the hospital?

Who are the people who know you have this disease.

What other methods of treatment have you taken before coming traditional medicine chemist shop private chemist



Other hospitals None No response