INSTITUTE FOR DEVELOPMENT STUDIES
UNIVERSITY OF NAIROBI

Working Paper No. 95

VENEREAL DISEASE AND SOCIETY

by

J. Mugo Gachuhi

April 1973

I.D.S. WORKING PAPER NO. 95.

VENEREAL DISEASE AND SOCIETY

by

J. Mugo Gachuhi

Abstract

The history of venereal diseases in Kenya and East Africa is reviewed. Charts and figures for venereal diseases in Kenya and Nairobi up to 1971 are presented. The argument has tried to show that besides being medical problems, venereal diseases are also social. As social problems, control of these diseases must have social dimensions.

Recommendations of control of these diseases are presented which calls for drastic reformulation of laws affect communicable diseases.

Venereal Disease and Society

Venereal diseases are as universal as life and death. No society, no class of people, no matter how sophisticated, no matter how "advanced" is immune from these diseases. In some parts of the world, venereal disease may be so rampant as to be declared public enemy number three or two or one. Unlike other diseases that afflict mankind, venereal disease is much more feared by many people because in addition to its being medical, it is also social. As a social disease, it is dreaded because to the person who has it, it is an indication to others of where he has been or what he has been doing. It is not unlikely that individuals who are known to have venereal diseases are ostracized by their friends. They become topic of conversation, they are isolated and even ridiculed. It is not unusual to find happy marriages ruined because of one of the partners has got the disease. Families have been known to be disrupted, carriers have been destroyed and even individuals have become mad because they have been unfortunate enough to get the disease. The social pressure surrounding the victim of venereal disease is insurmountable. Yet, the figures from different countries, show that venereal diseases, especially the gonorrhoea, are on the increase; that more and more people are exposed to the disease and that some do not even seek medical help, perhaps because they are embarrased to do so, or simply because they don't even know that they have the disease.

One of the major problems about venereal diseases is because they are shrouded with mystry. They are the type of disease that individuals do not boast about or indeed talk about even to their closest friends or in case of the married couples, to their spouses.

Why are venereal diseases so dreaded ? How do the victims of V.D. come to get it? What measures has the health authorities here in Kenya taken to combat these diseases? Should the fight against venereal diseases be left to the health personnel alone or do society's other Institutions have a major role to play in educating, treating and eradicating, or at least controlling the venereal diseases?

These and others not asked are all important questions which need asking and answers to them be provided. The sociology of venereal diseases needs to be discussed. The purpose of this

paper is a general introduction on the subject of venereal diseases. This introduction on a prelude to the studies we have been doing on venereal diseases and prostitution which we are now preparing for writing up. The present discussion is also an attempt to intiate a discussion aimed at public information and education about the nature and causes of venereal diseases and how they could be prevented or at least treated.

LITERATURE ON VENEREAL DISEASES IN EAST AFRICA

Literature on venereal diseases in East Africa while available in scattered form to any serious researcher, it is limited mainly to epidemiological aspects of the disease. Those studies that have looked at the social aspects of the venereal diseases are few in number and are not easily available. Nevertheless among those limited studies that are available, excellent accounts of the diseases and how they interact with the social fabric of the community are given. Perhaps one of the excellent studies, though unfortunately not yet published, is the one done in Mombasa by W.K. Rutasitara.(1) Rutasitara studied a sample of sixty Mombasa "bar-girls" and tried to relate occupation with prostitution and the incidence of venereal diseases. He utilized such variables as education, socio-economic background of the respondents, coitus frequency and choice of partners, and many others in order to show their relationships.

A.W. Southall and P.C.W. Gutkind have also looked at the human sexual relations in East Africa and their excellent accounts are contained in their book Townsmen in the making.(2) Professor F.J. Bennett, of the Department of Preventive Medicine, Makerere University medical school, has looked at the Social factors of venereal diseases in more details than many other commentators on the subject. Even though most of his studies have been confined to Uganda in general and Kampala in particular, his

---

(1) W.K. Rutasitara "Mombasa Girls: A Study of Prostitution and venereal Disease in a Kenya Seaport. A Dissertation Presented to Makerere University Faculty of Medicine for a Diploma in Public Health (D.P.H.), March, 1970. Unpublished.

(2) A.W. Southall and P.C.W. Gutkind Townsmen in the making. East African Studies No. 9 Makerere University, Kampala, 1957.

comments are generalizable to East Africa as a whole[1] O.P. Arya and F.J. Bennett have studied the attitudes of the elites towards venereal diseases.[2] While J. Carlebach has studied Prostitution among the Nairobi Juveniles.[3]

A.R. Verhagen and W. Gemert [4] have done a major study in seven urban and rural areas in Kenya in which 1,533 patients were investigated for gonorrhoea. In their study, Verhagen and Gemert compared the social background of positive and negative cases of the patients with those of the controls. In another related study[5], the researchers investigated three genital infections in 200 women in an urban East African Family Planning clinic (Nairobi) in which they divided the women into four groups of 50 according to marital and contraceptive history. A.M. Wilson[6] has investigated the presense of venereal disease in the former British Colonies.

---

(1) F. J. Bennett. "A Review of Venereal Diseases in University Students in East Africa" and "Prostitution and Venereal Disease in East Africa Towns" (1966) Personal Communication of 1st September 1972. "The Social Determinants of Gonorrhoea in an East African Town" East African Medical Journal Vol. 39, No. 6 332-342 "Gonorrhoea: A Rural Pattern of Transmission". East African Medical Journal Vol. 41, No. 4. April 1964

(2) O.P. Arya and F.J. Bennett "Attitudes Amongst College Students in East Africa to sexual activity and venereal Disease". British Journal of Venereal Disease Vol. 44 160-166 and "Venereal Disease in an Elite Group (University Students) in East Africa." British Journal of Venereal Disease, Vol. 43. pp. 275-279.

(3) Julius Carlebach Juvenile Prostitutes in Nairobi, Kampala, East African Institute of Social Research, 1962, East African Studies No. 16.

(4) A. R. Verhagen and W. Gemert. "Social and Epidemiological Determinants of Gonorrhoea in an East African Country". Nairobi. Medical Research Centre. Unpublished.

(5) M. Hopcraft, A.R. Verhagen, S. Ngigi and A.C.A. Haga "Genital Infection in an East African Family Planning Clinic". 1972. Unpublished.

(6) A.M. Wilson. "Venereal Diseases in the British Colonies". British Journal of Venereal Diseases Vol. 27, 1951. pp. 118-121.

J. W. Kibukamusoke has also commented on the occurence of venereal disease in East Africa,(1) while in the 1920's, A.L. Paterson(2) wrote a detailed report of venereal disease in Kenya. Other writers who have commented on the presence of, as well as the possible effects of venereal disease on the East African communities are George Mann, Roy Staffer et al whose report is based on serologic evidence for syphillis among the Masai(3) William Laurie has described of a pilot scheme to control venereal disease in East Africa,(4) while A.J. Richards and P. Reining(5) have looked at the causes of infertility among some East African women.

Popular writers have also commented on the social aspect of both prostitution and venereal diseases.(6) The local dailies, weeklies and magazines have from time to time carried on stories of venereal diseases as well as prostitution in Kenya and East Africa.

---

(1) J.W. Kibukamusoke "Venereal Disease in East Africa". Transactions of the Royal Society of Tropical Medicine and Hygien Vol. 59. No. 6. Nov. 1965. pp. 642-648.

(2) A.L. Paterson "Venereal Disease Work in Kenya" Kenya Medical Journal, Vol. 1. 1924-1925. pp. 366-372.

(3) George Mann, Roy Staffer et al "Survey of Serologic Evidence for Syphillis Among The Masai of Tanzania". Public Health Report Vol. 31, No. 6. June 1966.

(4) William Laurie "A Pilot Scheme of Venereal Disease in East Africa". British Journal of Venereal Diseases 1958. pp. 34-46.

(5) A.I. Richards and P. Reining "Report on Fertility Survey in Buganda and Bahaya". Kampala, East African Institute of Social Research, 1952.

(6) See Okello-Oculi, Prostitute, East African Publishing House, Nairobi 19 - and Charles Mangua - Son of Woman.

Okot-P'Teck Song of Malaya

On the international scene, the writingsson this subject is too numerous to list here. However, literature relevant to our discussion will be referred to when necessary. A general bibliography can be found at the end of this paper.

INCREASE OF VENEREAL DISEASES IN KENYA

While we do not have an exact accounting of when venereal diseases were first detected in Kenya, or how many people have been afflicted over the last fifty or so years, it seems from the limited figures we have that the diseases, especially the gonorrhoea has been present in East Africa for sometime. G.L.M. McElligott notes that ".....with regard to the history of V.D. in East Africa, gonorrhoea is considered to have existed in most parts of these territories from time immemorial, whereas, syphillis is thought to have been introduced to the coastal towns by the Arabs in the middle of the 19th century and to have remained a comparatively rare disease until the late 1870's".(1) Writing in 1948, Jules De Mello observed that "In 1940, we observed that the rate of infection to syphillis among the Africans in Kenya was increasing day by day. From January to June, 1940, we had examined in Nairobi, 645 African domestic servants of different tribes and out of these, we found that 230 were suffering from syphillis".(2) Writing in 1958, William Laurie states that ".....syphillis is relatively new to East Africa, having become widespread only between the two wars (1918-1939), partly because of the breakdown in the tribal rule (and partially because of Europeans immigration). Uganda is said to have experienced syphillis much longer than any other East African country".(3) Quoting Keane (1912) Lauries says that Kean stated (in 1912) ....." that there was about 90% incidence of syphillis in Uganda (Buganda) early in the 20th century".(4)

---

(1) G.L.M. McElligott, "Venereal Diseases in the Tropics". British Journal of Venereal Disease Vol. 27 (1951) p. 122.

(2) Jules De Mello "Syphillis in Africans" East African Medical Journal, (1948) p. 14.

(3) William Laurie "A Pilot Scheme of Venereal Diseases Control In East Africa". British Journal of Venereal Disease (1958) Vol. 34 p. 16.

(4) Ibid. Loc. cit.

While these early writing would seem to indicate wide-spread, prevalence of venereal disease in East Africa, most-probably the diseases were confused with related disease such as yaws which was common. Infact, other East African commentators on this point have pointed out this possible misdiagnosis and therefore mistaken notion that diseases such as yaws were venereal diseases. Thus, J.W. Kibukamukasa comments that ".....earlier workers.....had almost certainly confused this disease with widespread yaws"(4). De Mello, in disputing the high figures presented, states that "there is a great disparity on the figures generally quoted about the incidence of the disease in the African..... From our total of Africans examined for various diseases, women, children and men, of all ages, our percentage have come to only 19.4 percent". De Mello was referring specifically to the incidence of syphillis.

Regardless of the early incidence rates, one thing is clear today. That venereal diseases are on the increase both here and elsewhere, there can be no question. Infact some people here regarded venereal diseases to be such serious public health problem that it has been said to be the second most common cause of ill-health. Reporting on a pilot scheme of venereal disease control in East Africa, William Laurie (1958) quotes a report from the colonial office. "In a report from the colonial office (1950), it is stated that the venereal diseases are second only to malaria as a cause of ill-health in East Africa".(2) writing on the same subject dealing with East and Central Africa and also with West Africa, other authors have agreed that "the incidence (of V.D.) is very high -a formidable medical problem".(3)

Clinic records from which one can chart the increase or decrease of the venereal diseases in Kenya are not available. Thus we do not know what was happening between 1950 and early 1965. One thing does seem possible. That Kenya of 1950's was one where many services, especially in Central and Nairobi Provinces were disrupted because of the state of emergency. The health records that are available only give incomplete figures of what was going on at that time the exception being perhaps the city of Nairobi. The people who received venereal disease treatment were those from those tribes that were not affected by the state of emergence.

---

(1) Jules De Mello op. cit p. 17

(2) William Laurie op. cit p. 16. Emphasis ours.

(3) See G.L.M. McElligott. op. cit British Journal of Venereal Disease (1951) vol. 27. p. 122 R. Lees British Journal of Venereal (1951), vol. 27, p. 118.

Thus available figures for this period must be considered as unrepresentative and incomplete in as far as rates of venereal diseases are concerned. Furthermore, it should be pointed out that health services were not made freely available to all until 1961. It is therefore possible that some of the people who may have needed services could not come forward because of the costs involved.

It should be pointed out here that, many of the earlier investigations on the prevalence of venereal diseases were confined to the cities and the large towns. As we shall see below, this was so because venereal diseases have traditionally been urban disease and only recently have they become common among the rural communities. It would therefore seem that whether venereal diseases are considered to have affected many people or not, the absolute figure must have historically, at least in Kenya, been small in relation to the total population. Furthermore, it is only within the recent history (since independence) that the Africans have began to stay in the towns and cities for longer periods of time than was possible previously.

The following graphs give an indication of the increase of venereal diseases in Kenya since 1966. We present the figures for both the country as a whole and the city of Nairobi. They only show these cases which have been reported to the public health authorities. Chances are that there are many others, perhaps even a greater number of cases which are treated privately but never reported to the public health authorities. Equally possible, there might be many other cases, especially the females, who have contacted venereal diseases but have never sought help from any source. The diseases reported in the graphs and tables in this paper are: (1) The gonorrhoea, (2) The syphillis and (3) Other e.g. (Chancroid, NSU (none specific urithesis Lymphogranuloma venereum).

Figure I gives the state of venereal disease (gonorrhoea in this case) for Kenya (excluding Nairobi)[1] for the period between 1966 and 1970. It would seem that at first reading gonorrhoea in Kenya is decreasing if one compares the 1967 and 1970 figures. The curve was highest during 1967 and lowest in 1970. The true picture however must be different from the one shown by the curve.

---

(1) For Nairobi Figures see figures 8 - 10 below.

Firstly, 1966 is significant in Kenya's medical history because it is the year that free medical services became available. Secondly rural health centres began to give treatment for the venereal diseases around this time. If one looks at the national totals for 1966, there were only 39,000 out-patient gonorrhoea cases reported. The following year, 1967, 51,500 out-patients with gonorrhoea were reported - an increase of 12,500 within one year. We attribute the increase to the availability of free services as well perhaps better diagnosis of the disease by the medical personnel. The decrease as recorded in 1970 cannot be attributed to better health care but rather to some other factors such as increase of privately available medical services.

Figure I also indicates that by far, the males record the highest incidence rates of exposure to venereal disease than the women do. This can be explained in part by the fact that it is much easier to detect these diseases among the males than the case is true for the females. This is particularly so in the case of gonorrhoea. Men are also exposed to venereal diseases more often than are the women apparently because they have many more sexual partners.

The males in our society still have access to many sexual partners than the case is true of the females. This fact alone might explain why males, both here in Kenya and elsewhere in the world, usually have many more incidences of exposure to venereal diseases than the female population.(1)

Figure two (2) shows, as does figure I, the number of cases treated in out-patient clinics for the syphillis. Here too, the curve would seem to be droping with one exception. By 1970, more women than men were treated for syphillis at the out-patient clinics in Kenya. Whether this means that more women were exposed to syphillis than men is not quite clear. However, it would seem that chances of afflicted women being detected will be much better than the case is true of the men, mainly through the general prenatal tests which many of the women get at the maternal and child health clinics. Since men do not attend these clinics, their being discovered is rendered to be much more difficult.

---

(1) Exposure to venereal diseases as a result of many sexual partners will be discussed in greater detail below.

In figure 3 we note again the number of out-patients who were treated for "other venereal diseases"[2] in Kenya clinics and hospitals, again excluding Nairobi Municipality. Here too those detected and treated are on the decline, even though by 1970 the number of women treated had become greater than that of the men.

Table I below shows the number of venereal disease patients treated in out-patients departments in hospitals and health Centers. These figures do not include the City of Nairobi.

TABLE I

OUT-PATIENTS TREATMENT FOR VENEREAL DISEASES IN KENYA, EXCLUDING NAIROBI 1966 - 1970

Type of venereal desease*	Y E A R					
	1966	1967	1968	1969	1970	Totals
Syphillis	3500	3600	2700	1600	1100	12500
Gonorrhoea	38500	51500	49500	27500	17500	184500
Other	5800	7200	15300	14000	2900	45200
Totals	47800	62300	67[illegible]00	43100	21500	242200

* Source: World Health Organization. Return of Disease. Nairobi - Unpublished.

Hospital admission figures for people suffering from venereal diseases also show a rise and fall as those of out-patients. However, as of 1970, these figures were again on the increase. This increase is particularly noted for the syphillis which rose from the lowest level of 85 in 1969 to a high of 245 in 1970, an increase of 288 times in a year! Though hospital admissions for gonorrhoea and non specific venereal diseases are on the increase their rates of increase are not as fast as those of syphillis. From a public health view point this is not encouraging. Nevertheless, looking at the figures of recorded venereal disease mortality, in Kenya, we note that they are on the downward trend, and infact, in 1970 no reported female death was attributed to venereal disease. The male mortality had by 1970 been reduced from 15 in 1967 to one (1) by 1970. (see figure

(2) "Other venereal Diseases" are generally referred to as Non-Specific Urethritis (NSU) or they may be referred to as chancroid, lymblao-granuloma, etc.

4-7 below). While one would hope this is the case, it is doubtful whether in fact the temporary decline is forment or not.

TABLE "2

HOSPITAL ADMISSIONS FOR VENEREAL DISEASES IN KENYA

1966-1970 EXCLUDING NAIROBI

Type of V.D.	YEAR										
	1966		1967		1968		1969		1970		Totals
	M	F	M	F	M	F	M	F	M	F	
Gonorrhoea	310	140	240	255	460	270	120	100	170	150	2,215
Syphilis	85	90	100	65	65	35	60	30	170	70	770
Other	98	64	36	42	18	16	0	4	6	12	296
Totals	493	294	376	362	543	321	180	134	346	232	3,281

One figures for the nation must be taken with extreme caution. This is especially so for the out-patients clinics where it has been estimated that the medical assistant has only 45 seconds to examine and treat a patient. Secondly, returns from the hospitals outside the cities must be considered very unreliable especially when the details asked for in the record cards are rarely completed.

Venereal Diseases in the City of Nairobi

A comparison of venereal disease incidence between Nairobi and the rest of the country shows that whereas venereal diseases are shown as being on the decline in the country, they are actually on the increase in Nairobi.

This, as it were, does not tell us much. For one, it is well known that Nairobi as the nation's capital, has the best health facilities in the country. Nairobi also has specialized clinics that deal with venereal and other skin diseases with full time, fully trained personnel in venereology. Thus, detection and treatment of venereal disease in Nairobi is by far better than anywhere else in the country. The fact that venereal clinics have been in operation in Nairobi for along time also might be a determining factor in as far as the people who are in need of the services are concerned. Thus, many people, both from within the city and the countryside, will have heard about the services available in Nairobi and will utilise them if in need.Furthermore the unanimity of the city makes it possible for people to come for treatment whereas they probably would not have sought such help from their own home health centers where besides being known by the people they would meet there, they are also known by the health personnel. The nature of venereal diseases is such that, most people would suffer it rather than expose themselves to social ridicule.

It is on these basis that we believe that Nairobi clinics are not providing services for the city residents only, but also for many others from the country-side. The figures provided below are from one city council clinic only. It is known that private hospitals, as well as the Kenyatta National Hospital in addition to the private medical practitioners do provide treatment for venereal diseases. Thus, had we all the returns, the figures presented below might be extremely high.

The available Nairobi data for the female gonorrhoea cases show a decline as of 1971 having come from 3,200 cases in 1966 to only 1,400 cases in 1971. For the males, however, 1971 recorded the highest number of gonorrhoea cases from a low of 6,600 in 1965 to 13,800 by 1971. These cases, it should be mentioned, are the new cases for the years in consideration and do not take into account the revisit cases. Thus, had we to include the number of revisit cases for these years, the numbers would be much higher than what is shown. Table 2 gives the figures for gonorrhoea cases in Nairobi for both the males and the females for the period 1965 - 1971. Figure 8

shows the directions of the curve for the same period.

TABLE 3

RECORDED V.D. CASES FOR NAIROBI-1965-1971

Type of V.D.	YEAR														
	1965		66		67		68		69		70		71		Totals
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	
Gono.	4600	2200	7400	3300	7500	2500	9200	2500	9700	2100	10400	1700	13600	1400	78,100
Syph.	610	430	970	670	790	580	730	550	970	600	880	490	720	510	9,500
Other	4000	800	5100	1400	5600	2000	7600	2400	10000	2600	11000	2600	12000	3200	70,300
Totals	9210	3430	13470	5370	13890	5080	17530	5450	20670	5300	22280	4790	26320	5110	157,900

Table 4 below gives the cumulative totals of all the cases recorded in Kenya for comparison of all types of venereal diseases and compares the national figures with those of Nairobi. national and Nairobi figures in Table 4 is interesting in that, whereas by 1970 the national figures recorded a low of 22,078 cases, the Nairobi figures had jumped to 27,070 or 5,000 cases more than the country registered. 1971 Nairobi returns shows an increase of 4,360 cases over the 1970 figure.

TABLE 4

A COMPARISON OF NATIONAL V.D. RETURNS TO NAIROBI

RETURNS 1965 - 1971

YEAR	KENYA	NAIROBI	TOTAL FOR YEAR
1965	*	12,640	12,640
66	48,587	18,840	67,427
67	63,038	18,970	82,008
68	68,364	22,980	91,344
69	43,414	25,970	69,384
70	22,078	27,070	49,148
71	*	31,430	31,430
Totals	245,481	157,900	403,381

(* Means that National Figures for 1965 are not available and those of 1971 were not available at the time of writing).

Whether this means that there is a better screening of diseases in Nairobi in comparison to the rural areas is not clear. It might very well be. It is also possible that increase in Nairobi figures could be attributed to increase in the city's population[1] over the same period. Nairobi also has been known to have a tracer system - though imperfect - where a person with venereal disease is asked to bring his/her sexual partner for medical checkup. Irregardless of the forces at work, it is clear that venereal diseases are on the increase, especially in Nairobi.

While one would not want to read something into the data where it does not exist, Nairobi figures on venereal diseases, incomplete as they are, perhaps reflect the trend on the country as a whole. We believe that had proper records been kept by all the medical personnel who are connected with diagnosing and treating venereal diseases in Kenya, and had such records been regularly collected in a central place, say with the Ministry of Health Nairobi Headquarters, we are certain that the national venereal trend could give a different picture than we have at the moment. Understandbly, the medical personnel, especially in the rural areas are understaffed, and over-worked and, therefore, have no time for collecting and keeping statistics such as would be useful in a study of the kind we have here. Nevertheless it would seem that the Ministry of Health should make every effort to make sure that statistics, especially on communicable diseases such as venereal diseases, are kept. It is the only way that the country can allocate resource, be they in manpower, educational campaigns etc., Without these figures, it is exceedingly difficult to know, at least officially, whether certain diseases are on the increase or decrease at any given moment.

VENEREAL DISEASES AND SOCIETY

Venereal diseases are "so called because they are acquired and spread principally through sexual exposure"[2]

---

(1) Nairobi's total population increase for year is estimated at nearly 7%. Most of this is due to migration from the rural areas as opposed to the city's natural population increase.

(2) See Nicholas J. Fiumara "Venereal Diseases" in Pediatric Clinics of North America, Vol. 16 No. 2., May 1969. p. 334, emphasis ours.

Putting the relationship between sex and exposure to venereal disease in a more dramatic form, J. Burt and Linda Mecks state that"..... venereal diseases are almost as dependent upon the sex act as pregnancy".(1) To the extent that they are sexually transmitted - and therefore, through social relationship - the problem of these diseases ".....seems no longer medical as sociological".(2) Venereal disease is a "social disease which afflict its victims - socially, emotionally and physically - leaving behind a physical wreck with a mere skeleton filled with frustration and disappointment, a danger to public health, a grave risk to the family.....venerial diseases have been classed amongst the greatest modern plagues and their control a most stressful problem of preventive medicine. The ultimate solution of V.D. problems transcends the use of medical and hygiene methods. The problems comprise law, education, social work, religious and economics; and the ultimate control will depend upon the correct approach followed in each of these directions".(3)

The significance of venereal disease in society becomes more important when one considers how it is transmitted. Traditionally, venereal diseases have occurred with greater frequency in urban settings than in the rural areas. However, this is not to say that venereal diseases are not found in our rural communities. In urban East Africa where until recently, wives did not live with their working husbands, spread of venereal diseases from urban to rural areas cannot, historically, be discounted. This is likely to have been so, especially because men lacked sexual outlets in towns and cities where women were restricted. This restriction was enforced mainly through provision of inadequate housing - too small to accommodate a man and his family - and also through low wages which were paid to the African workers. In such situation, chances are that, males working in these towns and cities will not have their wives with them and, therefore, they will tend to seek sexual gratification

---

(1) John Burt and Linda Mecks, Education for Sexuality: Concepts and Programs for Teaching. London, W. B. Saunder's Company, 1970, p. 97.

(2) John Burton "V.D.: A Behavioural Disease" in International Journal of Health Education 11 (1968) 13. p. 14.

(3) C.M.S. Siddihu, R.C. Mahajan and B.C. Srivastava. "A Social-medical Study in Two Industrial Cities" The Antiseptic Vol. 66 No. 11, 1969 p. 843.

from such loose females as are available either on the basis of cash payment or through temporary union which may be contracted from time to time. Because such women are generally not tied down to any one man for any length of time, there does exist a strong possibility that they will be sexually involved with other males. Thus, because of frequent sexual inter-course with many different people, there are chances that these women will possibly be carriers of venereal diseases which they will transmit to their sexual partners.

Unless the male notices that he has contracted venereal disease before having sexual intercourse with his spouce who may be living in the villages, there is then a likelihood that he will transmit the disease to his sexual partner. As we shall show later, spread of venereal disease to our rural communities is now a much easier process than hither-to has been the case.

The rise and fall or increase and decrease of venereal disease would seem to depend on social-political-economic conditions prevalent in a given social system and environment. Some commentators have said that the "incidence of venereal diseases, especially the gonorrhoea, rises with the period of social unrest".(1) Such social unrest as ".....frustration, boredom, lack of fixed jobs, economic uncertainty etc., can form a background to diseases".(2) In Kenya, most of these factors are present for many people. The implication, however, is not that those who have no jobs and therefore likely to be frustrated after several futile attempts to acquire one, or those who are bored by whatever, etc, are the only ones who could contract the disease more often than others. There are other equally important factors which play a major role in the spread of venereal diseases. For example, rapid transportation can be considered to be one way through which diseases can be spread. It is possible for a person, for instance, to contract the disease in Europe, fly overnight and have sexual relation with someone in Nairobi the next day and thereby possibly transmitting the disease.

Likewise, it is possible for someone to have contracted the disease in Nairobi, who then drives or is driven to, say,

---

(1) A. Gimble, "Reflections on the Epidemiology of Gonorrhoea" BJVD (1965), 41, p. 186.

(2) Ibid.

Moyale, or any other part of the country and if he or she has sexual relations there transmit the disease if he had been exposed. Modern transportation may therefore be considered as a diffusing agent for not only venereal diseases but also other types of diseases. This factor alone, perhaps more than any other socio-cultural factors, makes detection, treatment and finally control of these types of diseases very difficult.

Migration, a factor related to transportation since it involves movement of people, can also be considered to be a means by which venereal diseases could be transmited from one part of the country to another. Thus, it is possible for some people from certain areas and who may have the diseases to migrate to another area where the diseases may not be present, and through social and sexual intercourse transmit the disease this way.

The changing roles of both men and women in our society are other factors which have an influence on venereal diseases. The changing role of women in particular, and the changing economy for both the rural and urban areas, bring about new relationships both between the sexes and across ethnic grouping.

As traditions take second place to modernization, as mores and taboos become "irrelevant" to the modernized man, so will, in our case, access to clandestine sex become prevalent. The greatest "obstacle to the spread of venereal infection in the part was undoubtedly the rigid tribal customs and taboos, with their severe sanctions against promiscuity, especially among the women"(1)

As a factor in the spread of venereal diseases, breakdown of the traditional social order is illustrated by the following passage, which, though it is referring to a Western Society, is nevertheless illustrative of what is happening to our own society, and indeed to other societies where modernization process is already in progress. ".....Our society has become more and more complex - we have changed from the days when the family and the extended family lived in close association, when the father worked near the home and was in and out several times daily, when children shared in maintaining the home,

---

(1) D.G.L.M. McElligoth "Venereal Diseases in the Tropics". British Journal of Venereal Diseases. Vol. 27 (1951) p.122.

when recreation was family-centered, when education began in the home and was closely supervised, when religious training was part of the heritage; when children were supervised by parents and the adults of the extended family. We now have (de-ruralization)(1) and urbanization of the family. Father works away from home; there is dispersion of the family members, the extended family to some extent has been dispersed, so when the clan gathers at a wedding or a funeral one meets an unknown relative or two. There has been a breakdown in religious education and sanctions that are inherent in religious belief. There is an increasing amount of leisure time which is not being constractively used either for recreation or for self improvement. We are being entertained rather than entertaining.....

> ".....A large number of parents have abrogated their responsibility in sex education of their children..... The churches are in a process of agonizing reappraisal of beliefs once held sacred".(2)

Breakdown of tribal moral codes due to pressures of social change, urbanization, transportation, etc, all have a major part to play in the spread of venereal diseases. Unanimity in towns and cities produce behaviours that would otherwise not be acceptable traditionally. Such behavious as being or solicitating a prostitute, uncontrolled alcoholic intake, are also factors which make the conditions for spread of venereal diseases ripe.

URBANIZATION, PROSTITUTION, AND ALCOHOL:
Their Roles in Spread of Venereal Diseases:

Undoubtedly, life in the city where codes of behaviour are different from those obtainable in the small rural communities, does tend to facilatate development of attitudes and practices which could be considered undesirable within the somewhat rigid rural

---

(1) My terms. One can also use such terms as detribalization, de-familization etc., with still the same effect.

(2) See Nicholas J. Fiumara "Venereal Disease" in Pediatric Clinics of North America. Vol. 16 No. 2, May 1969 p. 342 - 343.

societies. Venereal diseases, crimes and other socially dislikable behaviours tend to be more prevalent in cities than in the rural areas. Thus, in our case, chances of contracting venereal disease are far greater within urban environment than in rural areas. Researchers have been able to show that venereal diseases and especially in the male is "related to the big city and promiscous, unstable sexual relationship. Thus it is not surprising that prostitution is a factor in the spread of gonorrhoea".(1) Prostitution thrives best where:

(1) Unanimity exists such as in the cities

(2) Where the number of females is by far less than that of the males who need sexual gratification and are therefore willing to pay for services rendered by the females.

(3) In and near places where alcohol, regal or illegal is consumed in excess of what would be socially considered proper.

In conditions such as these where social-cultural barriers are broken down, where sexual intercourse is at random, venereal diseases are likely to be transmitted from one person to another. Showing these relationships in England, Laird and Morton comments that "The gonorrhoea study of the British Cooperative Clinical Group,(2) showed that in 1954, in certain large towns and cities in England, 35.7% of men with gonorrhoea had been infected by prostitutes. In the city of Manchester during 1956 and 1957 of all male patients seen for the first time, 34 percent had paid money and a further 22% had paid the woman in kind".(3) The same Cooperative Clinical Group found that the Manchester study revealed that 45% of the females were met in the street. Commenting further Laird and Morton state that "street prostitution, therefore plays a significant part on the spread of venereal diseases particularly of gonorrhoea."(4)

---

(1) S.M. Laird and R.S. Morton "Ecology and Control of Gonorrhoea". British Journal of Venereal Disease. Vol. 35, 1959, p. 191.

(2) This study is reported by S.M. Laird "Prostitution and Venereal Diseases in Manchester" British Journal of Venereal Diseases (1956) 32, p. 181-183.

(3) S.M. Laird and R.S. Murton: "Ecology and Control of Gonorrhoea". Loc. cit. p. p. 191.

(4) Ibid.

In some countries, laws have been made to prohibit prostitution mainly for moral rather than medical reasons. But driving the prostitutes out of the streets or out of the city neither eliminates prostitution nor in fact reduces the incidence of venereal diseases. Again quoting Laird, "Driving the prostitutes from the street will not help very much (in campaign to control V.D.). Prostitutes driven from the streets, will operate from bars, clubs, and dance halls; while the more prosperous ones may well become "call-girls" individually or on an organized basis"(1)

In the case of Kenya, the vagrant act under which prostitutes could be arrested and prosecuted does not work so well, partially because of the difficult nature of proving someone a prostitute and also because the transaction in many cases is done under perfectly normal social situations. Whether infact the common prostitute is the main carrier of the diseases or not is not clear as there are many conflicting reports. Thus, Laird argues that ".....prostitution is an insignificant factor in smaller provincial towns and rural communities, but it assumes a significant role in the largest cities especially when they are seaports"(2) Siddhu et al in their research found that 238 of 362 venereal disease patients got infected from the common prostitute.(3) Wilcox reports that "prostitutes were responsible for 90% of the infection in Japan and 96.9% in Singapore"(4) while Puncker and Rao state that in their study, "more than 90% of prostitutes had venereal diseases".(5)

Other studies trying to show the relationship between prostitution, especially professional prostitution, do not seem to attribute the spread of venereal diseases to prostitution alone. Thus, A.S.A. Hussain in reporting his prostitution and venereal disease data (6) quotes J.G. Moncini (7) Polish study which has "shown that the risk of contracting

(1) S.M. Laird "Figures and Fantacies" British Journal of Venereal Diseases (1958) 34, p. 142.

(2) S.M. Laird "Prostitution and Venereal diseases in Manchester". British Journal of Venereal Diseases (1956), 32, p. 181.

(3) C.M.S. Siddhu et al "A Socio-Medical Study of V.D. in Two Industrial Cities". op. cit. p. 844.

(4) R.R. Wilcox (1962 - BJUD 38 No. 1. March)

(5) Puncker and Rao. A Study of Prostitutes in Bombay Allied Publications. (Quoted in Siddhu et al, op. cit) p.847.

(6) A.S.A. Hossain "Prostitution and Venereal Diseases" Indian Journal of Dematology and Venereology vol. 32 (1966) p. 57.

(7) This study is found in J.G. Moncini Prostitutes and their Parasaites (Translated by D.G. Thomas) London, Elek Books, 1963.

gonnorrhoea is five times more from the casual amatures than the prostitute".(1) Quoting another study, Hossain states that "pickup girls were responsible for 76% of venereal disease transmission, while prostitutes were responsible for 6% of the venereal infection.."(2) Thus, he concludes that, "though prostitution has always been blamed for the spread of venereal infections and though the statistical possibility is much higher among them, so far no study could prove that the prostitutes are the main source.....various studies have conclusively proved that the good-time girls, and call-girls are the main source of spreading the infection".(3)

The role that alcohol consumption plays in bringing two people together sexually who would otherwise have not been interested in each other were they not drank is not quite clear.

However, as we have mentioned elsewhere in this paper, alcohol cannot be discounted fully in its influence of spreading venereal diseases. Prohibition of either alcohol, prostitution or even an attempt to control rural-urban migration will not solve the problem unless such decisions consider the sociological basis upon which these chronic problems are based upon.

In discussing the spread of venereal diseases or prostitution as well as alcohol, students of social problems have tended too often to concentrate their research on the woman as if the woman does those things alone. We contend that males, especially here in Kenya, are as much responsible for spread of venereal diseases as the females if not more so. For once, the drinking behaviour of the males in Kenya is such that it can be considered to have reached a chronic stage. Drinking which take place immediately after work until the bars or night clubs close — for seven days in a week, is ofcourse a symptom of something much deeper than the desire for alcohol alone.

---

(1) A.S.A. Hossain "Prostitution and Venereal Diseases" op. cit p. 57.

(2) Ibid loc. cit

(3) Ibid p. 58

In the cities as in the rural areas, most drinking is a result of boredom. Recreation, other than drinking - is limited for the majority of the people. The best place to socialize and gossip has now become the bar where one is almost guranteed to meet his friends. After a few drinks and some loud music, one is almost tempted to have a word or two with the mini-skirted girl roaming about in search of some conversation or daily bread. In the rural areas the pattern is the same. After a hard day's work in the shamba, men leave their women folks at home and meet their men friends at the pub to catch up with the days goings.

With improving economic conditions for a good many people, and with increasing money to spend, this general wealth allows for more regular participation in the only available and perhaps valued recreation of drinking alcohol and dancing, both which occur within the ecological setting of the gonococcus. No control measure, either of prostitution, over-drinking or spread of venereal diseases can be effective as long as we dont consider the male as an essential catalyst in the whole process.

CONCLUSION: TOWARDS SOME MEASURE OF CONTROL OF VENEREAL DISEASES

All along we have tried to show that venereal diseases, in addition to being medical, problems, they are also social. As social problems, control of venereal diseases must have social measures. One control program places emphasis on the medical treatment of existing infections, on the principle that by rendering cases noninfectious, spread of disease would diminish and the overall venereal disease reservoir could be reduced. This approach however, assumes that patients suffering from venereal diseases will avail themselves for medical treatment. This does not work always, especially when socio-economic variables are taken into consideration because of the very nature of the diseases - social. Since many people, especially the female, do not know that they have the disease, chances of their availing themselves for medical treatment are limited. Those who may suspect themselves, usually have a better education and possibly higher income. They do not attend public clinics but rather they go to private clinics where they can be examined and treated in privacy. Private physcians, in attempt to shield their patients

from embarrasment, generally have been reluctant to report detected cases of V.D. to public authorities. This is one of the problems that we in Kenya are faced with when trying to estimate the rate of increase or decrease of the venereal disease cases. There is no law in Kenya which requires private practioners to submit returns for these diseases - something that is desparately needed. Though medical consultations are privileged information between the patient and his doctors, the fact that no reporting of V.D. cases is made prevents follow-up treatment of contacts and allows these diseases to continue to spread in an uncontrolled manner.

The other type of control of venereal disease is the tracer approach. Through this approach, the patient is asked to say whom he/shehas had sexual contact with and such persons are brought for check-ups and treatment. This approach is used in Kenya but only in a very small way, partially because there are not enough medical personnel and also, because some people, especially those who come to public clinics particularly in cities and towns may not remember whom they had sexual intercourse with.

The tracer approach when geared to a program of eradication and control generally consists of four basic techniques:-

(1) Effectively interviewing and reinterviewing every reported case of venereal disease patients for sex contacts.

(2) Rapid investigation to bring contacts to medical examination within a minimum time period.

(3) Interviewing for and blood testing other persons who, by defination, (suspect or associates) are possibly involved sexually in an infection chain (cluster procedure). This technique is designed to motivate the patients not only to name contacts but to name persons other than sex contacts for whom an examination for venereal diseases would seem profitable (cluster suspects). In addition when named contacts are investigated, they are also asked to indicate persons on their social group whom they feel would likewise benefit from examination (cluster associates).

(4) Epidemiologic treatment of sex contacts to infectious venereal disease cases.

Because of the socio-cultural nature of the venereal diseases, this approach, while desirable would be difficult to follow to

any large extent at present time in Kenya. This is primarily so because few individuals, especially the married couples would be willing to disclose their sexual contacts if these contact have been extra marital. Furthermore, few people knew the signs for venereal diseases. To the extent that this is so, one of the most viable approach at the present, in addition to the above, is one of massive and continuous public education in regard to the nature and seriousness of venereal diseases. One of the major problems today in regard to venereal diseases is that of general ignorance. Facts must be known by the people. Education then seems to be the best option at the moment open to the Kenyans. Experience in certain Scandinavian countries supports the brief that "venereal diseases can be eradicated by an adequate control programme."(1) Venereal disease problems according to Burt and Meeks is best attacked through education".(2) Public education should be aimed at motivating persons who have exposed themselves to seek medical care. "People need to have accurate information that will be appropriate for their age and cultural status. They should know the early signs and symptoms and the manner in which these diseases are spread, where persons suspecting infection may go for examination and what constitutes good modern treatment".(1)

Within formal education, we would advocate that sex education be encouraged and be taught. At the present moment, we doubt whether the schools are either ready or capable of teaching this subject, simply because the teachers, themselves, victims of the general societal ignorance and fear of venereal diseases, have no factual information which they can impart to the students. The broad objective of sex education in schools should aim to achieve the following:

---

(1) See B. Sieff "Venereal Diseases in South Africa: Sociological Aspects" Medical Proceedings, 12(1960) p. 228.

(2) John Burt and Linda Meeks, Education for Sexuality: Concepts and Programs, London W. B. Saunders Company 1970. p. 111.

(3) N. J. Fiumara et al "Venereal Diseases To-day". New England Journal of Medicine, April 23, 1959. p. 866.

(1) Help the child know and understand himself physically, emotionally and socially.

(2) Apply this knowledge so that the child may achieve a socially approved role (this is on assumption that society has defined what these roles are).

(3) Prevent and eliminate the development of fears, anxieties and fallacies relating to sex and sexual development.

(4) Realize that physical, emotional and social factors influence the development of sex responsibility.

(5) Help the child to get along with members of both sexes and develop wholesome relationships among friends family and community.

(6) Help the child to develop a set of values and an ethical system as a guide to behaviour.(1)

In an attempt to control the diseases among the adult population we would propose the following:

(1) That a law be enacted which will require selective blood tests on some parts of the population, especially
   (a) on persons about to be married
   (b) all pregnant women
   (c) blood donors
   (d) hospital patients and patients with skin disease

(2) That all potential employees, as well as those who are currently employed in both public and private concerns, be required to have a complete medical examination including venereal diseases before they are employed and periodically thereafter:

(3) That public counselling facilities including mobile clinics be provided so that individuals needing advise can get it without too much trouble on his part and

(4) That there be a greater survillance of the venereal diseases. Physicians in private practice should be required by both their professional ethics as well as by law to report to the public authorities all treated cases of venereal diseases.

---

(1) See N.J. Fiumara "Venereal Diseases" Pediatric Clinics of North America, Vol. 16. No. 2. May 1969. p. 343.

Laws combined with public education which is aimed at informing the population of the nature and mode of spread of V.D. will take these diseases from the realm of secrecy and fear to one of understanding and treatment. Perhaps there are few other diseases which cause as great an anxiety as the venereal diseases among the members of society, young and old alike. It is therefore the responsibility of those who know something about these diseases to impart the appropriate knowledge to those who do not know. Not until such time that the society acknowledges that venereal diseases are interwoven with its prevalent social-economic fabric, and not until such time that accurate information in available to all can we expect to control the venereal diseases.

Bibliography

Arya, O.P. and Bennett, F.J. "Attitudes Amongst College Students in East Africa to Sexual Activity and Venereal Diseases" British Journal of Venereal Disease (B.J.V.D.) 44. "Venereal Disease in an Elite Group (University Students) in East Africa". B.J.V.D., 43.

Bennett, F.J. "A Review of Venereal Diseases in University Students in East Africa" - Unpublished "Prostitution and Venereal Diseases in East African Towns", 1966 - unpublished. "The Social Determinants of Gonorrhoea in An East African Town", East African Medical Journal (EAMJ). Vol. 39, No. 6 1962. "Gonorrhoea: A Rural Pattern of Transmission" EAMJ, Vol. 41, No. 4, 1964.

Brown, William; Donohue, James F. et al Syphilis and Other Venereal Disease Cambridge, The Harvard University Press. 1970.

Burt, John and Meeks, Linda, Education for Sexuality Concepts and Programs For Teaching, London, W.B. Saunders, Company, 1970.

Burton, John, "V.D. A Behavioural Disease" International Journal of Health Education 11, 1968.

Carlebash, Julius Juvenile Prostitutes in Nairobi, Kampala, E.A.I.S.R. 1962, EAS No. 16.

De Mello, Jules "Syphillis in Africans" EAMJ 1948.

Ekstrøm, K. "Patterns of Sexual Behaviour in Relation to Venereal Disease" BJVD, 46, 1970.

Fiumara, Nicholas J. "Venereal Diseases" Pediatric Clinics of North America Vol. 16, No. 2, May, 1969.

"Venereal Diseases Today" New England Journal of Medicine, April 23, 1959.

Gimble, A. "Reflections on the Epidemiology of Gonorrhoea" BJVD, 41, 1965.

Glass, L.H. "An Analysis of Some Characteristics of Males with Gonorrhoea" BSVD, 43, 1967.

Goodman, Herman "The Esoteric Male as a Focus for Spread of Venereal Disease". Acta Dematoveneologica, Vol. 37, 1957.

Häro, A.S. "Gonorrhoea and Its Control in Finland" BJVD., 37, 1961.

Hossain, A.S.A. "Prostitution and Venereal Diseases", Indian Journal of Dematology and Venereology Vol. 32, 1966.

Hopcraft, M., Verhagen, A.R. et al "Genital Infection in An East African Family Planning Clinic", Nairobi 1972, Unpublished.

Kibukamusoke, J.W. "Venereal Disease in East Africa". Transactions of the Royal Society of Tropical Medicine and Hygiene, Vol. 59 No. 6, 1965.

Laird, S.M. "Prostitution and Venereal Diseases in Manchester", BJVD Vol. 32, 1956.

"Figures and Fantacies", BJVD Vol. 34, 1958.
"Ecology and Control of Gonorrhoea" BJVD, 35, 1959
"Some Current Aspects of the Epidemiology of Gonorrhoea" BJVD, Vol. 39, 1963.

Laurie, William "A Pilot Scheme of Venereal Disease in East Africa" BJVD, 1958.

Lennart, Juhlin "Factors Influencing The Spread of Gonorrhoea" Acta Demoto-Veneologica, Vol. 48, 1968.

MaKay, D.H. "Venereal Diseases in Masai: A Field Survey - June and July 1950", EAMJ Nov. 1950.

Mangua, Charles, The Son of Woman

Mann, Gecrge, Staffer, Roy et al "Survey of Serologic Evidence for Syphilis Among the Masai of Tanzania". Public Health Report Vol. 31. No. 6. 1966.

McElliott, G.L.M. "Venereal Diseases in the Tropics" BJVD Vol. 27, 1951.

Moncini, J.G. Prostitutes and Their Parasites (Translated by D.G. Thomas), London, Elek Books, 1963.

Oculi, Okello The Prostitute, Nairobi, The East African Publishing House, 19

Okot B'Teck Song of Malaya, Nairobi

Paterson, A.L. "Venereal Disease Work in Kenya", Kenya Medical Journal, Vol. 1. 1924 - 1925.

Richards, A.I. and Reining, P. "Report on Fertility Survey in Buganda and Bahaya", Kampala, E.A.I.R. 1952.

Rutasitara, W.K. Mombasa Girls: A Study of Prostitution and Venereal in a Kenyan Sea Port A Dessertation presented to Makerere University, Faculty of Medicine. March 1970. Unpublished.

Siddihu, C.M.S., Mahajau, R.C. and Srivastava, B.C. "A Socio - Medical Study in Two Industrial Cities", The Antiseptic, Vol. 66, No. 11, 1969.

Prostitution and Venereal Disease in a Kenyan Sea Port. a Dissertation presented to Makerere University, Faculty of Medicine, March 1970, Unpublished.

Sieff, B. "Venereal Diseases in South Africa: Sociological Aspects", Medical Proceedings, 12, 1960.

Southal, A.W. and Gutkind, P.C. Townsmen in the Making, East African Studies No. 9. Makerere University, Kampala, 1957.

Verhagen, A.R. and Gemert, W. "Social and Epidemiological Determinants of Gonorrhoea in an East African Country", Nairobi, Medical Research Center. Unpublished.