SOCIO-CULTURAL PRACTICES THAT MAY FAVOUR THE TRANSMISSION OF ACQUIRED IMMUNODEFICIENCY SYNDROME 'AIDS' IN A RURAL YORUBA COMMUNITY: IMPLICATION FOR HEALTH EDUCATION

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A Dissertation submitted in partial fulfilment of the requirements for the degree of MASTER OF PUBLIC HEALTH (HEALTH EDUCATION) of the UNIVERSITY OF IBADAN

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DEDICATION

This dissertation is dedicated to my late mother, Madam MOJERE AYOKA-EDU AJUWON, who never lived long enough to see her son grow up to be a man. Your exemplary life and the hardship you endured to ensure that your children had a good education will always be remembered and appreciated.

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ABSTRACT

The Acquired Immunodeficiency Syndrome (AIDS) pandemic poses a major threat to global health and a major challenge to health workers especially health educators. The study was designed to identify socio-cultural practices that carry potential risks of transmitting the AIDS virus in Ago-Are, a rural Yoruba community in Oyo State, Nigeria. The study explored in-depth sexual, marriage and divorce and blood contact practices that may favour the transmission of AIDS virus and consequently aid the acceleration of the spread of the disease in Nigeria.

Qualitative methods were used to collect data from February to April, 1989. These were key informant interview, participants observation, review of records and group discussion. Opinion leaders in Ago-Are as well as others who posses specialised knowledge on blood contact and divorce practices served as key informants. Operations of blood contact practices, proceedings at the Grade C Customary Court in Ago-Are as well as the activities of prostitutes living in a hotel were observed.

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Review was made of the divorce cases determined at the court from 1982 through 1988 and finally discussions were conducted for groups of married and single men and women.

There are nine female prostitutes in Ago-Are, patronized by both indigenes and non-indigenes. A fee of ₦2.00 is charged for each sexual encounter. The prostitutes are mobile as they often move from one area to the other selling sexual services to men.

The lactation taboo that prohibits coitus between married couples during post partum is observed in the community. Findings revealed that men who cannot abstain during this period seek relief by indulging in extra-marital sexual relationships and resume normal sexual relationship with their wives once the abstinence period is over.

Casual sexual intercourse is common in Ago-Are during festivals like Easter, Christmas, "Egungun" and Eid-el-kabir mostly among the indigenes returning from cities to celebrate during these festivals on one hand, and between those living permanently in Ago-Are and those returning on the other. A room in a hotel rented out to

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customers for brief period facilitates casual sexual activities in Ago-Are.

Polygyny is a common practice and some of the factors that promote it in Ago-Are are influence of Islamic religion, infertility of a wife and the potential economic benefits of the practice.

A total of 134 divorce cases were determined between 1982 and 1988 at the Customary Court. Of these number, 124 or 95.5% were initiated by women. Lack of care from husbands was the reason often cited for divorce.

Male and female circumcision are widely practiced and the beliefs that promote circumcision in Ago-Are are deeply rooted. Other common blood contact practices in Ago-Are are ear piercing, uvulectomy, body, medicinal and facial scarifications. Circumcision, facial and body scarifications were performed under unhygienic conditions with the operator using an unsterilised knife for all operations.

The potential risks involved in the practices were assessed, the health education implications discussed and recommendations were highlighted.

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I owe a lot to many people for their contributions to the successful completion of this study.

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Finally, I am grateful to all my key informants in Ago-Are for their cooperation during the data gathering phase of the study.

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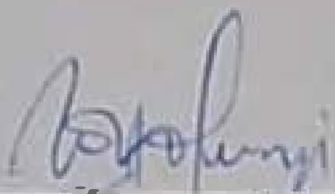
CERTIFICATION

We certify that this work was carried out by Mr. Ademola Johnson AJUWON, in the Department of Preventive and Social Medicine, College of Medicine, University of Ibadan, Ibadan, Nigeria.



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GLOSSARY OF YORUBA WORDS

Adalemosu: A married woman who is separated from her husband and live in her natal home.

Agoro: Traditional title of leader of Sando Ward in Ago-Are.

Agbole: A cluster of houses; extended family compound.

Alagunmun: A traditional healer who hawks various herbs and concoctions meant to cure ailments like dysentery, gonorrhea and malaria.

Ale: A person with whom one has sexual relationship other than one's legal spouse.

Aree: The traditional title of the ruler of Ago-Are.

Areoje: Traditional title of the leader of the adherents of Africa Traditional religion.

Baale: The head of a family compound who ensures disciplines and peace in the compound.

Baale: The traditional title of the leaders of Agere and Ito wards in Ago-Are.

Baba Egbe: Male leader of men's association.

Egungun: A Yoruba masquerade.

Egbe: An association or company of people formed to

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promote common interests of members in the areas of occupations, religion and recreation.

Enu abẹ: A form of body scarification made by Olola for people who intend to sympathise with a scarified or circumcised infant.

Gbẹẹrẹ: Medicinal scarification made by either a traditional healer or any other person aimed at preventing the occurrence of a mishap or curing a disease.

Iyaale: A woman who is a senior by marriage to another when both are married either to the same husband or to kinsmen.

Iya ẹgbẹ: The female leader of a woman's association.

Iyalode: The traditional title of the leader of women groups in a Yoruba community.

Jeri-Jeri: A cultural disease believed to be sexually transmitted.

Magun: Literally means "don't climb," a traditional medicine believed to evoke fatal accident on a man who has sexual relationship with another man's wife.

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Oju-binu: A form of facial scarification performed by Olola.

Olola: A specially trained person who performs the operations of many blood contact practices like scarifications and circumcision.

Onko: A Yoruba dialect spoken by the people of Ago-Are.

Osun: A reddish substance obtained from the bark of trees used by women as facial and body lotion to decorate and beautify their bodies.

Ọdan: Tree planted in front of a house whose shade provides relaxation.

Ọmọ-ale: A derogatory term for persons born out of wedlock.

Ọja baale: A daily market located in Ito ward in Ago-Are.

Ọja oba: A night market conducted with aid of kerosene lamps in Ago-Are.

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CHAPTER ONE

INTRODUCTION

The Acquired Immunodeficiency Syndrome (AIDS) was identified as a clinical entity in 1981, yet, epidemiological evidence suggests that the disease has been occurring as early as the 1970s in such parts of the world as United States of America (USA), Europe, Africa and the Caribbean (WHO, 1985). Since the year of its discovery, AIDS has remained a topical health issue in many countries around the world because of the threat it poses to global health. The cause of AIDS is Human Immunodeficiency Virus (HIV). HIV is a retrovirus that compromises the body's immune system such that it renders the body incapable of warding off certain opportunistic infections and cancers, some of which then become the direct causes of death (Najera and Herera, 1988).

The AIDS epidemic has been reported in virtually all parts of the world. Not only have the number of cases of AIDS worldwide increased rapidly since 1981 but also rising are the number of countries reporting the incidence of of the disease. For example, by 1st June, 1988, a total

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of 96,433 cases of AIDS was reported to the World Health Organization (WHO) from 136 countries from all continents of the world (Mann, 1988b). However, by 1st March, 1989, the figures had risen to 142,000 cases reported from 145 countries from all continents of the world (WHO, 1989c). Yet, these figures probably do not reflect the true picture of the global AIDS situation since the disease is under-reported (Mann, 1987). WHO has estimated that there are about 200,000 cases of AIDS worldwide while an estimated 5 - 10 million people are believed to be HIV infected already (Mann, 1986b).

Although remarkable progress has been achieved in terms of understanding the biology and the mechanism of pathogenesis of HIV, at present, there is neither a cure for AIDS nor a perfected vaccine against HIV. Treatment of AIDS patients is palliative, comprising mainly of managing specific infections that take advantage of immunodeficiency (Liskin, et al, 1986). Scientists have not been able to develop a vaccine against HIV partly because the antibodies produced by the body in response to HIV do not destroy the virus (Jefferies, 1988) and partly because HIV mutates very frequently (Francois and Petricciani, 1985).

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The impact of AIDS on social and economic development of nations may be far reaching since AIDS affects mostly people in their most productive years. Approximately 90 percent of all AIDS patients worldwide are people within the 20 - 49 year age group (Mann, 1986). In Uganda, for example, about 80 percent of AIDS patients were aged 20 - 49 years (Okware, 1988). In New York, USA, AIDS has become the leading cause of death among women aged 25 - 34 years (Mariasy and Radlet, 1989). In Mexico, young adults are the group most affected by AIDS (Sepulveda, 1988). Thus, AIDS robs society of its young men and women at a period it can ill afford.

In many parts of the developing countries, the emergence of AIDS may exacerbate existing health problems. In Africa, for example, the onset of AIDS may compound the current health problems brought about by high prevalent rates of malaria and tuberculosis, two major killers on the continent (Hubley, 1988b). As many developing countries respond to the threat of AIDS, the disease is likely to compete for resources with other existing health problems at a time when resources are not enough in the health sector (Sepulveda, 1988).

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Recognising that the AIDS epidemic is a global problem of extraordinary scope and unprecedented urgency (Mahler, 1988), the WHO created in 1987, the Global Programme on AIDS (GPA) to co-ordinate worldwide activities aimed at controlling the spread of the disease. In 1988, the GPA classified the AIDS epidemic into three patterns. Pattern one includes America, Europe and Australia where most of transmission was through homosexual practices. Pattern two includes African countries where HIV transmission was mainly through heterosexual practices. The Asian countries make up pattern three. Here, the level of AIDS was still low with the most probable mode of transmission being blood transfusion (Mann, 1988b).

In Africa, although HIV is predominantly transmitted through heterosexual intercourse (Johnson and Pond, 1988) there is a disparity in the prevalence rate of AIDS on the continent. Whereas high AIDS figures have been reported in the East, Central and Southern parts only few cases have so far been reported from the Northern and Western parts of the continent (Ona Pela and Platt, 1989).

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In Nigeria, the first cases of AIDS were reported in 1987. Although the current prevalence rate of AIDS in the country is low when compared to the ones in some countries in East and Central Africa, the AIDS cases reported in the country have been rising. As at 1988, of the 5,238 people randomly selected and screened at Lagos, Maiduguri, Enugu, Calabar and Potiskum, only 50 (0.95%) were positive by Enzyme Linked Immuno-sorbent Assay (ELISA). Only 12 (0.23%) of the 50 ELISA positive sera were confirmed by Western Blot as positive for HIV infection (Mohammed et al, 1988). However, by 1st March, 1990, of the 70,000 people so far screened in the country, 308 had been found to be HIV sero-positive, with 48 cases of AIDS, 21 of whom had died (Abebe, 1990). The current relatively low prevalence of AIDS in Nigeria presents an excellent opportunity for launching an intervention programme that will stem the spread of AIDS in the country. It is necessary to nip the AIDS problem in the bud in Nigeria not only because the disease is capable of spreading rapidly once it is introduced into an area (Biggar, 1986) but also because many scientists are not optimistic about the early development of an effective anti-viral drugs to cure AIDS or potent vaccine against HIV (Mann, 1988b).

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Given the limitations associated with many of the existing control technologies, primary prevention through health promotion is the only realistic means of controlling the spread of AIDS in Nigeria. Health education has a crucial role to play in prevention and control efforts on AIDS since HIV is transmitted mainly through certain behaviours that individuals can modify or change. Health education is concerned with changes in knowledge, attitude and behaviour. The principal purpose of education about AIDS is to prevent the transmission of HIV and the spread of AIDS by influencing the behaviours that place individuals at risk of contracting the virus.

To successfully influence risk behaviours on AIDS, health education planning demands detailed and indepth information not only about the nature of the behaviours but also detailed knowledge on the social and cultural context in which they occur as well as the belief system underlying them (Green, 1988). The success of education programmes on AIDS depends on the ability to identify and meet the needs of various target groups and to address them in ways that are culturally acceptable

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and individually relevant (Ademuwagun, 1990). At present, there is no such information upon which appropriate and culturally relevant health education programme aimed at controlling the spread of AIDS in Nigeria can be based. This study therefore addresses this problem.

The main objective of the study is to identify socio-cultural practices that carry potential risks of transmitting the AIDS virus in Ago-Are, a rural Yoruba community in the Ifedapo Local Government Area of Nigeria, where no cases of AIDS has been reported. This approach is aimed at facilitating the development of primary intervention in rural communities of Nigeria. In addition, the focus on the rural area is aimed at identifying priority risk behaviours which health education activities will target so that resources that are presumably limited are not spread out too thinly.

Since only two main behaviours have been implicated in the transmission of HIV, the focus of this study is limited to only sexual and blood related behaviours that may favour the spread of AIDS in Ago-Are. The blood related behaviours are those that involve use of

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skin piercing instruments by non-medically trained persons. The study also investigated indepth the social and cultural context in which the sexual and blood contact behaviours occur with a view to determining appropriate educational strategies that can influence them.

This brief introduction to the research problem serves as the first of five chapters in the text.

Chapter two reviews existing literature on various aspects of the global AIDS problem including, the clinical symptoms of HIV infection and AIDS, health problems posed by AIDS as well as the current status of AIDS control efforts worldwide. The chapter also discusses the levels of prevention model and how this applies to AIDS.

Since behaviours play an important role in the spread of AIDS, the review focuses on two types of behaviours namely, those that have been proven or implicated in the transmission of HIV and those that are likely to favour its transmission. These behaviours are grouped into two, those relating to sex and those relating to blood contact.

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Furthermore, since health education is a systematic, planned activity based on scientific principles, the processes involved in planning health education programmes are reviewed using the PRECEDE framework (Green et al, 1980). This then sets the stage on which past AIDS risk reduction efforts worldwide are reviewed and critiqued. The chapter ends with a review of some of the problems involved in studying human sexual behaviour and research approaches on the behavioural aspects of AIDS.

Chapter three focuses on methodology, which include, description of study area, objectives, research design, scope of study, instruments and methods of data collection, methods of data analysis, and reliability and validity of the methods of data collection.

Chapter four presents findings. These are in a descriptive form and are in three parts. The first deals with sexual practices while the second focuses on marriage and divorce practices. The findings on blood related practices are presented in the third part.

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Chapter five deals with the discussions of the findings and the implications for health education planning. It also provides conclusions, limitations and recommendations.

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CHAPTER TWO

LITERATURE REVIEW

The literature review covers four broad issues relating to AIDS, namely, the nature and extent of the problem, the role of human behaviour in the transmission of AIDS, role of health education in AIDS control and finally, methodological approaches in AIDS research.

Nature and Extent of the Problem

The Clinical Symptoms of HIV Infection and AIDS

AIDS is caused by HIV, a retrovirus that compromises the body's immune system in such a way that it renders the body incapable of defending itself against opportunistic infections and cancers, some of which then become the immediate cause of death (Najera and Herera, 1988). The clinical manifestation of HIV infection includes those due to opportunistic diseases and illnesses directly caused by HIV itself. Piot and Colebunders (1988) have subdivided HIV infection into at least

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five different stages which may not necessarily present in all patients or occur consecutively. These stages are acute illness, latency, persistent generalised lymphatenopathy, AIDS-related complex (ARC) and AIDS.

The acute illness stage may occur as early as a week after infection preceding the appearance of HIV antibodies in the blood. Symptoms associated with this stage include fever, lymphadenopathy, night sweating, headache and cough. There are neither symptoms nor illness during the latency stage which may last several years (Jeffries, 1988; Mann, 1988b).

The persistent generalised lymphadenopathy stage sets in when a patient with HIV infection develops lymph nodes larger than one centimetre in diametre in two or more sites other than the groin. This persists for at least three months in the absence of any current illness or drug use known to cause the condition.

As for ARC stage, some of the symptoms include weight loss, malaise, fatigue and lethargy, anorexia and abdominal discomfort. Others are diarrhoea without a specific cause, fever, night sweating, headache, itching, amenorrhea, lymphadenopathy and enlarged spleen.

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AIDS is the final and the most severe stage of the broad clinical spectrum of HIV infection. AIDS is characterised by life threatening opportunistic infections as a result of profound compromise of the body's immune system. Although there is similarity in the symptoms, signs and immunological defects in patients with ARC and AIDS, these are less severe in the former. For example, unlike AIDS patients, ARC patients have neither opportunistic infections nor malignancies (Johnson and Pond, 1988).

The clinical picture of AIDS varies markedly from one region to the other. Clinically, AIDS usually takes the form of opportunistic infections by pathogens common in the environment (WHO, 1987). For example, there are clinical variations of AIDS between the developed and the developing countries. In the first place, pneumocytis carinii pneumonia is the most common opportunistic infection in AIDS patients in the USA and Europe whereas this is less frequently found in African AIDS patients (Piot and Colebunders, 1988). Secondly, Kaposi's sarcoma, a form of skin cancer, seen in parts of Africa differs from the aggressive form of AIDS - related Kapoai's sarcoma found in the

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developed countries (Anyiwo, 1988). Finally, whereas gastro-intestinal diseases are common in African AIDS patients this is rare among American and European patients (Piot and Colebunders, 1988).

Johnson and Pond (1988) offered two major reasons for this variation. The first relates to the difference in the kind and incidence of infections experienced in the two types of environment. For example, the occurrence of fatal diarrhoea in many African AIDS patients is thought to be as a result of poor environmental sanitation and hygiene. The second reason has to do with the differences in resources available for diagnosis. As a result of lack of diagnostic equipments many opportunistic infections are not diagnosed in many African countries.

Certain neurological disorders occur in patients with HIV infection. These disorders include progressive memory loss, demetia, psychiatric symptoms, encephalitis and meningitis (Liskin et al, 1986).

The clinical manifestation of HIV infection and AIDS in adults is different from that seen in children. The two most common symptoms of AIDS among children are diarrhoea and failure to thrive (Nicoll, 1988; Liskin

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et al, 1986). Unlike in adults, Kaposi's sarcoma is uncommon among children (Liskin et al, 1986). AIDS is transmitted to children through two routes. The first is from mother to child before, during or immediately after birth. The second is through transfusion with HIV infected blood or use of infested blood product (Nicoll, 1988).

Furthermore, diagnosing AIDS is more difficult in children than adults. The difficulty relates to the fact that a correct diagnosis in a baby can take place only after the first 15 months of life. It may be difficult to diagnose HIV infection accurately in infants less than 15 months because HIV antibodies passed from an infected mother to her baby may last up to this period in the baby after birth. Thus, results of HIV test may reflect a mother's HIV status rather than that of the baby (Nicoll, 1988; Ndugwa and Friesen, 1988). Finally, HIV progresses differently in children than in adults. For example, in babies infected before or at birth the disease may advance much more quickly than in adults with some babies dying in the first few weeks of life (Nicoll, 1988).

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There is a difference in the rate at which people infected with HIV develops AIDS. Certain hypothesis have been postulated to explain the different rate of disease progression in HIV infected persons. In the first place, repeated infections and exposure to antigens may activate the replication of HIV thus enhancing the development of HIV related symptoms. Second, some investigators have speculated that the use of certain volatile drugs like nitrites (drugs inhaled to enhance sexual pleasure) may lead to HIV related illness (Liskin et al, 1986). Finally, co-infection with certain conditions like malaria and other parasitic diseases and malnutrition capable of compromising immune function may increase the chance of immunosuppression (Liskin et al, 1986). However, the time taken to develop HIV infection and ultimately AIDS not-withstanding it is widely feared that the great majority of HIV infected persons will ultimately develop AIDS (Johnson and Pond, 1988). Details about the clinical symptoms commonly seen in AIDS patients are in Appendix II.

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Health Problems Posed by AIDS

AIDS poses a major problem to global health. The first aspect of the problem relates to the pandemic of HIV infection and AIDS. Since the first cases of AIDS were reported in 1981, the disease has spread rapidly to virtually all countries around the World. Not only have the number of cases of AIDS increased but also increasing are the number of countries reporting the incidence of the disease. For example, as at September 9th, 1987, a total of 59,563 AIDS cases had been reported to WHO from 132 countries on all continents of the World (Mann, 1987). However, by 1st June, 1988, the figures rose to 96,433 AIDS cases reported from 136 countries from all continents of the World (Mann, 1988b).

These figures probably do not reflect the true picture of the global AIDS situation because AIDS is an under-reported disease. In the USA, for example, an estimated 10 percent of AIDS cases are not reported (Mann, 1988a). Some of the reasons preventing accurate up-to-date reporting in many countries of the world include, reticence in reporting cases from some areas,

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under-recognition of AIDS and under-reporting to national health authorities (Mann, 1987). The WHO has estimated that there are about 200,000 cases of AIDS worldwide while an estimated 5 to 10 million people are believed to be HIV infected already (Mann, 1988b).

The second disturbing aspect of the AIDS problem relates to the group of people mostly affected by the disease. AIDS has claimed the highest number of victims from among groups of people in the most productive phases of their lives. Approximately 90 percent of all AIDS patients worldwide are people within the 20 - 49 year age group (Mann, 1986). In Uganda, for example, about 80 percent of AIDS patients were aged between 20 - 49 (Okware, 1988). In Mexico, young adults are the group most affected by AIDS (Sepulveda, 1988). In New York City, USA, AIDS is the leading cause of death among women aged 25 - 34 (Mariasy and Radlclt, 1989). In addition, in New York and San Francisco, USA, AIDS has become the most important cause of premature mortality (Mann, 1986). Thus a disease that affects mostly the economically productive sector of the population is likely to have a far reaching impact on social and economic development in countries where there is a high AIDS prevalence rate.

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In many developing countries, especially those in Africa, the onset of AIDS may be exacerbated by existing high levels of two other major killers on the continent, namely, malaria and tuberculosis (Hubley, 1988b). The current economic crisis and shortage of resources being experienced in many parts of the continent may also impair control efforts and consequently compound the problem. However, governments in many parts of the developing countries are likely to be under serious pressure to spend more money on AIDS control programme as the disease spreads rapidly. In Brazil, for example, a sum of $1.5 million was used for AIDS control programme in 1987 (Cenasci, 1988). In Nigeria, a sum of ₦1.2 million will be spent on AIDS control programme in 1989 (The Guardian, 1989). Consequently, existing resources, which are inadequate in the first place, may be diverted from on-going health programmes to AIDS control programme. Specifically, the example of Brazil draws attention to the plight which many developing countries have to face to solve AIDS problem. In spite of a foreign debt of $116 billion and about 60 percent of its population living in absolute poverty, the Brazilian government had to launch a $1.5 million

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multi-media campaign in 1987 to control the spread of AIDS in that country (Cenasci, 1988).

The relationship between AIDS and other sexually transmitted diseases (STDs) reflects yet another aspect of the problem. Developing countries are especially affected. For example, STDs, are hyper endemic in many developing countries (WHO, 1986). In Africa, the common STDs are gonorrhea, syphillis, and chancroid (Anonymous, 1989). Yet, current studies suggest that certain STDs like chancroid, herpes and syphillis, generally called genital ulcer disease (GUD) facilitate the transmission of HIV (Pallagyo, 1989; Johnson and Pond, 1988; Piot et al, 1987). Thus the high prevalence of STDs in many developing countries may aid the propagation of sexually acquired AIDS in such countries.

Furthermore, the potential impact of AIDS on other diseases may pose other serious problems to public health. AIDS has altered the clinical picture of certain diseases. Tuberculosis is a good example. AIDS may magnify the impact of tuberculosis in areas where it occurs (Sabatier, 1987). Second, the presence of HIV makes the diagnosis of tuberculosis difficult (Nunn, 1988). Moreover, studies conducted among AIDS patients in Connecticut, USA, suggest that there is a high risk of developing active tuberculosis among AIDS

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patients with latent tuberculosis (CDC, 1987). In addition, AIDS has altered the clinical picture of certain STDS. In parts of East and Central Africa, for example, GUD symptoms persist in HIV patients for several weeks, sometimes months, despite the provision of normal medical treatment (Pallangyo, 1989).

Finally, the long incubation period of AIDS poses another major health problem. HIV may remain dormant in the body for years and most infected people are not aware of their infection (Mann, 1988c; Jefferies, 1988). Yet, asymptomatic carries may transmit the virus to either their sexual partners or offspring (Liskin et al, 1986).

Status of AIDS Control Efforts

This section traces the current status of AIDS control efforts worldwide, the technological and behavioural implications from four broad perspectives, namely, cure and treatment, screening, testing and contact tracing, vaccine issues, and finally personal protective activities. This then leads to the discussion of the five levels of prevention (Clark and Leavell, 1958, as quoted by Brieger et al, 1988) and how these apply to AIDS.

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Cure and Treatment Issues

AIDS is a new, fatal disease for which there is no cure yet. Treatment of AIDS patients is palliative, consisting mainly of managing specific infections that take advantage of immunodeficiency (Liskin et al, 1986). Of all the anti-viral drugs tested, Zidovudine (AZT), and Ribavirin appear the most promising. Both drugs cross the blood brain barrier and can be taken orally (Liskin et al, 1986). Secondly, AZT has been shown to prolong the life of AIDS patients (Mann, 1988b). But disturbing questions about its side effects and cost limit its therapeutic potantials. For example, the side effects produced by AZT include anaemia that is severe enough to necessitate blood transfussion (Sabatier, 1987). And AZT produces severe anaemia in about 25 percent of recipients (Johnson and Pond, 1988). The need for repeated blood transfusion over extended period of time os a result of use of AZT raises serious questions about its use on a large scale especially in countries where screening is not comprehensive.

Apart from side effects, AZT is also quite expensive. The recommended daily dose of 6 to 10 AZT tablets

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for a single AIDS patient in the USA cost between $10 to $20. Since treatment must continue for a long period, probably for the whole lifetime of the patient, only countries with well financed health care system may be able to afford the drug at its current price (Sabatier, 1987). Thus the high cost of AZT may limit its use on a large scale especially in resource poor nations.

Two major factors have impeded the prompt development of other effective anti-viral drugs for the treatment of AIDS. First, like other retroviruses, HIV attaches itself to the cells it infects and as a result becomes part of the human cell's genetic material (Jeffries, 1988). Eliminating HIV therefore implies damaging the infected cells thereby impairing the immune system even further (Sabatier, 1987, Listin et al, 1986). Second, HIV infects brain cells, yet, many anti-viral drugs do not cross the brain barriers that normally protect the brain tissues (Sabatier, 1987; Black, 1985).

The level of prevention relevant to cure and treatment is limitation of disability which involves prompt treatment of diseases once symptoms have been detected

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to prevent complications. At present, treatment for AIDS and HIV infection are palliative even though AZT has been shown to prolong the life of AIDS patients. This is not a feasible level of control since AZT may not be affordable to patients in resource poor nations. Its severe side effects in patients who use it (Johnson and Pond, 1988; Sabatier, 1987), is another major limitation. The next level is rehabilitation which takes place when the disease has been arrested and includes restoration and maintenance of health status against further deterioration. Since there is no effective treatment for AIDS yet (Liskin et al, 1986) and it is feared that the great majority of HIV infected persons will ultimately develop AIDS (Johnson and Pond, 1988), there is little or no opportunity for rehabilitation.

Screening, Testing and Contact Tracing

Screening has been proposed as a public health measure to control the spread of HIV infection and AIDS (Anonymous, 1988). According to Liskin et al (1986) screening of blood is the most effective way of keeping HIV contaminated blood out of blood supply. However, screening as a control measure for AIDS is fraught with

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certain problems. The cost involved in mass screening is a major limitation. The cost involved in carrying out a single reliable test is such that many developing countries may not be able to afford to screen on a large scale. A reliable test is one that is both sensitive and specific. Sensitivity refers to the power of a laboratory test to detect a given condition, thus a highly sensitive test will yield few false negatives. On the other hand, sepcificity refers to the power of a laboratory test to indicate when a given condition is not present, thus a highly specific test will yield few false positives (Kilmarx, 1988).

To ensure accuracy, two tests that detect HIV antibodies are usually carried out. The first is Enzyme Linked Immuno-sorbent Assay (ELISA) costing about $5 to $10 per patient. The second, a confirmatory test, called Western Blot, costs between $30 to $50 per patient (Sabatier and Cecil, 1988). Thus the high cost involved in screening places severe limitations on its use as a means of control especially in developing countries.

Diagnostic testing of individuals also presents some problems. In the first place, there are no tests

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that detect HIV. At present, available tests detect only the antibodies produced by the body as a response to the virus. Yet, the time lag between the period a newly infected HIV carrier contracts the virus and the time when he or she develops antibodies against it may last for several weeks (Liskin et al, 1986). The implication of this is that HIV tests may sometimes not reflect an individual's true HIV status. Finally, as Sabatier and Cecil (1988) pointed out, diagnostic testing in itself may be useful in gauging the extent and course of AIDS but it may not help in breaking the chain of infection since there is no cure.

Contact tracing is another public health measure that is related to testing. Contact tracing is the process of identifying contacts of infected persons and referring them for treatment and counselling. Contact tracing is an essential component of STD control strategies (Pallangyo, 1989; Van Parijs, 1975). Controlling existing STDs has always been difficult because of the taboos sorrounding sex which inhibit discussion on the subject; the asymptomatic nature of some STDS like gonorrhea and chlamydia; and the resistance of certain STDS to antibiotics (Paalman, 1988). Other reasons

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include lack of diagnostic facilities, trained health workers and lack of political will (Pallangyo, 1989).

Contact tracing may not be effective as a control measure because of the following reasons. First, the period between infection and actual development of AIDS is so long that tracing sexual contacts of infected persons may not be realistic. Second, the issue of human mobility places another serious limitation on this approach (WHO, 1986; George, 1986). Finally, considering the social stigma attached to the disease, it is unlikely that infected persons will reveal their sexual contacts (Johnson and Pond, 1988).

The appropriate level of prevention relevant to screening, testing and contact tracing is early detection. Early detection involves screening for disease condition in its asymptomatic stage when treatment can be more effective. ELISA and Western Blot tests can detect HIV antibodies in the blood. If antibodies are detected early and the carrier is counselled, disease progression may be delayed if the carrier refrain from actions that may expose him to more infections that can accelerate the rate of disease progression. This action may thus break the chain of transmission.

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The HIV carrier can be counselled to use condoms during sexual intercourse. Condom may benefit people infected with HIV in the sense that they prevent repeated infections by reducing the exposure to additional doses of the virus as well as other STDS. Avoiding such exposure prevents the stimulation of immune responses which might further increase viral reproduction (Liskin et al, 1986). However, the time lag between the period a newly infected HIV carrier contracts HIV and the time of development of detectable antibodies in the blood is a major limitation of early detection. The cost involved in tests is another limitation.

Vaccine Issues

The development of a vaccine for feline leukemia virus, a retrovirus causing AIDS related diseases in cats has raised the possibility of the development of a potent vaccine for AIDS in human beings (Francios and Petricciani, 1985). However, developing a vaccine against HIV has been particularly difficult for two reasons. In the first place, although the body's immune system produces antibodies to HIV these do not inactivate

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the virus (Jeffries, 1988). This suggests that vaccine induced antibodies may not destroy the virus. The second reason relates to the frequency at which HIV mutates (Francois and Petricciani, 1985).

The cause of AIDS worldwide is HIV-I. HIV-I was originally named Lymphadenopathy Associated Virus (LAV), by the French research team lead by Luc Montaigner that first isolated it in 1983. By 1986, a new virus, named HIV-II, was isolated among patients from Guinea Bissau and Cape Verde who were referred to Portugal for treatment (Francois et al, 1987). In 1985, a new virus, called simian T-cell Lymphadenopathy type III (STLV-III) was isolated. This virus infects captive manague monkeys in whom it causes immunodeficiency. Finally, in 1987, another retrovirus was discovered by Swedish scientists from a Gambian woman with AIDS. This was named SBL-6669 (Johnson and Pond, 1988). Thus with such a high frequency of genetic mutations, a vaccine derived from the viral envelope of one strain may not be effective against others (Francois and Petricciani, 1985). This implies developing multiple potent vaccines for each strain of the retroviruses.

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Even if a potent vaccine against HIV is developed, there are still other non-scientific problems that may limit its production or use on a large scale. For example, the private sector may not be willing to finance AIDS vaccine project because of the uncertainties involved in such venture. Such uncertainties include, the concern about the size of the market for the vaccine and the risk of the liability involved (Francois and Petricciani, 1985). Testing the potency of the vaccine may also present some problems. The chimpanzee is a likely candidate that may be used for initial trials, yet, chimpanzees are scarce and expensive (Liskin et al, 1986).

Furthermore, Wetzler and Seiff (1986) pointed out the growing concern about the reluctance of some scientists in the private sector to disclose valuable information on advances in knowledge on AIDS research that might lead to the quick discovery of a vaccine. Finally, even if an AIDS vaccine is developed soon, this will protect only those who are not yet infected. An AIDS vaccine will not reverse the HIV status of those already infected.

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The level of prevention relevant to vaccine is specific protection which refers to actions taken to forstall the occurrence of certain diseases or disability, for example, immunization and chemoprophylaxis targeted against certain diseases. At present, there is no vaccine against HIV so there is no opportunity for immunization. Neither are there prophylactic drugs for AIDS yet.

Personal Protective Activities

One means of controlling the spread of AIDS is primary prevention through personal protection. Studies have shown that the use of condoms reduces the risk of sexual transmission of HIV (Mann et al, 1987; Van de Perre et al, 1987). Condoms not only block the passage of HIV during intercourse but also help check the transmission of other STDS which act as co-factors (Schoepf et al, 1988). In addition, condoms may be beneficial to HIV carriers in the sense that they prevent repeated infections by reducing additional doses of HIV as well as other STDS. Avoiding such exposure reduces the chance of developing HIV related symptoms (Liskin et al, 1986).

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Apart from protecting its users from contracting HIV and other STDS, condoms have other advontages. For example, they can be easily purchased and they need not be prescribed by health workers (Hubley, 1988b). Moreover, condoms have no side effects and can be correctly used without medical supervision (Sherris et al, 1982). Finally, prevention of perinatal transmission of HIV in children requires primary prevention of HIV among infected mothers through use of condoms (Schoepf et al, 1988).

Yet, condoms are not widely used in both the developing and the developed countries (Sherris et al, 1982). The unpopularity of condoms around the world stems from a number offactors. First, many people refuse to use condoms on religious grounds. In Italy, for example, the Vatican disapproves the use of condoms to prevent the spread of HIV (Owen, 1988). The Catholic Church opposes birth control generally. The condom is defined as an unnatural birth control device so the Catholic Church opposes its use under any circumstance (Kipley, 1981).

Second, certain beliefs about the potential contributions of semen to women's health have also helped to

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make condoms unpopular. In Bangladesh, for example, a major reason why condom is not widely used is the belief that "semen is a necessary health tonic for women" (Sherris et al, 1982). In Zaire, there is a belief that condom use may injure women and even cause sterility. Other barriers to the use of condom in Zaire include; suspicion and hostility believed likely to result from proposing condom usage to a regular or even a casual partner; difficulties with in-laws over condom use with spouse; fear of loss of sensation that results from wearing a condom; fear that the semen remaining in a shealth might be used for sorcery; inability to ejaculate as a result of use of condom (Schoepf et al, 1988). Finally, cost may be another deterrent to condom use in many developing countries especially in the rural areas (Mariasy and Bekele, 1989).

The level of prevention relevant under personal protection is health promotion. Health promotion refers to factors which contribute to the health of individuals and communities. Examples are clean environment and good nutrition. Regarding the relevance of health promotion to AIDS, there are many steps the individual can take to protect himself from contracting AIDS. For

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example, the individual can abstain from sex or limit sexual relationship to only one mutually faithful and uninfected partner. A condom may be used during each sexual encounter with risk groups like prostitutes, intravenous drug users, homosexuals or bisexual men. The individual can also avoid the use of unsterilised needle and other skin piercing instruments.

However, not all these actions are feasible. Although abstinence provides 100 percent protection from sexually acquired AIDS, it may not be a realistic solution in the long run. On the other hand, monogamy may not be realistic in certain cultures especially where polygyny as a form of marriage predominates (Mariasy, 1988). When properly used, condoms provide protection against sexually acquired AIDS (Mann et al, 1987; Vande Perre et al, 1987). But use will depend on its cost, availability and acceptance. Finally, the use of sterilised instruments is also influenced by its availability when it is needed (Selwyn et al. 1987; Des Jarlais et al, 1985).

The conclusion that can be drawn from the foregoing analysis is that primary prevention through health promo- tion is currently the only realistic level of control

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against AIDS and health education is one of the feasible ways of achieving this. The key to prevention of AIDS lies in using educational strategies to encourage individuals at risk of contracting HIV to adopt personal protective activities, for example, use of a condom, that limit their chance of exposure to the virus. Infact, studies have shown that education can influence risk behaviours on AIDS. In Greece, for example, results of a study in which 350 Greek prostitutes received counselling on AIDS at an STD Clinic showed that condom use rose from 66.0 percent at pre-test to 97.9 percent at post-test.

As a result of the increased usage of condoms, the incidence of syphillis among the prostitutes dropped from 17.1 percent to 3.2 percent and gonococal infection from 14.0 percent to zero at pre and post-tests respectively (Roumeliotou et al, 1988).

Apart from the prevention of the spread of AIDS, health education has other roles to play in other aspects of control. For example, counselling can play a key role in control efforts by helping people solve problems arising out of HIV infection in themselves, their families or others to whom they are close. The

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WHO has recommended that counselling, as an aspect of control, should be provided to the following groups of people; healthy HIV carriers; those who are under-going HIV tests; intravenous drug users (IVD users); prostitutes; those tested and are found to be sero-negative; health workers; family, friends and other persons who come in contact with HIV infected persons and AIDS patients (WHO, 1988a).

The Role of Human Behaviour in the Transmission of HIV

Although HIV has been isolated in blood, breast milk, cervical and vaginal secretions, colostrum, urine, saliva and semen, only blood, cervical and vaginal secretions and semen have been implicated in its transmission (WHO, 1988b). The transmission of AIDS virus involves exposure to these body fluids from an infected person. This occurs through certain behaviours. The subsequent review focuses on both the behaviours that have been proven to transmit HIV and those that are likely to transmit it. These behaviours are grouped under two broad headings, namely, those relating to sex and those relating to blood.

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Behaviours Relating to Sex

The AIDS virus is predominately transmitted through sexual activities (Piot and Colebunders, 1988; Mann 1988b; Johnson and Pond, 1988). Anal intercourse has been proven to transmit HIV. Receptive anal intercourse is considered the most efficient means of HIV transmission because the mucosa lining the rectum are delicate and tear easily during anal intercourse thus paving the way for viral dissemination since the donor's sperm comes in contact with the receiver's blood (Broadbeer, 1987; Polts, 1987; Liskin et al, 1986). This pattern of sexual behaviour is common among male homosexuals and bisexual men. It is significant that AIDS was first reported in 1981 among young homosexuals men.

In countries of North America, Western Europe, New Zealand and Latin America, sexual transmission of HIV occurs predominantly among homosexuals (Mann, 1988b). For example, in the USA, approximately 73 percent of reported cases of AIDS have occured among homosexual and bisexual men (Fox et al, 1987). In Mexico, close to 90 percent of cases of AIDS have occurred among homosexual and bisexual men (Sepulveda, 1988). In Holland, 81 percent of AIDS reported at the beginning of October, 1988,

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have occurred among homosexual men (Marijinssen, 1989).

West (1955) defined homosexuality as the experience of being erotically attracted to a member of the same sex. He categorised homosexuals into three groups, namely over or practicing homosexuals, exclusive or obligatory homosexuals and facultative homosexuals. Practicing homosexulas are those who act upon their erotic feelings by participating in mutual sexual fondling or other forms of sexual stimulation but not sexual intercourse with a partner of the same sex. Exclusive homosexuals are those whose erotic feelings for the opposite sex are absent altogether or slight in comparison to their homosexual feelings. Exclusive homosexuality is considered permanent and unchangeable. On the other hand, facultative homosexuals are those who take to homosexual activities on odd occasions usually when deprived of contact with the opposite sex, for example during incaceration. Such persons resort to use of homosexual outlets as a substitute without it interfering with their normal heterosexual capacity or feelings.

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Homosexual activities in Africa does not fit into any of the categories already mentioned. There have been reports, for example, of African men in cities who are married and are not homosexuals but rent out their bodies to expatriate men to earn foreign exchange (Konotey-Ahulu, 1989).

It is not homosexuality per se that is risky but anal intercourse and promiscuity. Promiscuity involves having a large number of different sexual partners. Promiscuity is a common pattern of sexual behaviour among homosexuals. In San Francisco, USA, for example, some ano-receptive homosexuals have been known to have as many as 50 different sexual partners during one week-end (Konotey-Ahulu, 1987). The risk involved in having multiple partners is a result of increased probability of exposure to someone who is HIV infected. Having multiple sexual partners is also risky in the sense that it increases the chance of contracting other STDs which act as co-factors for HIV transmission. Especially affected are the GUDs which facilitate HIV transmission (Cameron et al, 1989; Pallangyo, 1989; Johnson and Pond, 1988; Piot et al, 1987).

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Promiscuity is not limited to only homosexuals, it also occurs among heterosexuals. Among the later, the prostitutes are a group that is often promiscuos. Prostitutes are at risk of acquiring and transmitting HIV and other STDS to their clients and offspring (CDC: 1987). In Africa where HIV is predominantly transmitted through heterosexual intercourse, female prostitutes constitute the major reservoir of STDS including HIV (Johnson and Pond, 1988; Van Dee Perre, 1985). Although all prostitutes are at risk of contracting HIV, result of Kreiss et al's (1986) study suggests that low income prostitute who report the highest frequency of sexual encounter may be at the highest risk of contracting HIV. Among the prostitutes surveyed by those authors in Nairobi, Kenya, HIV was detected from the sera of 66 percent of women of low socio-economic status comapred to 31 percent of those from high social economic status. In addition, Schoepf et al (1988) pointed out thot low income prostitutes have high number of recurrent STD episodes, particularly chancroid, syphillis, genital herpes and chlamydia which cause open sores.

Studies have shown that women go into prostitution for various reasons. In Italy, for example, some women

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resort to prostitution to earn money with which to finance drug addiction (Owen, 1988). In Ghana, many girls who left their country for the neighbouring countries of Nigeria and Ivory Coast in the wake of the economic crisis of the late 1970s and early 1980s resorted to prostitution on account of lack of jobs (Konotey-Ahulu, 1989). In Nigeria, unhappy home, desertion, and a broken home were some of the reasons most frequently cited by female prostitutes who solicit in hotels in Lagos (Oleru, 1980). Because female prostitutes constitute one of the high risk groups for AIDS, many risk reduction efforts have been targeted at them in different parts of the world (Yeboah-Afari, 1988; Roumeliotous et al, 1988 Ngugi et al, 1988).

Not only are prostitutes at risk of contracting HIV (Cameron et al, 1989; Clumeck et al, 1985) this may be transmitted to clients. Cameron et al's (1989) study has also shown that the acquisition of GUDS in men as well as in intact foreskin significantly increase the chance of contracting HIV from an HIV infected prostitue.

Apart from anal intercourse, promiscuity and frequent contact with femalo prostitutes, there are other

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sexual practices that are unique to certain cultures that may favour the transmission of HIV. Among the Giriama of Zambia, for example, ritual sexual intercourse takes place between a widow and a male member of the deceased husband's family. If the deceased was polygynous, the male members must have sexual intercourse with each wife in turn in order of their seniority or else the sexual act could be simulated by touching the sexual organs (Brokensha et al, 1987). The risk involved in this practice is that if the deceased spouse was an AIDS victim then this may contribute to the spread of the disease.

A similar practice, namely levirate marriage, may also contribute to the spread of AIDS. Among the Yorubas of Nigeria, customary laws permit a man to inherit his brother's widow (Ekundare, 1969).

Other sexual practices that may contribute to the spread of AIDS includes those found among the coniagui of Guinea (Gessain, 1971) and the Gwembe Tonga of Zambia (Brokensha et al, 1987). In these societies, husbands who either on account of impotence, sterility or old age cannot make their spouses conceive arrange that other men have intercourse with their wives and

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the resulting children are considered theirs. In particular, Gwembe Tonga men use euphemistic invitation "go and cut wood for me my friend." This practice under-scores the desire to begat children that is common in many African societies.

Furthermore, some women in different parts of African countries offer sexual services to men to augment their incomes or meet special needs. As Brokensha et al (1987) pointed out, this practice differs from prostitution in which women earn their daily living by selling sexual services to clients. Such women are referred to as "spares" in Zimbabwe, "meanwhiler" in Ghana or "town-wives" in other West African countries.

Ethnographic studies have also shown that there is a wide spectrum of premarital sexual activities which may contribute to the spread of AIDS where such practices exist. For example, according to Gessain (1971):

> Coniagui girls (of Guinea) are allowed great deal of sexual freedom for they are allowed to have a lover in each village (and there are about 80 villages) and every forthnight may spend a couple of days or so with one of them.

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In addition, among the Fulani Woodaabe of Nigeria, girls are allowed a great deal of sexual freedom since no value is attached to virginity. Woodaabe girls are expected to have a great deal of sexual experience before marriage (Dupire, 1971). Hrdy (1987) also reported that among the Lese of Zaire, there is a period after puberty and before marriage when sexual relationship between young men and a number of eligible women is virtually sanctioned.

Ethnographic studies on divorce also suggest that this may contribute to the spread of AIDS in societies where it is common. The risk involved in divorce is related to the assumption thot divorced women are more likely than married women to engage in casual sexual activities or prostitution (Brokensha et al, 1987). For example, omong the Hausas of Sabo, in Ibadan, Nigeria, many divorced women become prostitutes for a certain period of time before they eventually remarry (Cohen, 1969). Olusanya (1971) has also pointed out the relationship between frequent divorce and fertility. According to him, frequent divorce reduces fertility by spreading STDS through frequent change of spouses. Studies have shown that there is a high frequency of

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the incidence of divorce among certain groups of people in African societies. For example, the incidence of divorce is high among the Woodaabe Fulanis and Yorubas of Nigeria (Dupire, 1971; Lloyd, 1968; Sofoluwe, 1965; Okediji and Okediji, 1965).

In summary, it can be seen that although receptive anal intercourse, promiscuity and frequent contact with prostitutes are the sexual behaviours so far proven to transmit HIV, there are nevertheless a broad range of sexual practices that are likely to favour the spread of AIDS.

Behaviours Relating to Blood Contact

Two types of blood related behaviours place individuals at risk of contracting HIV. The first relates to the use of shared unsterilised instruments while the second involves exposure to HIV infected blood. First among behaviours that involve use of shared skin piercing instruments is intraveneous drug injection. Intraveneous drug injection has been implicated in HIV transmission (Des Jarlais, 1985). The risk involved in this behaviour stems from the practice whereby intraveneous drug (IVD) users inject substance directly into the blood stream and often draw blood back into the syringes to ascertain

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whether or not the needle is in the vein (Hrdy, 1987). And since in most cases such needles are shared, this result in the exchange of blood.

IVD users occupy a pivotal position in the spread of the AIDS epidemic because they serve as a bridge of transmission to two other groups of the heterosexual population, namely, their sexual partners and offspring (Selwyn et al, 1987; CDC, 1987).

Two behavioural factors are associated with HIV transmission among IVD users (Des Jerlais and Friedman, 1987). The first is the frequency of drug injection. The more frequently IVD users employ unsterilised needles the more likely is the chance of contracting HIV. The second behaviour relates to the use of "shooting galleries" as a place of injecting drugs. "Shooting galleries" are places where IVD users rent and share injection equipments. Because shooting galleries attract many IVD users, it increases the risk of exposure to HIV through increased likelihood of sharing needles.

Studies have shown that there is a high prevalence of HIV infection and AIDS among IVD users in certain countries. In Italy, for example, 70 percent of AIDS cases have occurred among IVD users (Owen, 1988). In Ireland, 58 percent of the AIDS cases

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reported have occurred among IVD users (Vaughan, 1989). Furthermore, studies by Selwyn et al (1987) show that non-availability of sterile needles was the most frequently cited reason why IVD users, WHO were fully aware of the risk of contracting HIV, did not use sterile needles. This underscores the issue of availability of resources as a motivating factor in behaviour modification. The results of a related study by Des Jarlais et al, (1985) suggest that the very nature of the AIDS disease has helped to limit the perception of risks by IVD users. In most cases, IVD users do not perceive themselves at risk of contracting AIDS because of the relatively long latency period between exposure to HIV and the development of AIDS. In addition, IVD users do not consider AIDS as a singularly important cause of death compared with the many other causes of death common among them.

Needle stick injuries have been implicated in HIV transmission (Anonymous, 1984). To reduce the risk of HIV transmission through needle sticks and other sharp skin piercing instruments the WHO (1987) has recommended that all health workers should handle needles and other

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sharp instruments with adequate care and store them in puncture proof containers.

There are other drug injecting behaviours that may contribute to the spread of AIDS where they occur. Hrdy (1987), in a comprehensive review of cultural practices that may favour the transmission of HIV in Africa, pointed out the possible role that quacks who administer intramuscular injections to clients can play in propagating the spread of AIDS. These quacks are usually mobile and administer over the counter parenteral antibiotics. They give intramuscular injections using poorly or never sterilised needles for a wide range of infections. This practice is often reinforced by social and economic factors. In many parts of Africa, for example, there is a cultural preference for medications delivered by injections (Johnson and Pond, 1988). The preference for injection in treating all types of afflictions in Africa stems from the successful campaigns to eradicate yaws in the 1920s and the 1930s. Cost factors have also resulted in the use of non-disposable needles and syringes in some health facilities thus reinforcing cultural preference (Dawson, 1988).

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However, compared with IVD use, the activities of quacks may carry less risk for transmitting HIV. This speculation arise because IVD users inject substances directly into the blood stream and draw bllod to determine whether or not the needle is in the vein whereas the quacks utilize intramuscular method which involves less exposure to blood (Hrdy, 1987). Furthermore, Dawson (1988) argued that the needle does not play a major role in AIDS transmission in Africa. His arguement is predicated on two points about the AIDS situation on the continent. First, AIDS patients in Africa are mainly sexually active young adults and children under five years. The second correlates the first, namely, that AIDS is uncommon among the 5 - 15 year age bracket and old men and women even though this group also receive injections. If the needle plays a major role in the transmission of AIDS in Africa, it is difficult to explain why the disease is not common among the 5 - 15 years age group who also receive injection.

Another practice that involves the use of unsterilised needle that may transmit HIV is tattooing. Doll's (1988) study among prison inmates who were tattooed

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during incaceration using unsterilised needle and who later developed HIV infection raises the possibility of HIV transmission through this practice.

Other practices that involve the use of skin piercing instruments are group circumcision and ritual scarification. In many parts of Africa, circumcision is a ritual practice that usually takes place at long intervals and as a result, many boys and girls are circumscised in groups at the same time. In societies in which circumcision is a ritualised procedure, the operation serves as a form of initiation rites from childhood into adulthood. Among the Gusii of Kenya, for example, both male and female initiation rites involve circumcision which occur annually lasting from October through December. It is through circumcision that the Gusii teenage graduates into adulthood (Levine and Levine, 1966). Among the Coniagui of Guinea, group circumcision for girls takes place at about the age of 18 years while boys are circumcise at about the age of 6 or 7 years. Excision of the clitoris and the foreskin change the status of girls and and boys respectively in this society (Gessain, 1971). Since only one instrument is usually employed during such operations, HIV may be transmitted.

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Ironically, male circumcision in itself is a practice that may reduce the risk of contracting STD generally including HIV. Studies have shown that the presence of an intact foreskin in males significantly increases the risk of exposure to STDS during intercourse (Cameron et al, 1989; Simonsen et al, 1988). Fink (1986) has also argued that there is abundant evidence that both genital herpes and syphillis are more common in uncircumcised men than in circumcised men. This suggests that circumcision reduces the risk of exposure to STDS during intercourse. Cameron et al (1989) offered one possible explanation why the foreskin increases susceptibility to HIV. Their explanation relates to the ability of the prepuse to physically trap infected vaginal secretions and provide a more hospitable environment for the infected inoculum thus enhancing virus survival.

Despite worldwide efforts to eradicate it, female circumcision has persisted in many parts of Africa (Hosken, 1982). Three types of female circumcision exist in Africa. The mildest form, called "Sunna," involves the excision of clitoral propuce (Oduntan and Onadeko, 1984). A moderate form involves the removal

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of prepuse and glans of the clitoris together with the adjacent part or whole of Labia minora without including labia majora and without closure of the vulva. The extreme type, called infibulation or pharaonic circumcision, consists of removal of the whole clitoris, the labia minora and the medial part of the labia majora. In addition, the two sides of the vulva are stitched together using silk or catgut with a small opening allowed for urine and menstrual flow (Bakr, 1982).

Female circumcision may favour the transmission of HIV in the sense that genital mutilation may result in tears in the mucosa during sexual intercourse thus paving the way for viral dissemination. It is in this sense that the presence of lesions in the vagina may enhance male to female transmission of HIV (Hrdy, 1987). However, the fact that areas of high HIV seropositivity in Africa have very little overlap with areas where female circumcision is practiced on the African continent suggests that the risk involved in it is not much (Johnson and Pond, 1988; Hrdy, 1987).

Facial scarification is a common practice in many parts of West and Central Africa. In these areas, it is a ritualised activity. The instrument used for the

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operation is usually shared thus creating the possibility of viral transfer among recipients (Hrdy, 1987).

Furthermore, there is a wide range of practices in Africa which result in exposure of blood. Among the Efe of Zaire, for example, a woman in labour is assisted by other women one of whom inserts her fingers into the vagina periodically to monitor the baby's position (Hrdy, 1987). Among the Yorubas of Nigeria, medicinal scarification results in exposure of blood. The practice involves making incisions on any part of the body using either a knife or a razor blade and then rubbing powdery substances meant to cure a disease into the wound. During the process, the operator is exposed to the blood of the recipient (Akinawonu et al, 1985). Other common practices in Africa that result in exposure to blood include blood letting, genital tattooing, blood brotherhood and uvulectomy (Hrdy, 1987; Brokensha et al, 1987).

Role of Health Education in AIDS Control

As a systematic and planned activity based on scientific principles, health education is concerned with the improvement of the health and quality of life of individuals, families and communities. It deals with changes

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in knowledge, attitude and behaviour. Health education attempts to either reinforce behaviours that promote health or discourage behaviours that are detrimental to health. To achieve these objectives, health education activities are planned in a way that encourage people to make informed decisions that promote, maintain and improve their health (Green et al, 1980).

The principal purpose of AIDS education, given the existing control technologies, is to prevent HIV transmission and the spread of AIDS by influencing related risk behaviours through educational activities. One essential principle that governs all health educational activities is that diagnosis comes before intervention (Burton, 1968). In the diagnostic phase, information is collected on the factors contributing to the problems to be solved. The step is aimed at gaining insight into the interacting factors contributing to the problem with a view to determining the various strategies that can be used to either overcome or circumvent the problem. On the other hand, during the intervention phase, an input is introduced to solve the problem. In addition, information collected during the diagnostic phase constitutes the base-line data on which planning and subsequent evaluation of the programme is based.

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Since HIV is transmitted mainly through human behaviour, diagnosis must start with the identification of behaviours which make individuals susceptible to HIV and factors influencing such behaviours. The first and second processes are called behavioural and educational diagnosis respectively (Green et al, 1980). According to Green et al (1980):

> ... Behavioural diagnosis is the systematic identification of health practices that appear to be causally linked to the health problem or problems identified in the epidemiological diagnosis.

With regards to AIDS the behaviours that have been causally linked to HIV transmission include anal intercourse, promiscuity, frequent sexual contact with prostitutes and drug injection. Furthermore, once these behaviours have been delineated the next step in behavioural diagnosis is to determine among which groups of people are these behaviours common. This is important because the educational intervention will be targeted at the group at risk. This is essential because educational interventions that are not targeted at any particular group of people may not lead to the desired results

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(Des Haes and Shuurman, 1985). The risk groups for AIDS are homosexual and bisexual men, prostitutes, male clients of prostitutes and IVD users respectively.

Once the behaviours causally linked to the health problem have been delineated the stage is set for the next step which is educational diagnosis. Educational diagnosis involves the determination of the factors influencing the behaviours that have been implicated to cause the health problem. According to Green et al's (1980) PRECEDE frame-work these factors can be grouped into three, namely, predisposing factors, enabling factors and reinforcing factors. Predisposing factors provide motivation or rationale for action. These could be knowledge, attitude, beliefs and values. Enabling factors facilitate the realisation or achievement of the motivation. These refer to resources and skills. Reinforcing factors promote the perpetuation of the behaviour. Examples include influence of peer groups, family members and significant others. According to the PRECEDE framework any given behaviour may be considered a function of the interacting influence of these three factors. Therefore any health education plan aimed at influencing behaviour must take into account the

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influence of the three interacting factors. According to Green et al (1980):

> ... Programme in which health information is disseminated without concurrent recognition of the influence of enabling and reinforcing factors will most likely fail to affect behaviour.

Review of Documented AIDS Risk Reduction Campaigns

With the discussion of the behavioural and educational diagnosis the stage is set for a review of documented AIDS risk reduction campaigns around the world.

A review of the literature shows that various innovative AIDS awareness campaigns have been launched in different parts of the world in response to the challenge that AIDS poses to health workers. A common feature of some of these campaigns is that diagnosis did not precede intervention, it is not surprising, therefore that such programmes did not produce the desired results. In the United Kingdom, for example, a year after the introduction of the billboard caption, "AIDS: Don't Die of Ignorance," up to 93 percent of the people exposed to such information were informed about AIDS

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and its routes of transmission. Yet, up to half of the 16 - 24 year age group surveyed said absence of a condom would not prevent them from having intercourse (Mariasy, 1988). This result shows that information may increase knowledge but may be insufficient to influence a change in behaviour (Ram, 1989; De Haes and Chuurman, 1985.

Furthermore, AIDS awareness campaign in Ireland provides another example of a billboard message that failed to yield the desired results. The billboard caption says "AIDS: Don't Bring It Home." This message lends itself to different, often conflicting interpretations. On one hand, such messages can be interpreted as warning prospective travellers from contracting AIDS while they are aborad. On the other hand, the message suggests denial and an attitude that AIDS is a foreign disease that should not be imported into the country. Yet, by the end of January, 1989, Ireland had recorded a total of 81 cases of AIDS while 793 are reported to be HIV seropositive already (Vaughan, 1989).

In Tanzania, a poster caption that says "Have sex with only one faithful partner" did not yield the desired results. Instead, it was greeted with derision, as one married man who has read the poster put it,

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"what am I going to do with my other wives?" (Mariasy, 1988). This poster message failed to yield desired results because it did not reflect cultural norms of polygyny existing in that country. Certain conclusions can be drawn from the three examples above. The programmes failed because: they were not targeted at any specific group: they emphasised on the predisposing aspect of the factors influencing behaviour while neglecting the enabling and reinforcing components.

By contrast, risk reduction campaigns that involved diagnosis before intervention have resulted in change in behaviour. A health education programme targeted at construction workers in Rio de Janeiro, Brazil, provides a good example (Hughes, 1988). Construction workers in the city were identified as a group at risk of contracting HIV because of their sexual lifestyle. Being separated from their wives for a long time, many of the workers sought sexual relief by visiting prostitutes while others resorted to homosexual activities. A survey provided baseline information of the demographic characteristics of the workers and local terminologies for different sexual activites. This was used to plan a health intervention that promoted the use of condoms

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among the workers. The workers were involved in programmed planning through their representatives. The programme succeeded in fostering a positive attitude to the use of condoms among the workers. The success of the educational programme can be attributed to the following factors. First, the intervention was preceded by diagnosis. Secondly, the programme was targeted at a specific group of people whose sexual lifestyle make them susceptible to HIV. Finally, the workers participated in the planning of the intervention. Active involvement of the target group in the development of AIDS education programme ensures the development of culturally acceptable health education messages, as well as the use of an acceptable health education methodology. It could also facilitate the identification of factors beyond the control of individuals and the removal of external constraints. In addition, involvement may lead to the development of feasible health education programme that addresses the perceived needs of the target population (Johannes Van Dam 1989).

The review has also shown that developing programmes especially for certain targeted group is crucial for changing behaviour. In Nairobi, Kenya, for example,

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health education activities targeted at female prostitutes resulted in a striking increase in condom use (Ngugi et al, 1988). Programme planning involved the prostitutes through elected representatives who served as lay educators to other members of the group. Health messages emphasised the risk involved in prostitution and encouraged the women to either quit the practice or at least insist that their clients used condoms during each sexual encounter. These messages were disseminated at community meetings and during individual counsellings. Condoms were freely distributed to women who requested for them.

For post intervention evaluation, the women were divided into three groups. Women in group 1 received counselling, attended community meetings and received free condoms, women in group 2 attended community meeting and received free condoms. Finally, women in group 3 attended community meetings only. Pre-test survey results show condom use to be 10, 7, 7 percent respectively. At post test, condom use rose to 81, 70 and 50 percent respectively.

The results of a similar pilot programme targeted at prostitutes in Accra, Ghana, showed a positive

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outcome (Yeboah-Afari, 1988). About 75 women took part in the programme among whom were selected leaders who were trained as lay educators to other prostitutes. The messages disseminated through the lay educators encouraged the women to either quit prostitution or protect themselves from contracting HIV and other STDS through use of spermicides or insisting that their clients use condoms during sexual intercourse. Spermicides and condoms were freely distributed to the women by lay educators. To evaluate the impact of the programme, some men posing as clients made periodic spot checks on the women to find out whether or not the women offered clients condoms or use spermicides. The men do not have intercourse with the women but pay for their time. The results showed that almost all the women had condoms handy and almost all of them were careful to use spermicides.

The success of these programmes can be attributed to a number of factors. First, unlike billboard messages, these programmes were targeted at specific groups. Large scale media campaign like billboard messages, for example, may be successful in raising levels of knowledge but may not bring about changes in

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actual behaviour (Ram, 1989; De haes and Shuurman, 1985). Second, the target group actively participated in the planning and execution of the educational intervention. The lay educators may have positively influenced other prostitutes since people are usually more willing to change their behaviour if approached by a trusted member of their own group rather than an outsider (Hubley, 1988a). Finally, the availability of free condoms may have contributed to the success of the programme. Because of the supply of free condoms, the prostitutes had a realistic option to quiting prostitution. As the results of drug injection among IVD users suggest (Selwyn et al, 1987; Des Jarlais et al, 1987), availability of resources play a crucial role in influencing behaviour.

The review above has shown that education can succeed in influencing risk behaviours for AIDS if such programmes are well planned.

Methodological Approaches in AIDS Research

This section focuses on the problems involved in studying human sexual behaviour and discusses the various approaches to research on behavioural aspects of AIDS with attendant implications.

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Problems involved in Studying Human Sexual Behaviour

In spite of its importance to the maintenance of human societies, the subject of human sexuality has received scant attention from scholars especially those from the developing countries (Brokensha et al, 1987). Given existing control technologies, changes in sexual behaviour are necessary if the AIDS epidemic is to be controlled. Yet, basic information about sexual behaviour on various groups of people in both the developing and developed countries are lacking. As Brokensha et al (1987) pointed out,

> ... social anthropologists have devoted relatively little attention to the systematic study of sexual behaviour ... where sexual practices are mentioned, they are often of a generalised nature (e.g. in intercource the male lies on the right side, the woman on her left) and lack the sort of specific information that would be useful for our purpose.

The emergence of AIDS has greatly kindled many scholars' interest in studies on human sexual behaviour, especially since sexual activity is the predominant

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route of HIV transmission worldwide (Piot and Colebunders, 1988; Johnson and Pond, 1988; Mann, 1988c; Liskin et al, 1986). It is probably in realisation of the dearth of information on sexual practices that the WHO identified human sexual behaviour as one of its research priorities (WHO, 1989). Also advocating for research, Hrdy (1987) suggested priority areas where studies on sexual activities should focus on by posing a number of questions namely, how does viral transfer occur from male to female and from female to male? Is there a close correlation between AIDS and sexual promiscuity in rural as well as urban areas? Are the few cases of AIDS reported in pre-pubertal children related to sexual activity? Does the spread of HIV seropositivity in Africa track movements of migrant labourers, armies and prostitutes out of central Africa?

An attempt has however, been made to categorise the patterns of sexual behaviour on a worldwide basis. Three broad patterns exist worldwide (Aral and Holmes, quoted from WHO, 1986). In the first pattern, found in a small number of societies, both men and women avoid extra marital sexual relationships. The second pattern exists in many developing countries where women are expected to

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have only one suxual partner while men are less strictly controlled. The third pattern, found in industralised countries, has arisen during the past 25 years. Here, both men and women tend to have several sexual partners. Although this categorisation provides broad information on sexual behaviours on a global basis, few generalisations can be drawn from this since it does not reflect variations across tribes, subcultures or age groups.

Human sexuality has received little attention from scholars probably because the subject itself is fraught with many problems. In many societies, the issue of sex is often shrouded in mysteries and taboos. Among the Yorubas of Nigeria, for example, sex is seldom freely discussed. Discussion about sex is considered obscene and reference to it, when it is considered absolutely necessary, is usually euphemistic (Demehin, 1984; Ademuwagun, 1976; Olusanya, 1967). As a result, the Yorubas are likely to show either negative reactions or incorrect responses to questions about their sexual behaviour. This attitude may have discouraged many scholars wishing to study the Yoruba's sexual behaviours.

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Another common problem relates to the stigma attached to certain sexual behaviours especially homosexuality. Homosexuality is considered sinful by some, unnatural and sickly by others. In California, USA for example, results of a poll showed that 40 percent of fundamentalist christians believed AIDS is a punishment from God for homosexual lifestyle (Mariasy, 1988). In many African socieities, homosexuality is a difficult behaviour to study, as it is a taboo subject and very few Africans self-identify as homosexuals (Johnson and Pond, 1988). As a result of this negative attitude to the behaviour, not much attention has been focused on the homosexual sexual lifestyle.

Apart from the stigma attached to homosexuality, methodological factors may have served as other impediments to studies on sexual behaviour. According to Johnson (1970), because of its sensitivity, people tend to answer questions on their sexual activities in ways that reflect norms prevailing in the society. In other words, people seldom reveal sexual behaviour that represents a deviation from the approved pattern of sexual behaviour. This raises the question of validity and reliability of the data that depends on respondents' honesty about their sexual behaviour.

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Finally, Reiss (1967) pointed out that some investigators may have been discouraged from studying human sexuality because of the belief by some scholars that such studies will have little practical application to human societies since sexual activities are so commonplace. Consequently, information about human sexuality is often obtained through indirect indices such as marriage, fertility and infertility rates and the prevalence of STDS (Johnson end Pond, 1988).

Approaches to Research on Behavioural Aspect of AIDS

Research methods are of two basic types, namely, quantitative and qualitative methods. Quantitative methods use numbers to measure the variables being investigated. Surveys are good examples of studies that use quantitative methods. Survey data are systematic, standardised and easily aggregated for analysis (Patton, 1980). By contrast, qualitative methods rely on words and description of situations, events and observed behaviours being investigated. Example of qualitative methods include participant observation and focus group discussion. As Patton (1980) noted, qualitative data are often long, detailed and varied in content.

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Both quantitative and qualitative methods have been used by investigators for cata collection in AIDS research. Investigators have used the former to gather certain kinds of data, mainly those that relate to knowledge and attitude on AIDS. For example, Hubley (1988b) reported Feldman and other authors as having conducted a survey in which 33 visitors to a hospital in the capital of Rwanda were formally interviewed, using a questionnaire, to elicit their perception on AIDS. Result of the study revealed that only a third of the sample could correctly state the mode of transmission of the AIDS virus and only half could mention a single symptom of the disease. In addition, although many of the respondents admitted that they were frightened of AIDS, none reported to have changed their sexual behaviour. The results of a similar survey conducted in the United Kingdom a year after the introduction of the billboard caption "AIDS - Don't Die of Ignorance" show that 93 percent of the respondents were informed about AIDS and its routes of transmission. Yet, up to half of the 16 - 24 year year age group surveyed said the absence of a condom would not prevent them from having intercourse (Mariasy, 1988).

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Surveys such as the ones described above are useful in providing the necessary background information on the levels of knowledge and awareness on AIDS of the population and the need for health education intervention, but they may not provide sufficient insight on risk behaviours on which health education planning can be based.

One major limitation of quantitative methods regarding AIDS research is that the surveys used to gather such information on AIDS may not yield reliable data on risk behaviours especially those that are stigmatized, socially proscribed and covert, for example, homosexual and intraveneous drug injecting behaviours (Coxon and Carballo, 1989). This is likely to be the case since quantitative approaches usually involve use of questionnaires which is a formalised interview. Because the activities of homosexuals and intraveneous drug users are secretive and socially invisible, Coxon and Carballo (1989) have advocated for the use of qualitative methods to collect reliable and valid information on the groups' behaviour. In addition, quantitative methods may not be suitable for the collection of information on another risk behaviour,

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namely, prostitution, since very few women identify themselves as prostitutes (Johnson and Pond, 1988).

Many social scientists agree that qualitative methods are well suited for the collection of data on the risk behaviours on AIDS (Hubley, 1988b; Schoepf et al, 1988; Green, 1988). Green (1988) specifically advocated for the use of qualitative methods like key informant interviews, focus group discussions and direct observation to gather information on AIDS. According to the author, the use of these methods is likely to yield detailed and indepth information on the social and cultural context of risk behaviours and the belief systems that underlie them. The author concluded that such detailed information are essential for the selection of effective strategies that may influence the risk behaviours. Qualitative methods are capable of generating indepth information because, unlike quantitative methods, they afford the investigator an opportunity for indepth probing.

The results of the study conducted by the CONNADISA group (Schoepf et al, 1988) in Zaire exemplify Green's (1988) view point. A combination of group discussion and indepth interviews was used to elicit

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information on the perception and reaction of people to AIDS. Results revealed the deep seated socio-cultural and psychological barriers to condom use. The insights gained on risk behaviours became useful in the selection of intervention strategies.

Des Jarlais et al's (1985) study among IVD users in a New York City (USA) neighbourhood is another example that reinforces Green's (1988) argument. The authors conducted indepth interviews and observations for 18 IVD users who were not in treatment. Results of the study revealed that all the IVD users have heared about AIDS and believe that it was spread through needle sharing. They reported an increase demand for new needles as a result of AIDS but stated that the critical factors in sustaining increased use of new needles were not only the intentions of the drug users but also the availability of new needles at the appropriate time.

The discussion above has implication for this study. The major aim of the study is to gather detailed information on potential risk behaviours that may favour the transmission of AIDS in a rural community in order to develop culturally relevant educational

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programmes aimed at controlling the spread of the disease in Nigeria. Since health education planning on AIDS demands more than the broad and superficial results characteristic of quantitative methods (Ramakrishna and Brieger, 1987), qualitative methods are better suited for the collection of such information.

In addition, the sensitivity surrounding human sexuality especially among the Yorubas, who seldom discuss the subject publicly (Ademuwagun 1976; Olusanya, 1967) calls for the use of qualitative approaches to gather reliable data on sexual behaviour. As Hubley (1988b) noted, the taboos surrounding human sexuality impose severe limitations on the use of simple interview and questionnaires to obtain valid information on sexual practices. For the reasons aforementioned, qualitative methods were used for the data collection in this study.

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CHAPTER THREE

METHODOLOGY

Description of the Study Area

The major aim of this study is to collect indepth information on practices that may favour the transmission of AIDS in a rural community in order to plan appropriate and culturally relevant health education programme aimed at controlling the spread of AIDS in Nigeria. Qualitative methods are better suited for the collection of such detailed information (Ramakrishna and Brieger, 1987). But qualitative studies take a considerable long time to accomplish (Pickering, 1988; Hubley, 1988b). To overcome the problem of time limitation of the Master of Public Health (MPH) programme vis-a-vis use of qualitative methods, it was considered necessary to study a community with which the investigator is familiar. Thus, Ago-Are, the investigator's home town, was chosen as the site of this study. The choice of a familiar community has

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some advantages. Stephenson and Greer (1981) indicated that investigator's familiarity with a culture not only help speed up the process of data collection but also enhance the correct interpretation and meaning of such data.

Ago-Are is a rural Yoruba community in Ifedapo Local Government Area of Oyo State, Nigeria. Situated approximately 170 kilometres North of Ibadan City, Ago-Are is bounded on the North by Saki, on the East by Tede, on the West by Iranwo and on the South by Sabe.

According to the 1963 Census, Ago-Are had a population of 8,215. Using the annual growth rate of 2.5 percent, the projected population of the area for 1988 is 15,230.

Ago-Are is traditional in its ways of life, adhering to many of the norms and values of the traditional Yoruba society. For example, the traditional pattern of communication whereby a town crier disseminates information predominates in the community. In addition, kinship ties based on blood and marriage are very strong in the community. Finally, there is respect for seniority based on age. In Ago-Are, it is the rule rather than the exception that a junior defers to elders in all matters and in all activities.

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In Ago-Are, the base of most economic activities is agriculture. Men are predominantly subsistence farmers and cultivate mainly food crops, namely, yam, cassava, maize, and groundnut. Tobacco, which is the only cash crop in the area, is grown by a few farmers. Women are mainly petty traders and sell basic food items like vegetables, pepper, tomatoes, palm oil and salt. The farm products are sold in three of the markets in Ago-Are. The first, a local market called Oja Bale Ito, holds everyday. The second, a centralised market called Oja Sango, is bigger and more organised. It holds every fifth day and attracts traders from neighbouring towns and villages. The third, a night market called, Oja Oba, is located in front of the Oba's palace. Buying and selling activities in Oja Oba are conducted with the aid of kerosene lamps. The common traditionally hereditary occupations in Ago-Are are blacksmithing, soap making and drumming.

Ago-Are is a homogeneous community comprising predominantly Yorubas who live in extended family compounds. The people speak "Onko" dialect of Yoruba language. There are however, other Nigerian ethnic groups living in the area including the Igbos, the

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the Hausas, the Igedes, the Fulanis and the Idomas. The non-Nigerians living in the area are from Ghana and Republic of Benin. The proportion of these two groups is low with none of them numbering up to 50. The Igedes are in the majority among all the non-indigenes.

The non-indigenes in Ago-Are engage in different economic activities. The Igedes and Beninoise, for example, are mainly farm labourers. Majority of the latter live in the satelite farm hamlets of Ago-Are where they work for indigenous farmers. Some of them especially those who have lived in the area long enough to develop stable relationships with the indigenes, own farms. Mostly males, some of the Beninoise are married with their families living with them at the hamlets. The Beninoise usually come to Ago-Are mostly on market days and on Sundays.

By contrast, the Igedes live mostly in the town from where they move to the farms to work everyday. Only few of the married Igedes have their wives and children with them. The Igedes are generally more mobile then the Beninoise. The former arrive in Ago-Are at the onset of the rainy season in March/April

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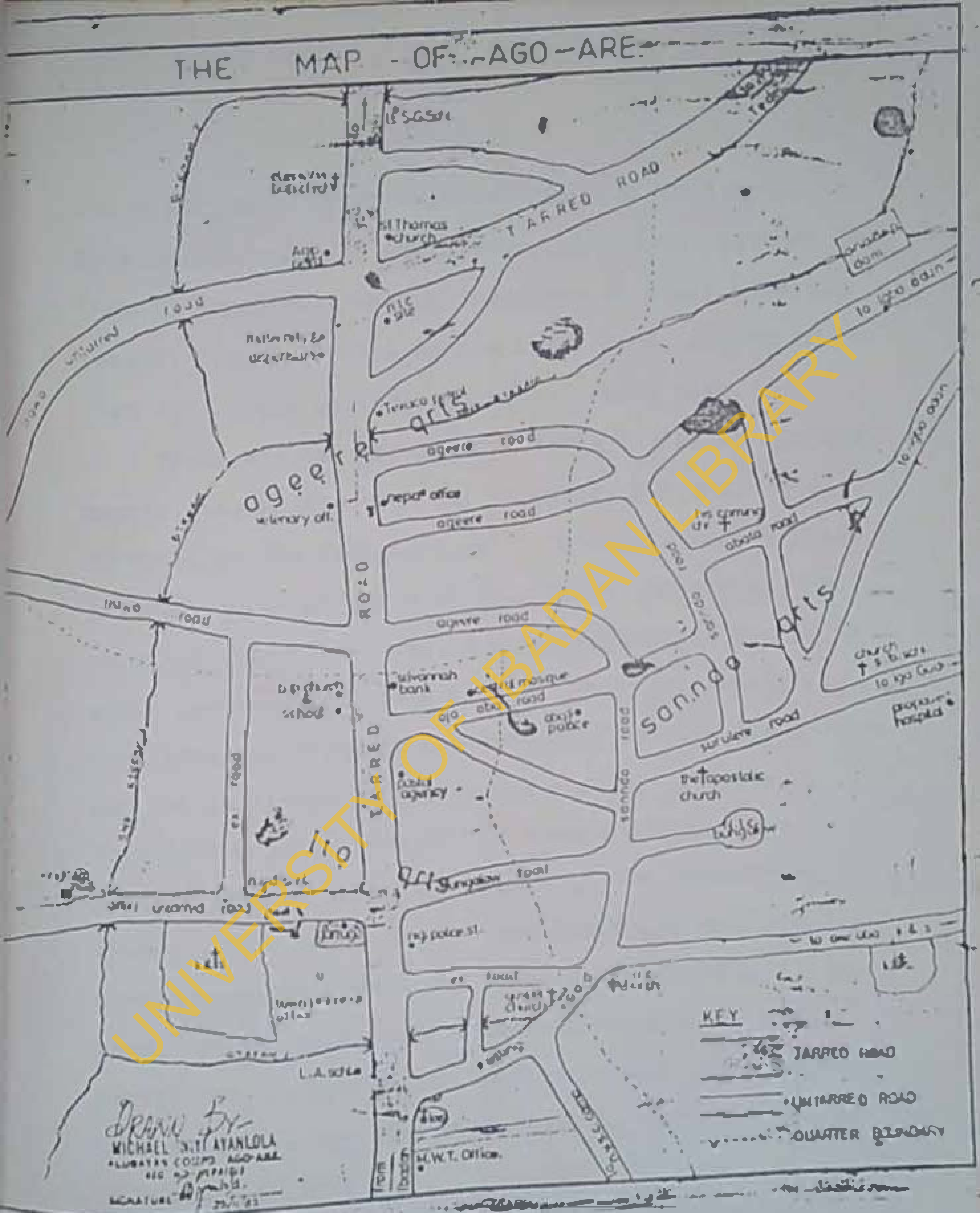

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and return home after the harvesting of food crops in November/December of every year. It is not unusual for them to frequently change locations at every planting season. The Beninoise on the other hand, remain in the town for longer periods before returning home.

There are two groups of Fulanis living in Ago-Are, namely, the nomadic and the Sedentary Fulanis. The Bororos, as the indigenes refer to the former, migrate from the Northern parts of Nigeria to Ago-Are at the onset of the dry seasons, around October, in search of green pastures for their cattle. Over the years, an unhealthy relationship has developed between the Bororos and the indigenes of Ago-Are as a result of alleged destructive activities of the Bororo's herd. The Bororos live in makeshift camps in the surrounding bushes of the town. Bororo men graze the cattle while Bororo women hawk milk and other dairy products in the town. As the next rainy season approaches in March/ April, they return to the Northern areas. This pattern of movement is repeated every year by different groups of nomadic Fulanis.

The sedendary Fulanis, on the other hand, are relatively more stable. Like the Bororos, they also own cattle. But unlike the Bororo's they engage in

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farming activities. In addition, they live in permanent structures built with mud. Although there has been attempt at social integration between the indigenes and the sedentary Fulanis through inter-marriages, there is still considerable spatial segregation between the two groups. The Sedentary Fulanis live at the outskirts of Ago-Are.

The Ghanaians in Ago-Are are mainly mobile shoe menders. Mostly males, many of the Ghanaians are not married. They usually travel to neighbouring towns and villages seeking patronage. Many of the Ghanaians have previously worked as shoe menders in different parts of Nigeria before moving to Ago-Are. The Igbos and the Hausas are fully integrated into the local social system and are living permanently in Ago-Are. Most of them are married. The Igbos are mainly petty traders while the Hausas engage in butchery and other petty trading.

In the event of ill health, people living in Ago-Are have a variety of health services option to choose from to cure their diseases. First, there are modern health facilities including a Local Government Dispensary and a Maternity as well as three privately owned

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health facilities (two clinics and a maternity). The dispensary and maternity are staffed by trained community Health Assistants and Staff Midwives respectively. Both facilities suffer from a chronic shortages of drugs and inadequate basic health equipments. As a result, patient utilization of the two facilities is poor. Although one of the clinics has a resident physician and is often well stocked with drugs, consultation fees are high. The privately owned maternity has almost folded up on account of lack of patronage. The second clinic was opened shortly before the end of this study, therefore, the kind of patronage it will receive from the people is yet to be seen.

Because of the high consultation fees charged at the first clinic, people make use of it only during periods of emergencies. To treat perceived minor ailments, many prefer the services of patent medicine sellers, who, in addition to selling drugs, prescribe, dress wounds and administer intramuscular injection to their clients. There are ten of such patent medicine sellers who move from one compound to the other soliciting patronage. In addition, some of the patent

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sellers occasionally travel to many of the surrounding hamlets to provide health services to the people living there.

Traditional medicine flourishes in Ago-Are. Two groups of healers provide health services to the people. The first, locally called "alagunmun," sell mainly herbs and other concoctions meant to cure ailments like dysentery, malaria and gonorrhea among others. There are five of such sellers, who either hawk their wares along the streets or make occasional calls at compounds seeking potential clients who might need their services. The second group of healers provide both preventive and curative services. Unlike mobile sellers who hawk their wares, clients go to their homes for consultation. There are about 20 of such healers in Ago-Are.

Like in most rural Yoruba communities in Nigeria, the basic housing unit in Ago-Are is the traditional extended family compound called "Agbole." A compound is a cluster of houses built by members of the same patrilineal lineage. All members of a compound except those admitted into it by marriage are paternally related to one another. Each house in a compound is typically occupied by father, his wife/wives and their

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children. The eldest male is usually the head of the compound and he is called "Baale," meaning father of the house. As Fadipe (1970) pointed out, being the leader, the "Baale" is expected to maintain order, peace and discipline in the compound. A typical house in Ago-Are is designed in a way that allows the construction of an overhead loft where grains and food crops like yam and yam flour are stored. In addition, domestic animals like pigs, goats and chicken are reared and these are a common feature in many compounds. Another typical feature of housing pattern in Ago-Are is the presence of "Odan" tree in front of many houses. In the years gone by, the trees were used mainly to dermacate landed properties. These days, however, their main utility lies in the shade they provide for relaxation in the afternoons and evening periods. Finally, each house in Ago-Arc, is linked with the other through a network of foot paths which make it convenient to move from one house to the other.

In Ago-Arc, the leadership structure is monarchical. The "Aree" is the traditional ruler of the area. The town is divided into three wards, namely, Agere, Ito and Sando each of which has its own traditional leader.

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The traditional title of the leaders of Agere and Ito is "Baale" while Sando has the "Agoro." The position of the "Aree," "Baale" and "Agoro" are hereditary and are often designated ruling houses.

Historically, the indigenes of Ago-Are are unanimous about their claim of Oke-Iluku (Iluku mountains) as their place of origin. According to oral history, the ancestors of the people migrated from different parts of Yorubaland to Iluku mountains because of the protection it offered to the people during the frequent intra and intertribal wars that characterised the pre-colonial era. With the coming of the colonial masters however, the incidence of the wars reduced considerably such thot people left the mountain area and settled elsewhere. Under the leadership of a warrior named Aree Laniya, the people migrated from the area, and after brief sojourn in different locations, finally settled at the present location of the town. Upon arrival there, the people initially lived in camps. Now, in those early days such comps were identified by the name of the leader of the people who occupied them. Thus with time, the camps came to be identified as Ago-Are, meaning Are's camps or Are's settlement.

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In Ago-Are, there is a long standing tradition of forming associations, called "Egbe." These associations are formed mainly to promote the common interests of members in the field of occupations, religion and recreation. In Ago-Are, it is the rule rather than the exception for people to belong to at least one association. One typical feature of these associations is that they are formed along gender lines. Except for religious associations that often include spouses, most others are exclusively male or exclusively female. Members derive certain benefits from their membership of an association. For example, it is customary for members of an association to contribute money which is given to a member who intends to host ceremonies like funeral, child-naming or house warming.

Most homes in Ago-Are have access to potable water. Potable water is obtained from two main sources, ten public taps located at strategic points in the town and from privately dug wells in compounds. Piped water is supplied from Owo Dam, a joint project between the community and the then Oyo North Agricultural Development Project (ONADEP). Other facilities in the area include, two secondary and four primary schools. Finally, the

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three main religions in Nigeria, African Tradi-
tional Religion, Christianity and Islam flourish
in Ago-Are.

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OBJECTIVES OF THE STUDY

Certain broad sets of practices have been linked to AIDS transmission in other communities and countries. This study is aimed at identifying and determining the nature and extent of practices that are potential routes of AIDS transmission in a rural community where no cases of AIDS have been reported.

This approach is aimed at facilitating the development of primary prevention interventions.

The objectives of this study are:

1. To identify sexual practices that carry potential risks of transmitting AIDS.
2. To identify and describe marriage and divorce practices that carry potential risks of transmitting AIDS.
3. To identify and describe traditional blood contact practices that involve use of skin piercing instruments.
4. To describe the conditions under which the operations of blood contact practices are carried out.

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5. To document reported levels of such practices in the study area.
6. To determine the social and cultural factors that may influence the above practices.
7. To discuss the implications of these findings for health education planning on AIDS.

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RESEARCH DESIGN

The study is both exploratory and qualitative in nature. Using the anthropological technique of participant observation, the investigator participated in the daily activities of people in Ago-Are from February to April, 1989. Participation in normal community activities afforded the investigator the opportunity to closely observe natural community processes. This facilitates the identification of practices that carry potential risks of spreading AIDS as well as the factors that influence them.

SCOPE OF THE STUDY

The AIDS pandemic poses a major problem to the health of individuals, families, communities and nations. Behaviours play a crucial role in the transmission and spread of AIDS around the world. Two types of behaviours have been implicated in the transmission of the AIDS virus, namely those relating to sex and those relating to blood contact (Mann, 1987). In addition, the AIDS virus may also be transmitted from an HIV

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infected mother to her baby before, during or immediately after delivery (Mann, 1988c).

The study focuses only on the behaviours relating to sex and blood contact that carry potential risks of spreading AIDS in a rural Yoruba community. The study also investigated the social and cultural context in which these two behaviours occur with a view to developing culturally relevant health education strategies that can influence them.

INSTRUMENTS AND METHODS OF DATA COLLECTION

Multiple data gathering instruments were used to collect data for this study including interview, observation, records and discussions.

Data Gathering Methods

Key Informants Interview

The key informant approach is one of the data gathering methods commonly used to obtain information in community diagnosis (Digman and Carr, 1981). The aim of the use of key informants was to identify individuals in the community who can supply reliable

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information on the nature and extent of the sexual, blood contact and marriage and divorce practices being investigated. As Barrett (1984) pointed out, the rationale behind the use of informants for data collection is based on the premise that:

> Every individual who has been socialized and has hence learned the customs, rules and behavioural norms of the society, possesses a store of knowledge that the fieldworker can profitably tap into.

Opinion leaders in Ago-Are are generally people who are very knowledgeable about community values, norms and lifestyle. In Ago-Are, opinion leadership is based on certain general criteria. Some of the commonly used criteria are, leadership of association (egbe), leadership of religious groups, leadership of professions. This is in addition to certain formal leadership positions that exist in the community. Since opinion leaders are knowledgeable members of the Ago-Are community they served as the key informants for this study. The aforementioned general criteria were used for the selection of informants.

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Leadership of Association

Informants selected using this criterion are the leaders of the biggest male and female associations in Ago-Are. The first is the "Baba Egbe" (leader) of "Egbe Iwa Bi Olorun," a convival association started in 1957, comprising of about 50 young married men. Second, is the "Iya Egbe" (leader) of "Egbe Omowumi," another convival association, comprising of about 40 married women.

Leadership of Religious Groups

The leaders of each of the three religious groups in Ago-Are were selected using this criterion. These are the christion and moslem religious leaders as well as the "Areoja," the leader of the adherents of African traditional religion in Ago-Are.

Leadership of Professions

The court clerk of the Grade C Customary Court in Ago-Are was selected as a key informant because he posseses specialised information on Yoruba divorce practices. Two "ololo," who perform the operation of many blood contact practices that involve use of skin piercing instruments in Ago-Are were selected as key

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informants because of their specialised knowledge on these practices.

Formal Leadership Positions

The holders of two of the most influencial positions were selected as key informants using this criterion. The positions are that of the Chairman of Ago-Are Ifelodun Union (a union established in the early 1960s to which all indigenes of Ago-Are belong) and that of the "Iyalode," the leader of all women groups in Ago-Are. The informants are referred to in this text by the positions they occupy in the community. A detailed biography of each of these informants is contained in Appendix I.

The investigator personally conducted in-depth interviews for all the key informants. A general interview guide (see Appendix III) was used for all interviews. The items in the interview guide focused mainly on sexual, blood contact and marriage practices. Yoruba language was used during all interviews while questions were framed in an open-ended fashion. Furthermore, all interviews took place in the informants' houses and at a time convenient for them.

As for the interview of the "olola" and the Court Clerk, two separate interview guides (see Appendix III)

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were used. The interview of the Court Clerk took place inside the court premises after court proceedings. The interviews for the "olola" were held in Ago-Are and Tede.

Other interviews conducted were for persons whose divorce pleas were heard at the Customary Court during February through April, 1989 (see Appendix III).

Participant Observation

Observation was a supportive instrument for data collection. The investigator participated in the operations of blood contact practices carried out by the "olola." The main objective of the observations was to determine the condition of the instruments of operation before and in-between use. Observation was also aimed at determining the possibility, or lack of it, of the transfer of blood between, the operator and the clients, on one hand and between clients on the other. A guide was used to record the pre- and post-operation procedures (see Appendix III).

Non-participant observation methods was also used. The investigator observed the proceedings at the Customary Court which sits every Tuesday morning. Observation at the court was aimed at gaining insight into the

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nature of divorce practices in the community. In addition, observations were made of the activities of prostitutes living in Idera Hotel. This action was aimed at determining the nature of client patronage of the prostitutes.

Observations in the hotel took place in the morning and evenings for one hour each on Mondays, Wednesdays and Sundays.

Observations were recorded in field notes. Three types of field notes were used. Mental notes were used for the operations of blood contact practices. Jotted notes were used to record proceedings at the court and activities at the hotel while a comprehensive note was used for all observations and these were written shortly after the events to avoid problem of recall.

Review of Records

A review was made of documented civil cases heard between 1982 through 1988 at the Customary Court. This step was aimed at determining the total number of divorce cases recorded annually, sex of persons who initiated divorce action and the reasons often cited for divorce.

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The focus on divorce stems from the premise that divorced women are more likely than married women to enter into casual sexual relationship (Schoepf et al, 1988; Brokensha et al 1987; Cohen, 1969). Moreover, previous studies showed that there is a high incidence of divorce and remarriage among Yoruba women Lyoyd, 1968; Sofoluwe, 1965; Okediji and Okediji, 1965). Since these studies were conducted many years ago, it was considered necessary to review past records with a view to determining the current status of divorce practices in the community.

Focus Group Discussion

Focus group discussion was used as a diagnostic tool to gain insight into the social and cultural factors influencing the behaviours identified as having potential risks for the transmission of AIDS in Ago-Are.

Folch-Lych and Trost (1981) defined focus group discussion as:

> ... a discussion in which a small number (usually 6 to 12) of respondents, under the guidance of a moderator talk about topics that are believed to be of special importance to the investigation.

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Based on the findings made through interviews, observations and record review, a guide was developed for the discussions (see Appendix IV). The discussions focussed on seven broad issues namely, premarital and extra-marital sexual relationships and prostitution. Included also are polygyny, divorce, circumcision and finally evaluation of participants' level of awareness of the potential risks involved in the practices above. The specific questions asked during group sessions were first drawn in English Language and were later translated into Yoruba Language.

Focus group discussion was used for data collection not only because the group forum provides an atmosphere where sensitive topics, like human sexuality, can be discussed freely but also an opportunity for depth probing (Folch-Lycn and Trost, 1981). Such opportunity for in-depth probing is likely to produce detailed information that is necessary for the planning of health interventions that will be effective, acceptable and successfully implemented (Basch, 1987).

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Sampling Procedures

Between 6 - 8 persons participated in each group session. As suggested by Kruger (1988) and Folch-Lyon and Trost (1981), a purposive sampling procedure was used to recruit participants. Thus, a homogeneous group was recruited for each session. Group homogeneity was in terms of sex, marital status and religion. The use of homogeneous groups was aimed at encouraging participants to discuss freely during sessions since people are likely to disclose their behaviour and attitudes in company of people with whom they share similar attributes (Folch-Lyon and Trost, 1981). In all, twelve sessions were conducted. Three male groups were recruited from the population of bachelors, one each from Christian, Islam and Traditional religions. Three female groups were recruited from the population of spinsters from the three religions. The same procedure was adopted for married men and women.

Six trained volunteer high school graduates assisted the investigator in the recruitment process. Two volunteers served as assistant recruiters in each of the wards. Out of a total of 50, five family compounds were

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randomly selected in each of the wards. Persons aged 15 years and above were recruited as potential participants. In an unobtrusive manner, the names, sex, marital status and religion of such persons were noted during visits to the randomly selected compounds.

The names were then compiled and matched for sex, religion and marital status. Matched participants were then invited to take part in group discussions.

The topics to be discussed were not disclosed during the recruitment process so as not to sensitize participants to the issues of discussion between the period of invitation and actual group session.

Potential participants were told that the discussion would centre on certain Yoruba practices and that the aim of the exercise was to collect information which will be used for research purpose.

Mode of Conduct of Each Session

Each group session was conducted by trained moderators who introduced and directed the discussion of the topic using a guide (see Appendix IV). A male and a female moderator conducted sessions for groups of their

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own sex. This step was aimed at reducing biased responses since discussions focused mainly on sexual behaviour which Yorubas seldom discuss publicly especially with someone of the opposite sex (Adėmuwagun, 1976; Olusanya, 1967).

The moderator's training focused on the following issues; introduction and purpose of group discussions; development of the following skills; depth probing through use of follow-up questions', techniques of ensuring full participation and listening. Training also included how to keep discussions focused through use of the guide, timing and level of contributions from moderators.

The female moderator is aged 30 years, married and holds the Teachers' Grade II Certificate. She was considered suitable to moderate group sessions because of her experience in group process at the First Baptist Church in Ago-Are. The male moderator is aged 36 years. He is married and holds the Teachers' Grade II Certificate. He was chosen as a moderator not only because of his experience in group activities in the town but for his good sense of humour.

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Tape recorded sessions lasted not more than two hours. Participants' consent was sought before actual recording started. The investigator assisted the moderators with the conduct of each session by welcoming participants' to the venue of discussions, operated the tape recorder, observed pattern of responses noting non-verbal communication and recorded pertinent quotations. Light refreshments (biscuits) were served during sessions.

The sitting room of a house served as the venue for all discussions. The place was considered suitable not only because the house was located in a quiet part of the town where there is little noise and distractions but also because the furniture in the room afforded the opportunity of face-to-face sitting arrangements. Finally, a pilot test was conducted before the documented tape recorded sessions started.

Method of Data Analysis

The data for this study are presented mainly in a descriptive form. Findings from key informant interviews were cross compared, and described with appropriate quotations presented to buttress some points.

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A detailed description of the pre- and post-operations procedures constitute the data for participant observations. Findings of the review of records are presented with the aid of frequency tables.

Data from the focus group discussions were first transcribed and then translated from Yoruba into English Language. These were then coded and analysed. Verbatim quotes that reflect participants' knowledge and attitude were also presented.

Reliability and Validity

A number of procedures were taken to enhance the validity and reliability of the methods used for data collection. To teat for general reliability, the investigator constantly cross-checked information by asking informants the same questions.

Through participant observation, the investigator was able to compare reported and actual behaviour.

Furthermore, focus group discussion was pilot tested. The test was aimed at determing the adequacy of moderator procedures especially probing skills, the suitability of the venue and the adequacy of the

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alloted time for discussions. At the end of the exercise participants were requested to suggest ways of improving the conduct of subsequent sessions. As a result, the sequencing of the questions were rearranged. The questions on circumcision were asked first instead of questions on premarital sexual relationships that was originally proposed.

The use of multiple data collection methods enhanced considerably, the overall validity and reliability of the data collected.

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CHAPTER FOUR

FINDINGS

The findings of this study are presented in three parts: sexual practices; marriage and divorce practices and blood contact practices.

Sexual Practices

Prostitution: Data from Observation and Informal Interview

There are nine female prostitutes in Ago-Are. Of this number, five live in "Idera Hotel" while the remaining four live in rented houses at two separate locations in the town. Six of the prostitutes are from non-Yoruba speaking areas of Nigeria, one is a Yoruba while the remaining two are Ghanaians. A fee of ₦2.00 is charged by the prostitutes living in the hotel for each sexual encounter with a client while a fee of ₦10.00 is paid by clients who want all night sexual experience euphemistically called "Day Break Service" by the prostitutes. "Day Break Service" is provided

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either in the prostitutes' rooms in the hotel or at the clients' houses.

All the prostitutes in the hotel have previous sold sexual services to men in places like Lagos, Oyo, Saki, Irawo and Tede before settling in Ago-Are. Only one of the prostitutes has lived in the hotel for about a year. The prostitutes are patronised by clients mostly at nights, when they wear dresses that expose their bodies showing the brassiere. Each prostitute solicits by sitting in front of her room in the hotel.

Although both indigenes and non-indigenes patronise the prostitutes, greater patronage comes from the latter who reside in the satelite hamlets surrounding Ago-Are. While patronage from non-indigenes is generally open and undisguised, indigenes are discreet limiting visits to the hotel to night time only. Clients also come from neighbouring towns like Tede and Saki.

Patronage is generally higher on Sundays than other week days because Sundays are work free days for majority of farm labourers with many spending the day in town. Whereas on most of the week days each prostitute has an average patronage of 3 clients, each Sunday records an additional average of five. To determine the

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pattern of local patronage, each of the five prostitutes in the hotel was informally asked to mention the specific group of local people that patronise her. Four women implicated all groups, including the young, the old, the married and the single. The other woman, a Ghanaian, put her response this way:

> That is hard to tell because working is like being in a market where you sell to a lot of people. So, how can you know all the people who buy something from you? Sometimes, it is at night you cannot see who is it. You are working, you do not look at people's face before you provide service.

Observation revealed that the prostitutes are mobile. Two women left the hotel before the completion of this study. The first, a Ghanaian, left for Saki on account of disagreement with the owner of the hotel. The second, a Nigerian, left for Abu Simoni, a satellite hamlet of Ago-Are, on account of poor patronage. Shortly before the completion of this study, two other women arrived at the hotel. The first, a Yoruba woman had previously sold sexual services to men in Iseyin while

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the second, a non-Yoruba speaking woman, previously sold sexual services to men in Saki.

Informal interview further revealed that all the prostitutes in the hotel perceived themselves as being at risk of sexually transmitted diseases especially gonorrhea. To limit her risk of exposure, one of the women said she regularly visits a patent medicine seller who gives her injection every week. Three women simply said they depend on "family planning" especially tablets. The other woman said she treats herself by buying tablets from any patent medicine seller.

All key informants agreed that prostitution is a socially disapproved behaviour and consider any Yoruba man who patronises prostitutes as shameless. As the Moslem leader said:

> It is shameful for a decent Yoruba man to patronise these prostitutes. Although I am aware that one of them is a Yoruba, I still maintain that it is only Yoruba men devoid of shame who patronise them.

Prostitution: Data from Group Discussion

Participants identified drivers, non-indigenes and some local people as the clients of prostitutes in

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Ago-Are. Some participants said most drivers of public transport and their apprentices visit the prostitutes when they stop over in Ago-Are to buy agricultural products. As one participant observed "after arrival (in Ago-Are) and while they wait for their buses to load, they visit the prostitutes to relax."

Non-indigenes, especially farm labourers and other foreigners like Ghanaians and Beninoise were also implicated. Among indigenes, married men and others who are either physically or mentally handicapped were also identified as clients of prostitutes. As one participant said, prostitutes serve as a last resort for the handicapped since "they (prostitutes) are like traders who welcome everybody."

Speaking about the pattern of patronage, one participant commented this way:

> In terms of not hiding it, not being shameful and regarding it as normal, the non-indigenes stand out as the clients of prostitutes in Idera (hotel). They regard visiting the prostitues as normal, even in the morning. But with we Yorubas, we may delay our visits till night time when we go

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there secretly. But to go there in broad daylight? Only few Yoruba men will attempt that except the Yoruba man is a visitor to this town.

Concerning factors influencing patronage, majority felt that non-indigenes do so because not all of them have their wives with them in Ago-Are. As one participant said:

> The prostitutes are not there to serve the Yorubas. They are there to cater for the (sexual) needs of non-indigenes whose wives are not here with them.

A similar comment was put this way:

> Some of these non-indigenes did not bring their wives with them and you know that sexual urge is like food to some people. Some of them cannot do without it in a week, so when they feel sexual desires, they go straight to the prostitutes.

Another factor cited was convenience. According to some participants, a man visiting a prostitute need not entertain fear of being detected. The participants said this is not true when men indulge in other types of extra-marital relationship.

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The cost of each sexual contact with a prostitute was also cited. Many male participants felt that indigenes who patronise prostitutes do so because it is a cheap way of satisfying their sexual desires. Furthermore, the tendency of some Yoruba men to desire a variety of sexual partners was also implicated as a factor influencing patronage. As one participant lamented "they (married men) will neglect their wives at home and visit the prostitutes."

Finally, lactation taboo that discourages sex during post partum was considered by some to predispose men to visit prostitutes. One participant gave an elaborate explanation this way:

> You know, it is not part of our custom to nurse a baby and have intercourse with our husbands at the same time. We have to wait until the baby is 2 to 3 years old. A man who does not have two or more wives cannot restrain himself for this long period. He may not tolerate it to sleep without sexual partner for long and he may even demand for sex from her who may refuse because the child is still small. So he may be forced to go to the prostitutes.

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Concerning the risks involved in prostitution, many participants considered prostitutes as the major source of many sexually transmitted diseases. Many participants (married men) mentioned the following diseases, that may be contracted through sexual contact with a prostitute: "wet" and "dry" gonorrhea, dry cough and AIDS. Other male participants (bachelors) also mentioned these diseases. Some female participants said prostitutes could make men smoke and drink excessively. AIDS was discussed in only three of the twelve group discussions.

The following comments were made in respect of the disease:

"AIDS is not a common disease among Yorubas. It was imported into the country by foreigners."

"Victims of AIDS die within 24 hours."

"AIDS has claimed more lives than those lost during the second world war."

"AIDS began through homosexual practices."

"Loss of weight is one of the signs of the disease."

"AIDS was introduced to the world as a form of divine intervention. It is a sign that the world is coming to an end."

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Some participants said the disease can also be transmitted through head shaving, food and from homosexuals. The sources of information on AIDS are newspapers and television.

Extra-marital Sexual Relationship: Data from Key Informant

Extral-marital sexual relationship, locally called "ale yiyan" is a common practice in Ago-Are. "Ale" refers to any person with whom one has sexual relationship other than one's legal spouse. "Ale" is nearly equivalent to the word "concubine," but both differ in the sense that "ale" refers to either a male or female whereas concubine refers to only females. Given this difference, coupled with lack of a suitable alternative English word, "ale" will be used in subsequent discussions.

Informants agreed that certain lactation taboos are observed in the community. In Ago-Are, sexual intercourse is discouraged during post partum because of the belief that semen could contaminate breast milk, render it sour, and consequently have a deleterious effect on the growth of the infant. It is also believed that since the abstinence rule is for the welfare of the

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infant, it is expected of the mother to abstain to ensure the survival and growth of the infant. Informants said the abstinence period lasted about 2 to 3 years in the past but that the period has reduced in the community in recent times especially among the young educated couples. The "Iyalode" and Iya Egbe," however, insisted that the period cannot be less than six months even among the educated couples.

Informants said the abstinence rule is not applicable to men in Ago-Are in the sense that they can seek relief through sexual outlets like polygynous marriage or extra-marital sexual relationship during post partum. During post partum, men in monogamous marriages who cannot abstain look for other women with whom they maintain regular sexual relationship until their wives' abstinence period is over when they resume normal sexual relationship anew.

Although men in Ago-Are may indulge in extra-marital sexual relationships while their wives abstain during post partum, they are nevbrtheless expected to be discreet when seeking "ale."; Men may have as many "ale" as they desire so long as they have the means of maintaining them.

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Men usually assist their "ale" in cash and in kind when the latter is hosting a party especially a funeral ceremony. In return, she provides him sexual favours.

All the male informants lamented over the costs of maintaining "ale" in Ago-Are in recent times. As the Moslem leader said:

> In those days it was not a big problem to have "ale," as little as three tubers of yams was enough to seduce and win a woman. But these days, it is money and more money. "Ale" demands all sorts of things from you, she would want you to give her financial assistance during naming ceremony, funeral ceremony, apprentice graduation ceremony and all what not.

In Ago-Are, women are less likely than men to engage in extra-marital sexual relationship during post partum. The possibility of an unwanted pregnancy and the fear of detection are two main reasons why married women are less likely to indulge in extra-marital relationship before the infant is weaned. The fear of a resulting pregnancy from such relationship and hence birth of "omo ale," a derogatory term meaning "ale's

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offspring" inhibits a woman's adulterous impulses. As a result, women who may want to have "ale" usually wait until they resume normal sexual intercourse with their husbands when it becomes difficult to detect them. According to the "Iya Egbe" and the Iyalode," it is only women who are willing to divorce their husbands who engage in sexual relationship with "ale" before the weaning period. Such women disregard abstinence rule only after they have been assured of marriage by their "ale."

Furthermore, both the "Iyalode" and "Iya Egbe" also pointed out that some women in Ago-Are wait until they become pregnant before having extra-marital relationship so as to ensure the paternity of their children while others wait until they reach menopausal age before they do so. Because extra-marital relationship is a strongly disapproved practice for married women in Ago-Are, they are said to be more discreet about such relationship than men.

In Ago-Are, men generally do not invite their "ale" into their homes because of the fear that their wives may either quarrel with them or follow suit. Instead they use either a friend's or a relative's house for dealings with their "ale."

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The major risk involved in having "ale" is "magun," (meaning do not climb). "Magun" is a traditional medicine believed to evoke fatal accident on a man when he is having intercourse with a woman on whom the medicine has been placed. As the three religious leaders pointed out, the magical substance causing "magun" is made exclusively by traditional healers in different forms, the commonest being that made in form of a waist band. The magical substance is unsuspectingly placed on a woman who is suspected by her husband to be indulging in extra-marital sexual relationships. The husbands of such women usually have immunity against the magical substance. All the informants agreed that "magun" is no longer common in Ago-Are. The moslem leader said the last time the incidence of magun occurred in Ago-Are was in 1982. The chairman, "Iya Egbe" and "Iyalode" said that instead of using "magun," men sue and claim damages from seducers at the Grade C Customary court in Ago-Are.

Extra-Marital Reltionships:
Data from Group Discussion

The first question asked about extra-marital sexual relationship relates to the extent of the practice in Ago-Are.

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The general reaction to the question was that although the practice is common in Ago-Are, it is not peculiar to the town. To illustrate this notion, a participant (married woman) used a Yoruba proverb that says "Obinrin to lo ko ti o lale kole nii aso tegbe ni" (a married woman without "ale" cannot own the dress of her peer group). "Aso egbe," a group uniform, was used metaphorically in this sentence. "Aso egbe" is an identity for social groups. Another general comment among married women was that although both men and women in Ago-Are indulge in extra-marital relationships, the women are generally more discreet than men in the conduct of such relationships. As one married woman put it:

> You know a Yoruba woman cannot have two husbands at the some time, that is impossible, she will have to hide one of them.

In addition, some married men and women cited anonymous examples in Ago-Are of women who have many children, none of whom resemble the other. This was thought to be a result of extra-marital sexual relationship on the part of the woman.

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The general pattern of response of bachelors and spinsters to this question was to cite anonymous examples of men and women whom they claim indulge in extra-marital relationships.

Concerning factors influencing the practice in Ago-Are, most women considered lack of adequate care by husband the major cause. Lack of care was the most frequently cited factor by all groups of women. Some of their typical comments include:

> It is not that married women are greedy as some men say. We are sometimes forced into it - the major cause is lack of care in the home.

Another married woman put her response this way:

> Sometimes were are unable to divorce our poor husbands and marry someone better off because of our children. Instead we combine the two, the "ale" will help us out and assist us in taking care of our children.

Other factors cited by women include lack of control on the part of some women and the love of money.

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On the other hand, many spinsters considered the corupting influence of peer group (married women) as the major cause of the practice. A few others mentioned lack of care.

The general response of male participants (both married and single) to the question was to blame women for the practice. Married men implicated the following factors: one, lack of restraint and perseverance. Men considered women to be easily seduced by money and other material things. Two, the desire to host elaborate funeral ceremonies. Some men claimed that in an attempt to host lavish parties some women befriend many "ale" so as to get a lot of money to finance the party. Three, corrupting influence of prostitutes. Some men felt that some women indulge in extra-marital sexual relationship and they may have done so to get a lot of money so as to emulate the ostentacious lifestyle of the prostitutes in Ago-Are.

There was a general feeling among bachelors that husbands themselves are sometimes responsible for their wives' indulgence. Many of them felt that some men in Ago-Are are not discreet enough in their relationship with "ale." As a result, their wives emulate them. A few other bachelors mentioned lack of care by husbands

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and the influence of Western civilization on women as other factors responsible for the practice.

Generally, most participants felt the practice is most common among Moslems whose religion is said to favour polygyny. Extra-marital relationship is said to be the first step towards polygyny. However, a few men felt that the practice is common among all groups in Ago-Are.

Majority of the participants considered extra-marital sexual relationships the most risky practice out of those discussed. The risks associated with the practice are "magun" and sexually transmitted diseases. "Magun" was considered dangerous because it leads to instant death. The sexually transmitted diseases mentioned are gonorrhea, which was said to be of various kinds, namely, the "dry," the "wet" and the "bloody" types, and a cultural disease called "jerijeri," whose symptoms include severe pains and genital perforation. Another risk associated with extra-marital relationship is its indirect influence on the welfare of married women. Some women felt that extra-marital relationship on the part of men often leads to the neglect of their wives.

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Casual Sexual Activity: Data from key Informants

Increased pre-marital and extra-marital casual sexual activity occur furing festive periods in Ago-Are. Such festive periods include Easter, Christmas, "Egun-gun" (festival of masquerades) and Eid-el-Kabir. The chairman said that sexual permisiveness predominates during these periods especially at Christmas. Several factors are responsible for this development. According to the chairman, there is a tradition of defering most ceremonies in Ago-Are till the Christmas season because of the following reasons: First, it is the most convenient time to finance such ceremonies since farmers would have harvested and sold their farm products. Second, with farm products already harvested, there is usually less work to do until the next planting season approaches. As a result, ceremonies like house warming, apprentice graduation and funerals are deferred to this period.

These ceremonies attract a lot of indigenes of Ago-Are living in towns and cities like Lagos, Ibadan and Ilorin as well as other surrounding villages who normally

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return home during the yuletide season. This facilitates casual relationship among the "home comers" and also between those living permanently at home and the home comers.

Furthermore, because men have more money to spend at this period, it is believed that they are likely to engage more in casual sexual relationships. Most casual sexual activities take place in one of the two hotels in Ago-Are. A room at "The People's Bar," available to customers for short period, facilitates this practice. A user fee of ₦2.00 is charged per one hour while ₦10.00 is charged per night. According to the Manager of the hotel, the room is mostly used during Eid-el-Kabir and Christmas periods.

Premarital Sexual Activity: Data from Key Informants

All key informants noted that pre-marital sexual activity is common in Ago-Are. The informants agreed that the traditional Yoruba custom that discourages pre-marital sexual intercourse is no longer observed in the community. Both the Christian and the Moslem leaders particularly lamented over increased sexual activity among secondary school students in the community. As

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evidence of the outcome of this behaviour, informants cited anonymous examples of young girls having illegitimate babies because the paternity of such infants were disputed.

According to the Christian leader, it is common place for boys to deny responsibility for pregnancies on the grounds that they could not be sure of the paternity of the foetus since many of them had sexual intercourse with such girls are regular intervals.

Other problems cited by informants include, increasing incidence of induced abortions that often lead to death and high dropout rate from schools among pregnant secondary school girls. In addition, high drop-out rate was considered to exert additional financial and social burden on the parents of girls with illegitimate children who have to cater for both mother and child.

Asked why the custom that discourages pre-marital intercourse is no longer observed in the community, informants attributed this to many factors including, love of money by young girls, corrupting influence of Western civilization, lack of control by parents and lack of restraint by both young boys and girls.

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Pre-Marital Sexual Activity: Data from Group Discussion

Participants were asked to comment on the sexually active behaviour of young unmarried persons in Ago-Are.

The general feeling of the participants was that this is a problem in the community. The social and health problems attributed to this pattern of behaviour are increase in the incidence of unwanted pregnancies and induced abortion undertaken by quacks often leading to death. The problem of unwanted pregnancies has also forced many girls into early marriages. High incidence of drop-out among secondary school girls was also mentioned as an outcome of the sexually active behaviour of students.

In particular, married participants (men and women) lamented over the general moral laxity among students in Ago-Are. Many of the participants spoke nostalgically about sexual norms in their youthful days when virginity and pre-marital chastity were highly valued. The following comments illustrate this feelings:

> In our days we go to the farm early in the morning and return in the evening very tired and exhausted: where is the energy

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> to run after girls? Whereas these days days boys and girls wake up in the morning take their bath and meet at a point (school), how will they not be sexually attracted to each other?

The other comment was put this way:

> In our days, if you are not well grown up, when you are already a man, your parents must not find you playing with a girl how much more of sleeping with one (euphemism for sexual intercourse). But these days small boys and girls have regular coitus and no one dare question them.

One of the factors identified as being responsible for the behaviour was lack of adequate parental care. This was the factor most frequently mentioned by spinsters. Many of them felt parents are not providing enough care for them. As one girl put it:

> When I ask for something (money) from my parents, may be I need it to buy a blouse or something that many of my friends already have and my parents cannot give

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me the money then I have to go to the person (boys) who can give me the money and I know that boys do not give something for nothing so I cooperate with them.

The second factor cited is the corrupting influence of parents whom the bachelors and spinsters accused of discussing their sexual exploits in their presence thereby inadvertently approving such behaviour. One bachelor illustrated the point with the Yoruba maxim, "Esin iwaju ni tii eeyin nwo sare" (a horse takes its cue from the horse ahead of it) meaning that parents set bad examples for them to emulate.

The third factor is peer influence. Some bachelors and spinsters remarked that some members of their groups are sexually active as a result of the influence of their peers. Some spinsters said it is customary among some groups of girls to call those observing the chastity and virginity rule old fashioned and uncivilised. A spinster used a Yoruba maxim to illustrate this point. She said: "aguntan to nb'aja rin yoo je gbee" (a sheep that befriends a dog will certainly consume rubbish as the dog) meaning that bad companionship may adversely influence a person's behaviour.

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Finally, the influence of urbanisation and civilisation particularly among students who regularly travel to cities during holidays was also mentioned.

On the other hand, married men and women identified four factors as being responsible for sexually active behaviour of young unmarried persons in Ago-Are.

The first is lack of contentment believed to be common among girls. Some men remarked that unlike their own days when they were easily satisfied with whatever their parents could afford, the reverse, they noted, is the case today. Many men said that their children are hardly ever satisfied with what they provide for them.

The second factor is lack of job opportunities to keep boys and girls busy especially the young school leavers.

The third is lack of restraint on the part of girls who are unable to caution themselves when boys make sexual passes at them.

Regarding the risks involved in pre-marital sexual activity, spinsters, men and women mostly mentioned unwanted pregnancies and neglect of babies as the possible outcome of this behaviour. A few bachelors

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implicated gonorrhea and AIDS. The specific comments made on AIDS has been discussed earlier.

Marriage and Divorce Practices

Polygyny: Data from Key Informants

Polygyny, the union of a man to two or more wives, is a common practice in Ago-Are. Informants are split on the proportion of men in Polygynous marriages in Ago-Are. Four informants, including the three religious leaders and the "Baba Egbe," agreed that the practice is more common among members of the Moslem community, the other three informants were of the opinion that the Practice cuts across the three religious groups.

Key informants cited various factors influencing the prevalence of polygyny in Ago-Are. All informants pointed out the influence of Islam as a strong motivating factor. It is believed in Ago-Are that Islam favours polygyny. The chairman mentioned the potential economic benefits as another strong motivating factor. Men tend to marry many wives so that the wives can assist them on the farm so as to increase their farm products thereby enhancing their economic prosperity.

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Furthermore, as the "Iyalode" and the "Iya Egbe" said, some monogamous men are encouraged by their wives to marry additional wives so as to reduce the burden of domestic chores on them. Sometimes, the wife takes this action in order to secure for herself the traditional privileged position of the first wife. The first wife, traditionally referred to as the "Iyaale" (mother of the house) is expected to be accorded respect by younger wives who in addition are expected to obtain her consent in all domestic affairs. Each wife in a polygynous union is given a separate room in the compound where she and her children live.

The "Iyalode" and the Christian leader mentioned the custom of widow inheritance as one of the practices that promote polygyny in Ago-Are. Widow inheritance refers to the custom whereby a junior brother inherits the wife or wives of a senior deceased brother. The consent of the widow is however, sought before she is inherited. The "Iyalode" gave a detailed explanation of the process of widow inheritance.

The process of inheritance is usually conducted by the "baale" in a compound after the widow has completed a mourning period of about five months. The junior

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brothers interested in inheriting the widow usually make their intentions known to the "baale" immediately after the mourning period. If she wishes to remain in the deceased's family and there are more than one person interested in inheriting her, the widow is then presented with a number of sticks (with explanations) each representing a brother of the deceased. She is expected to choose one stick representing the man whose wife she likes to be. After the choice, she is considered his legal spouse.

On the other hand, if a widow is not interested in being inherited or none of the junior brothers of the deceased wish to inherit her, she has to refund the bride wealth paid on her at marriage to the relative of the deceased before she can remarry.

Informants are split on the current prevalence of widow inheritance in Ago-Are. While the chairman, the "Iya Egbe" and the three religious leaders believe the practice is no longer common in Ago-Are, the other informants said it is common among the old and uneducated people in Ago-Are.

Finally, all the male informants mentioned the Yoruba traditional love for children as another factor

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that promotes polygyny in Ago-Are. It is customary for parents, especially female parents, to insist on their male children marrying many wives so that they can have many grand children.

Polygyny: Data from Group Discussion

Participants identified a number of factors influencing polygyny in Ago-Are, including the following

First, influence of Islamic religion. Many participants believed that the influence of Islam is a strong motivating factor for Moslems who are polygynous. The views of many Moslem men, however, diferred from that of other participants on this issue. The general feelings of Moslem men was that although polygyny was attractive to them in the past, it is no longer so in recent times. The response of a moslem participant illustrates this feeling. He said:

> In the past, polygyny was something prestigeous. But responsibilities were not as burdensome then as they are today. In those days, people go to farms and there was no schooling and feeding was not a problem.

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But today, polygyny is no longer attractive because of the responsibilities involved.

Female infertility was noted by some male participants who strongly felt that a situation in which a woman is unable to be pregnant calls for the man to marry another woman who will bear him children. Furthermore, some married women stated that some men marry a second wife so as to improve the undesirable behaviour of the first. This action is based on the assumption that a woman is likely to behave properly if she has a rival so that the two can compete for the man's attention and favours.

Divorce Practices: Data from Observation and Interview

Divorce cases involving customarily married couples are determined in Ago-Are at the Grade C Customary Court that sits every Tuesday morning. The "Are" "Baale" of Ito Ward and the "Iyalode" preside at each proceeding at the court.

The customary court uses the Marriage, Divorce and Custory of Children Adoptive Bye Laws Order of 1958 which listed the following matters for consideration

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by a customary court when making an order for the dissolution of marriage:

a. Betrothal under marriageable age.

b. Refusal of either party to consummate the marriage.

c. Harmful diseases of a permanent nature which may impair the fertility of a woman or the virility of a man.

d. Impotence of the husband or sterility of the wife.

e. Conviction of either party for a crime involving a sentence of imprisonment of 5 years or more.

f. Ill treatment, cruelty or neglect of either party by the other.

g. Venereal diseases contracted by either party.

h. Lunacy of either party for three years or more.

i. Leprosy contracted by either party and

j. Desertion for a period of two or more years.

In Ago-Are, although a woman has as much right as a man to take divorce action based on any of the reasons stated above, she may not base her plea for divorce on grounds of adultery. As the Court Clerk explained, a

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man who indulges in extra-marital sexual relationships for example, can easily defend himself by pleading that he intends to marry the woman. This is tenable since Yoruba Customary Laws permit polygyny. Men, however, could sue for adultery and claim damages from seducers. According to the Court Clerk, all that is needed as a proof of adultery is the woman's confession of having sexual intercourse with her seducer.

In Ago-Are, divorce actions are often taken by women. According to the Court Clerk, a divorce action on the part of married women is usually an outcome of previous extra-marital relationships. He cited two factors as being responsible for this.

First, the financial implications of divorce action by men often deter them. A man who divorces his wife is obliged to pay her an amount not exceeding ₦50.00 every month for her upkeep and that of the children, if there are any, until she remarries. In addition, such men are not entitled to demand for the refund of the bride wealth from the woman.

The second factor relates to the implications of divorce action on the woman's subsequent marriage prospects in the community. It is generally believed in

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Ago-Are that a man will take divorce action only as a last resort, to save his life from the evil machinations of a woman. As a result of this belief, women divorced by their husbands are stigmatised and usually find it difficult if not impossible to remarry since men consider them unsuitable.

As the Court Clerk further explained, such women usually leave the community for another area to start life anew. Therefore, instead of jeopardising a woman's prospects of remarriage by taking divorce action against her, a man who is no longer interested in the marriage is expected to ignore her and expect the woman to cater for herself within the extended family compound. In other words, the man refuses to perform his marital obligations on the woman. At this point, the woman may invite older members of the man's kin group to intervene and appeal to the man to change his attitude. If despite the intervention, the man's attitude does not change the woman is likely to start indulging in extra-marital relationship with the hope of finding another man who will be willing to marry and refund the bride wealth paid to the husband she is about to leave. Therefore, customarily married women are likely to take divorce

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action when they meet an "ale" who is willing to refund the bride wealth to their husbands.

Furthermore, the court clerk explained that the bride wealth is the money or goods brought by the bridegroom to the bride's kin at the initiation of marriage. He said it is the bride wealth that establishes the legality of the union. In the eventof a divorce instituted by a woman she is expected to refund the bride wealth paid on her to her husband. As the Court Clerk revealed although there are cases when women pay such refund from their purse, it is the rule rather than the exception that the refund is paid by the prospective husband. Prior to the actual divorce, the relationship between the woman and her "ale" is kept secret until the woman abscond to her "ale's" house from where she immediately initiates divorce action in court.

The husband is then served a civil summons by the Court. During the court proceedings, the husband is expected to enumerate his expenses on the woman including the bride wealth. This may be disputed by the woman and eventually an amount is agreed upon by the court. The Court Clerk said the duration of marriage is one of the factors considered in determining the

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the amount to be refunded and the amount decreases with years of marriage.

The prospective husband, who often does not appear in the court, is considered responsible for all the expenses incurred during the process of divorce. He is not expected to show up at the court to prevent the occurrence of open confrontation or fight that might have been engineered by the husband of the woman. Instead, he is represented by either a friend or a relative who pays all the husband's refundable fees and the Ago-Are Customary Court fees of ₦9.00 and ₦5.00 representing the summon fees and transport fare of the court messenger respectively.

Such money are handed over to the former husband. The refund thus represents the annulment of the old union and the beginning of a new marriage. The payment of this legally binds the new man and the woman. Consequently, it is the refund of the bride wealth that facilitates the circulation of women among men in Ago-Are.

However, it is not in all cases that insolvent disputes between customarily married couples end up with divorce at the customary court. As the Court

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Clerk revealed, in some cases, some women simply pack out of their husbands' houses and return to their natal homes. Such women are called "adalemosu" in Ago-Are. "Adalemosu" is a derogatory term for a woman who is separated from her husband and returns to live in her natal home. In Ago-Are, marital separation is a socially disapproved behaviour because it is believed that a married woman who separates from her husband does so because she cannot persevere the troubles of married life. These women are also believed to terrorise other married women in their natal compounds, hence they have been given the name "Ile mosu daleru," meaning one who has come to disturb the peace of the compound. In addition, these group of women are believed to be sexually active and change sexual partners frequently since they are not under the control of any man.

As the "Iya Egbe" revealed, the "adalemosu" in Ago-Are are free women and it is whosoever that is interested in them who visit her. Although all informants agreed on the sexual lifestyle of the "adalemosu" in Ago-Are, they are split on the proportion of such women currently living in the town. While three of the informants, namely the Christian and Moslem leaders and the "Iya Egbe"

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said there are many of such women in Ago-Are, the other informants said they know of only a few of them in the area.

Documentation of Divorce Cases

Records of civil cases at the Grade C Customary Court in Ago-Are were reviewed for the years 1982 through 1988. Data for 1985 was not available as the court was closed during this period. A total of 134 divorce cases were heard, of which 96.5 percent were initiated by women. A yearly average of 22 cases were heard with most (32) in 1988 and the least (7) in 1986.

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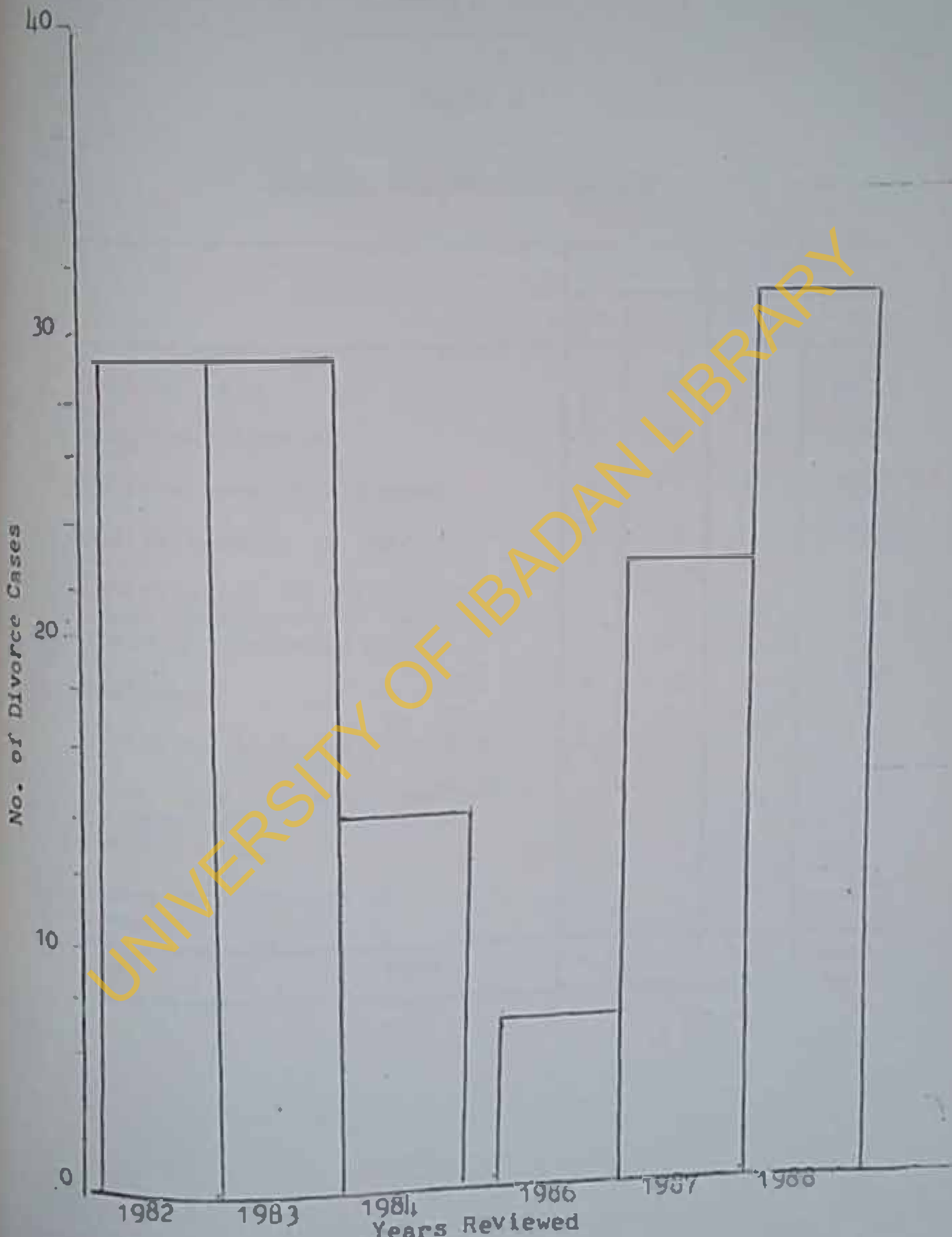
FIG. 1: Divorce Cases in Ago-Are, 1982-88



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Note: 1985 data are not available

TABLE 1

Reasons for Divorce by Sex

Reasons	Sex		Total	
	M	F	No.	%
Lack of care	0	66	66	49.3
Frequent fighting	0	34	34	25.4
No more love or interest	3	21	24	17.9
Untimely death of husbands	0	2	2	1.5
Cancellation of marriage contract on grounds of being under marriegeable age	0	2	2	1.5
Adultery	2	0	2	1.5
Inability to become pregnant	0	2	2	1.5
Going back to former husband's to take care of children begat to him	0	1	1	0.7
Claim of ownership of pregnancy	1	0	1	0.7
Total	6	128	134	100.0

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TABLE 2

Reasons for Divorce by Year

Reasons	Year						Total	
	1982	1983	1984	1986	1987	1988	No.	%
Lack of care	20	11	1	2	12	20	66	49.3
Frequent fighting	4	14	5	4	3	3	34	25.4
No more love or interest	1	-	6	1	8	8	24	17.9
Untimely death of husbands	1	-	1	-	-	-	2	1.5
Cancellation of marriage contract on grounds of being under marrie-geable age	1	1	-	-	-	-	2	1.5
Adultery	-	1	1	-	-	-	2	1.5
Inability to be-come pregnant	1	1	-	-	-	-	2	1.5
Going back to former husband's house to take care of children begat for him	1	-	-	-	-	-	1	0.7
Claim of owner-ship of pregnancy	-	1	-	-	-	-	1	0.7
Total	29	29	14	7	23	32	134	100.0

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Findings from interview of women whose Divorce Pleas were heard at the Grade C Customary Court

Five divorce pleas were heard at the customary court in Ago-Are during February to April, 1989.

All who initiated divorce action were females aged 35, 30, 27, 26 and 25 years. Two of the women mentioned neglect by husbands as reasons for divorce while the remaining three cited no children, no more love for my husband and no proper care from my husband respectively.

Three of the women had divorced two former husbands in the past while the remaining two had divorced one husband in the past.

All the women were in polygynous unions in their last marriages. Three of the women were going into a polygynous marriages, one into a monogamous marriage with her prospective husband not been married before. The fifth woman said she was not getting married to anybody.

One of the dissolved marriages lasted ten years, three lasted five years and one lasted six years. Only one of the women did not have children for her former husband. Three of the women gave birth to two children each while the last woman had one child for her former

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husband. Four of these children are with their fathers while one is with the mother.

Divorce Practices: Data from Group Discussion

Married women identified four factors why women take divorce actions.

One, lack of adequate care. This was the most frequently cited factor. Participants who identified this factor felt that once a woman is not properly catered for, it is almost inevitable for her to divorce her present husband and try another man with the hope that things might be better with the latter. As the explanation of a woman illustrates:

> A woman may divorce and remarry today and discovers that conditions in her new husband's house are worse than those in her former husband's house. Eventually, she has to try another place until she gets a good place where she remains.

Two, lack of perseverance. Some women felt divorce might be as a result of a woman's inability to persevere troubles normally encountered in married life. Three, sexual deprivation. In the opinion of

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a female (married) participant, some women might be forced to take divorce action if their husbands do not have regular intercourse with them especially when a woman is not nursing a baby.

Finally, it is believed by some women that forced marriage might lead a woman to hastily take divorce action.

Some married men and bachelors considered lack of peseverance as the major cause of divorce by women. As one married man said:

> A little trouble experienced in the man's house and the woman will pack her things to leave for another man's house.

Some men however, commented that divorce is more common in Polygynous marriages than in monogamous ones. As one man explained:

> If a man has only one wife he will not want to loose her and even the woman will not want to go (divorce). A man will do all in his power to cater for the woman so as not to loose her because if the woman divorce him people will ridicule him by saying "how shameful, he has only one wife and he cannot

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cater well for her such that she divorce him." He will be ridiculed by everyone. In addition, divorce is common in polygynous unions because men tend to marry more wives than they can adequately cater for.

However, some participants noted that frequent divorce and remarriage at the Customary Court is no longer common in Ago-Are these days because of the change in the mode of marriage in the community. According to a married man:

> There is no formal ceremony these days. The woman merely moves into the man's house and packs out when she is no longer satisfied with the man. Majority of the divorce cases (heard at the Customary Court) involved marriages that were formalised long ago.

As factors influencing divorce, spinsters cited lack of restraint by some married women, lack of adequate care and bad companionship.

The risks involved in divorce as identified by few male (married) participants relate to the harm a woman about to institute a divorce can cause her husband.

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Blood Contact Practices

Introduction

The following traditional blood contact practices that involve the use of skin piercing instruments exist in Ago-Are, male and female circumcision, facial and body scarification, ear piercing and uvulectomy. The investigator observed the operations of all the practices except uvulectomy. In Ago-Are, body scarification are of two types, one is made for medicinal purposes, locally called "gbeere," the other is made for beautification and locally called "enu abe."

The "olola" performs all operations except ear piercing, uvulectomy and "gbeere." Two of such "olola" were identified and they served as key informants. The "olola" live in Tede and occasionally make business trips to Ago-Are when their services are need. Occasionally too, other clients from Ago-Are go to them for services. At present, there is no resident "olola" in Ago-Are. According to the Moslem leader (himself a member of "olola" family) since the last "olola" died many years ago without handing over the job to any of

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his sons, the community has depended on the services of itinerant "ololo" from Tede.

The two "ololo" who served as key informants on blood contact practices have made regular trips to Ago-Are in the last ten years. Although the investigator conducted seperate indepth interviews for both of them in Tede and Ago-Are, it is the operations performed by one (Mr. Ademola Adetayo) surgeon in Ago-Are that are described in this text. The second "ololo" was not invited to Ago-Are throughout the duration of this study.

The "ololo" makes regular business trips to Ago-Are mostly on Sunday morning. Upon arrival in the town, he makes regular calls to his maternal extended family compound where he collects the names and compounds of clients in need of his services. Thereafter, he moves from one compound to another to fulfil previously fixed appointments. In the process, he meets other potential clients who fix appointments for his subsequent trips. The "ololo" made five of such trips to Ago-Are between February and April, 1989. In all, he performed 7 male circumcision, 7 female circumcision, 5 facial scarification and 1 body scarification adding

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up to a total of 20 operations. The investigator observed all these operations.

The highest number of operations performed in a day was 7, consisting of 4 female circumcision, 2 facial scarification and 1 body scarification. The "olola" has only one knife which was used for all operations that were observed. This may not be a typical practice among surgeons because the second surgeon has four different types of knives, each used for sepcific operations. Asked why he uses only one knife, he explained that he had lost his collection of knives during one of his trips back home. He said the one he currently has was made to be used temporarily pending the time when he would request a black smith in Tede to make new ones for him.

All the operations that were observed were carried out at the homes of clients usually at the backyard to the compound. Except the knife, all other materials used for operation were provided by clients. As a participant observer, the investigator and some other persons that were present during operations assisted the surgeon in 18 of the 20 operations observed. Before the presentation of the actual description of the

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operations, the beliefs that promote the practice in Ago-Are are discussed. Since in most cases, the "olola" repeated the same procedures for each category of operations, a typical operation is described. As for "gbeere" and ear piercing, one operation was observed in each case.

Circumcision

In Ago-Are, both male and female circumcision are performed by either the "olola" or the health staff at the Local Government Maternity. A few of ₦10.00 is charged for circumcision at the maternity while no fixed fee is charged by the "olola", the determining factor being the nature of the existing relationship between the parents of the infant and the "olola." The closer the relationship, the less is the fee charged.

The father, traditionally regarded as "the owner" of the child, makes the decision as to whether or not and when the child should be circumcised and he pays for the services. The two "ololas" agreed that the first month of life is the ideal time for circumcision while the operations are usually performed very early in the

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morning. It is preferable to circumcise in the first month of life because the "olola" believe that the ch child will not experience much pain from the operation at that period. In addition, they believe that wounds generally heal faster during this period than other times.

Circumcision is performed early in the morning to prevent the occurrence of excessive bleeding. Concoctions or hot water is used to dress the wound every morning until it heals. However, the wound of the female is believed to heal faster than that of male circumcision.

Male Circumcision

Members of the Moslem community in Ago-Are believe that prayers from an uncircumcised male is not acceptable to Allah (God). In addition, Moslems believe that an uncircumcised male should neither be touched nor buried by a circumcised Moslem. It is generally believed in Ago-Are that the fore-skin accumulates dirt and germs that could destroy the penis. Finally, injuries and other diseases are believed to heal faster among circumcised males than among the uncircumcised male.

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The materials used for circumcision are a woman's cloth (wrapper), a bar of native black soap, a bottle of coconut oil, a bowl of cold water and a lump of "osun" (a redish substance obtained from the bark of a tree used by women as facial and body lotion to decorate and beautify their bodies) and the "olola's" knife.

The mother of the boy to be circumcised spread the cloth on a swept floor at the backyard of the house. The boy, aged about four months, completely nude, was carefully laid on the cloth in a supine position. The "olola" brought out his knife from a brown leather bag and dropped it into the bowl of cold water.

The "olola" and two assistants squatted around the cloth. The "olola" sprinkled some drops of water on the boy's genital region because he believes this procedure will cool the area. The assistants spread the boy's legs and arms apart and forcefully pinned them to the floor to make the boy immobile. Using his left index finger and thumb, the "olola" pulled the fore-skin, paused briefly, before making the first cut.

The wound bled and the boy writhed in pain while the assistants tried to keep him still. After the first

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cut, the "olola" then dropped the knife into the bowl and used his fingers to carefully tear the foreskin around the tip of the penis. He also removed the smegma accumulated around the tip of the penis and rinsed his fingers inside the bowl. At regular intervals, he scooped water on the penis to wipe away blood from the wound. After the tear, the foreskin, now handing loosely, was cut off the penis and dropped inside the bowl.

Post operative procedures began with placing the mixture of "osun" and balck soap on his palm which was used to wash the fresh wound. This procedure is believed to prevent excessive bleeding. Thereafter, he cut off a loose piece from the cloth spread on the floor, dipped same inside the bottle of oil and carefully bandaged the wound excluding the tip of the penis and the urethra. This procedure was aimed at speeding up healing process and preventing the wound from "getting hard." On the instructions of the "olola;" the assistants freed the boy from their hold. And post operative procedures ended when the "olola" wiped away the boy's blood from his thighs and buttocks and handed

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him over to the mother who immediately put him to the breast to pacify him amidst songs of praise.

The operation completed, the "olola" rinsed the knife with his fingers inside the bowl of cold water for a few minutes, wipe it clean with the cloth on the floor and dropped it into his leather bag. The excised foreskin was wrapped with a piece of cloth to be sold later to hunders. The "olola" believes that the possession of the foreskin or the clitoris induces good luck during hunting expeditions. As a result of this belief, he usually retains the foreskin and the clitoris after circumcision.

Finally, he instructed the mother of the boy to dress the wound with hot water every morning until it heals. He was later entertained by the boy's parents with food and local alcoholic beverage. He was also given some pieces of kolanuts as gifts.

Certain procedural differences were noted in all the male circumcision that were observed.

First, a live snail was used on three occasions as part of post operation procedures. After the foreskin was cut, the end tip of the snail's shell was cracked on a nearby stone and the slimy liquid from it

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was directed on the fresh wound. This, the "olola" believes, will have a cooling effect on the wound and ease the pain experienced by the boy. Asked why the snail was not used during other operations, the "olola" said the snail was in actual fact now an essential material for circumcision. He added that he does not usually demand for snails from clients who are close to him but from those not well known to him.

The second observed difference relates to the fees paid for circumcision. The "olola" charged ₦12.00 and ₦10.00 respectively only on two occasions. The average time for male circumcision was seven minutes.

Regarding the materials he uses for circumcision, the second "olola" mentioned native black soap, salt and "osun." As for the use of foreskin and the clitoris, the second "olola" said he bury them to prevent evil people from having access to them and possibly using them to cause him or his clients mishap.

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PLATE I: CIRCUMCISION OF A BOY IN AGO-ARE

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Female Circumcision

In Ago-Are, the beliefs favouring female circumcision are numerous. It is generally believed that the clitoris is capable of automatic arousal such that can motivate a girl to be promiscuous. It is also believed that the head of the foetus must not touch its mother's clitoris during delivery. If this happens, the growth of the child will be impaired. In addition, it is believed that an uncircumcised woman will experience a protracted labour. Finally, it is believed that without the excision of the clitoris, penile-virginal penetration will be difficult if not impossible, since an unexcised clitoris is believed to be capable of enlargement. It is therefore compulsory in Ago-Are that the clitoris should be excised.

The same materials as in male circumcision were used for female circumcision. Similar pre-operative procedures were repeated for female circumcision. The circumcised girl was aged about six months.

With the knife held in his right hand, the "olola" reached out for the girl's clitoris with his left index finger and thumb. He tried to have a firm grip of the clitoris but failed. As a result, he rubbed

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his left fingers on the ground so as to coarsen them. At the third attempt, he succeeded and held up the prepuce and the clitoris between the two fingers and swifly cut off the latter. The wound bled while the girl writhed and cried in pain as the assistants continued to forcefully make her immobile. The excised clitoris was dropped into the bowl of water and the "olola" used his hand to wipe away blood from the fresh wound.

Post operative procedures began with making a paste of the "osun" and the black soap on the "olola's" palm. Using the right fingers, the "olola" rubbed the paste on the fresh wound. This procedure was aimed at preventing excessive bleeding.

On the instructions of the "olola," the assistants freed the girl while he wiped away the girl's blood on her thighs and buttocks with the cloth spread on the floor. He then handed the girl over to the mother who promptly started breast feeding her. The clitoris was picked from the bowl of water and wrapped with a piece of cloth for the same purpose explained earlier.

The "olola" then rinsed the knife with his fingers inside the bowl of water for a few minutes, wiped it

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PLATE II: CIRCUMCISION OF A GIRL IN AGO-ARE

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clean with cloth spread on the floor and dropped same inside his leather bag. The same instruction that was given to the mother of the circumcised boy was repeated. And the surgeon was also entertained by the parents of the circumcised girl. The average time for female circumcision was four minutes. Finally, the second "olola" uses similar materials for circumcision.

Attitude of Participants to Circumcision

Majority of the participants expressed positive feelings towards both male and female circumcision. Some of the typical comments that illustrate positive feelings towards male circumcision include:

"It is shameful for a man not to be circumcised"

"The foreskin harbours germs and other harmful organism so it should be excised"

"It is a compulsory ritual in Ago-Are"

"Circumcision makes penile-vaginal penetration easy"

Some of the typical comments on female circumcision include:

"Prostitution is common in areas where females are not circumcised"

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"It is a custom that we inherited from our ancestors, we will continue to practice it and hand it over to our children"

A similar comment was put this way:

The clitoris is sensitive and capable of automatic arousal. Once this happens, the urge for sexual intercourse is heightened. So circumcision is done to prevent such promiscuous tendencies.

However, a few participants expressed an ambivalent feeling to female circumcision. These were mainly educated bachelors and spinsters who said that although they were aware that the practice is common in Ago-Are, they do not understand the reason why it is done. Only one participant (a married woman) expressed a negative feeling toward female circumcision. She disagreed with other participants who linked circumcision with promiscuity. According to her, she has come across many Yoruba women who are not circumcised and are not promiscuous.

Concerning factors influencing the preference for the services of the traditional surgeon to that provided

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by health staff at the maternity, the relatively low fees charged by the former was the most frequently cited reason by participants. For example, one participant explained this point this way:

> The "olola" will do it (circumcision) free of charge for some us, all we give is food and some pieces of kolanut. Since we can get this service free of charge, why should we take the child to the maternity where fees are charged?

Moreover, as some participants noted, even if the "olola" demands for money this is often negotiable unlike the situation in the maternity where a fixed fee is charged.

Furthermore, the belief that the "olola" is more efficient than the health staff at the maternity was also mentioned. Unlike the latter, the former is believed to posses magical powers with which he can overcome likely complications like excessive bleeding and death during circumcision. That the "olola" received the blessings of his forefathers as well as his many years of experience were cited as additional criteria for patronage.

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Other reasons cited are, the belief that circumcision performed by the "olola" enhance erection and lack of knowledge that circumcision services are provided at the maternity. Finally, family influence was also cited. Some participants said parents insist on the services of the traditional "olola" because they belong to the "olola" family.

Regarding the risks involved in circumcision as performed by the "olola", participants mentioned excessive bleeding and death.

Scarifications

Scarifications are a common blood contact practice in Ago-Are. There are three basic types in the area namely, facial scarification, body scarification and medicinal scarification. The "olola" performs the operation for the first two types while the third may be performed by either a traditional healer or any other person.

Facial Scarification

Facial scarification, or "oju bibu" as it is locally called in Ago-Are, involves cuts of about 1 to 2 inches long made on the face. The cuts are either

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patterned on a straight or on parallel lines. In most cases, only one cut is made on each cheek.

This kind of scarification is different from tribal marks in one aspect. First, unlike tribal marks whose cuts are many, cuts of "oju bibu" often do not exceed four, most patterns of tribal marks exceed this number.

Regarding the prevalence of tribal marks in Ago-Are, the two "olola" agreed that the practice is no longer common in the area. The first "olola" explained that he had made only three tribal marks in Ago-Are in the last five years. The second "olola" said he had not performed any during the same period.

Fees are not charged for "oju bibu" since it is considered a minor operation and sometimes an extension of a major surgery, that is circumcision. According to the "olola," the operation is done for who ever is interested but it is more common among females since it is a form of beautification. The ideal time for the operation is the first year of life and the infant's mother usually makes the decision as to whether or not and when the child should be scarified.

Fiver operations were observed of which four were for girls and one for a boy. The following materials

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were used for scarification; a woman's cloth, a bowl of cold water, a lantern and the "olola's" knife. Three persons assisted the "olola. The same pre-operation procedures described earlier were repeated. The scarified girl was aged about seven months.

On the instructions from the "olola" two assistants forcefully pinned the girl's legs and arms to the ground while the third assistant held her head to immobilise her. That done, the "olola" sprinkled some drops of water on the girl's left and right cheeks to cool the area. He then made skin cuts of about 1 to 2 inches long first on the right cheek and secondly on the left. The girl cried out in pain as the assitants struggled to keep her immobile. While the operation was going on, the "olola" wiped blood from the wound with his left hand and dipped this inside the bowl to rinse it. In addition, the knife was regularly dipped inside the bowl to rinse it.

Post operation procedures began with the "olola" scooping out soot from the roof of the lantern which was then rubbed into the wound. The "olola" believes this will prevent excessive bleeding. The drops of blood that splashed on the other parts of the girl's

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body were wiped away with the cloth spread on the floor. Finally, the girl was handed over to her mother who started breast feeding the girl.

The "olola" repeated the same knife cleaning procedures described earlier. He instructed the mother of the girl to apply either the soot from a lantern, kerosene or coconut oil into the wound after it is dressed with hot water each morning. He was later entertained. The average time for all operations observed is five minutes.

Body Scarification (Enu abe)

"Enu abe" involves cuts made of different patterns on the arm. This is usually performed shortly after a major surgery like tribal marks, or circumcision. In Ago-Are, it is performed free of charge to clients.

According to the "olola" in the years gone by, it was a compulsory ritual for mothers to have this kind of scarification immediately after their children have either been scarified (tribal marks) or circumcised. The ritual was aimed at ensuring that the mother also partake of the pain that the infant experienced. This was based on the assumption that such a mother who had also experienced some discomfort as a result of

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scarification was likely to take adequate care of the infant's wound so that it could heal quickly. In other words, a mother who has not experienced a similar pain was considered not likely to take adequate care of the infant's wound.

These days, however, "enu abe" is no longer limited to only mothers. According to the "olola", nowadays, whoever is present during scarification and circumcision and is willing to sympathise with the infant will be scarified as well by the "olola." The "olola" is obliged to scarify as many as those willinng to sympathise with the infant. In addition, the "olola" pointed out thatsince "enu abe" is a gesture symbolising love and affection for the infant, he usually honour the wish of any willing person. All the key informants as well as the second "olola" expressed similar points of view. Specifically, the second "olola" said that although "enu abe" is not compulsory, it is rare for people not to sympathise with the infant after scarification or circumcision. Only one of such operations occurred during the course of this study. A girl sympathised with her junior sister who was circumcised. In almost all the operations for male and female

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circumcision observed, there were many persons who wished to have "enu abe" but were too scared of the pain involved to attempt it.

The "olola's" knife, a bowl of cold water and a lantern were the materials used for operation.

The girl, aged about 13 years, stood while the "olola" squatted. The same knife, and bowl of cold water used for her sister's circumcision were used. The interval in-between the two operations was less than five minutes.

Before the actual cuts were made, there was a brief discussion between the girl and the "olola" on the pattern of scarification the former wanted. A rectangular pattern, representing a hand bag, was agreed upon. As usual, the "olola" sprinkled some drops of water on the girl's right arm to cool the area. He held the girl's out stretched hand with his left hand while holding the knife on the right hand.

As soon as the first cuts were made she cried out in pain. As the operation continued, it became difficult for the girl to keep herself still and this prolonged the operation. At regular intervals, he appealed to her to remain immobile so that he could

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continue with the operation. Meanwhile, he occasionally dropped the knife into the now very coloured bowl of water to rinse it and used his left hand to wipe away blood which was also rinsed inside the bowl.

All in all, eight cuts, each of about 2 to 3 inches long, were made on straight lines with one long line across them.

As post operation procedures, the "olola" scooped out soot from the lantern and rubbed this into the wound to prevent excessive bleeding. He later instructed the girl to dress the wound with kerosene and hot water every morning until it heals.

Finally, the "olola" repeated the same knife cleaning procedures described earlier. The average time for the operations observed was eight minutes.

There are certain noted procedures that differ from those already described. On two occasions, the post operation knife cleaning procedures differed from that described earlier. On those occasions, the "olola" rubbed the knife on the floor to clean off the blood on it before rinsing it and dropping it into his leather bag.

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Secondly, on one occasion operation did not take place at the backyard area. On that occasion, the kitchen was used for operation because the floor in the backyard area was wet due to rainfall that occurred few hours before the "olola" arrived in Ago-Are. Asked why he prefers to use the backyard area for operations, the "olola" explained that the reason lies in the adequate illumination provided by the area.

On three occasions, operation occurred in almost rapid succession with intervals of less than five minutes. The last two operations described above illustrate the first occasion of this. A girl, aged about 6 months, had both circumcision and facial scarification on the second occasion. The last occasion was when two brothers, aged about two years and six months respectively were circumcised. On these three occasions, the same basic materials were used for all the operations. During other operations, there is usually an interval of between 30 to 40 minutes in-between operations. The only deviation from this time interval occurred when a mother, on hearing that the "olola" was in Ago-Are quickly ran home to bring her daughter to the compound where the "olola"

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had just circumcised a boy. The girl's circumcision started 20 minutes afterwards. Again on this occasion, the same materials were used.

Medical Scarification (Gbeere)

"Gbeere" is a form of body scarification done for medicinal purposes. It involves making incisions on any part of the body so that already prepared herbs can be rubbed into the wound. The procedure is aimed at introducing such herbs into the blood stream. In Ago-Are, "gbeere" is based on the belief that certain herbs can be effective only if introduced into the blood stream. It is done for both preventive and curative purposes. For example, it is done to Prevent the occurrence of mishaps like road traffic accidents, snake bites and scorpion stings. It is also believed to cure certain ailments such as headache.

"Gbeere" is usually recommended for a client by a traditional healer who either performs the operation himself or asks the client to look for someone who can do it for him. Some form of "gbeere" are accompanied by incantations as part of the ritual majority of which are performed by the traditional healer. The incisions made vary in number depending on the type of problem it

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is supposed to solve. For example, there are those that involve making 21 incisions, 7 incisions, 1 incision or 4 incisions. The incisions are usually on the affected part of the body. The forehead, for example, is the usual site where incisions aimed at treating severe headache are made.

Depending on the purpose, three kinds of instruments are used to make "gbeere". These are razor blade, a piece of broken bottle and a knife. Usually it is the clients that provide these materials while the traditional healer makes the herbs. According to the "Areoje," as part of the rituals, the materials used during the operation must be discarded immediately by the client in such a way that no other person have access to them. Violating this rule renders the herbs ineffective. In addition, the instruments used must be new otherwise the herbs may not be efficacious.

The materials used in one of such operations were a new razor blade and herbs made in a powdery form. The incisions were aimed at curing severe headache performed by the "Areoje" for a married woman. She was asked to sit on a stool while he stood. Using the blade, he made a total of seven incisions. Using his

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right hand, he then rubbed the herbs into the wounds. Some form of incantations were recited after which the woman was asked to dispose both the razor blade and the remaining herbs. The operation lasted about seven minutes. No fee was charged for the operation.

Ear Piercing

Ear piercing is a common practice in Ago-Are. The practice is limited to only female infants. It is a form of beautification. In Ago-Are, ear piercing is usually done by elderly women or women who have reached the menopausal age in each extended family compound. The ideal time for the small operation is the first week of life when the infant is believed not to experience much pain as a result of the operation. Fees are not charged for the operation. According to a grand mother who performs the operation in one of the extended family compounds in Ago-Are, the materials used for operation are a new needle, a piece of thread and ear rings. The reason underlying the use of a new needle, according to her, is that since the child is new, it is important to use new things for her.

The materials used in one of such operations were a long needle and a pair of ear rings. The same

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grandmother, whom the investigator had previously interviewed performed the operation. It was observed that contrary to her earlier statement on the need to use a new needle, she actually used an old one. This was kept in between her woven hair before it was used. The pair of ear rings were, however, new ones.

The neonate, aged three days, was placed on her lap, lying across it. The lower lobe of the girl's right ear was held with the woman's left hand while she used the needle in her right hand to pierce the ear. The girl cried out in pain as this was done. One of the ear rings was inserted into the new hole created as a result of the piercing. The same procedure was repeated for the left ear. The neonate was immediately handed over to the mother who immediately put her to breast to pacify her. The operation lasted about six minutes.

After the operation, the woman was asked why she did not use a new needle for the ear piercing, she explained that this was because the girl was her grand daughter and she did not want to trouble the mother by making her buy a new needle since she is the wife of her own son. She added that were it be an "outsider,"

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she would have insisted on a new needle. She normally retains such needles.

Asked about the frequency of ear piercing she has performed in the past, the woman explained that intervals between operations often span weeks, sometimes months. She performed only the operation described above throughout the duration of this study.

Uvulectomy

The woman who performs the operation in Ago-Are did not answer questions from the investigator. Nor did she allow him observe the operation. She referred the investigator to the man who trained her for interviews and observations. The man no longer lives in Ago-Are.

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CHAPTER FIVE

DISCUSSION AND IMPLICATION FOR HEALTH EDUCATION PLANNING

As in the presentation of findings, the discussion in this chapter are grouped under three headings: sexual practices; marriage and divorce practices; blood contact practices. The potential risks involved in the practices are assessed on the basis of current knowledge on AIDS. In addition, the health education implications of the assessment and the limitation of this study are discussed and appropriate recommendations are highlighted.

Assessment of the Risks Involved in Identified Practices

Sexual Practices

Prostitution

Of all the sexual practices identified during the course of the study, prostitution potentially carries the highest risk of transmitting HIV in Ago-Are. The female prostitutes in Ago-Are are at risk of contracting

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HIV because they engaged in frequent sexual intercourse with many different sexual partners. Having many different sexual partners increases their chance of not only encountering someone who is HIV infected but also exposes them to other STDs that facilitate the transmission of HIV. The STDs that enhance HIV transmission are chancroid, syphilis and genital herpes (Cameron et al, 1989; Pallangyo, 1989, Johnson and Pond, 1988; Piot et al, 1987).

It is significant that the prostitutes in Ago-Are charge only ₦2.00 for each sexual episode with a client. Since these women depend entirely on the income made from soliciting, they need to have many sexual partners to earn a living. As Kreiss et al's (1986) study suggests, low income prostitutes as those in Ago-Are may be at the highest risk of contracting HIV. A survey was conducted by those authors among prostitutes soliciting in Nairobi, Kenya, and the results revealed that 66 percent of women of low socio-economic status tested were HIV positive. In addition, Schoepf et al (1988) pointed out that low income prostitutes who report the highest frequency of sexual encounters are the group most likely to have a history of recurrent

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STD episodes, especially chancroid, syphilis, genital herpes and chlamydia which cause open sore.

Not only are the prostitutes at risk of contracting HIV and other STDs, they may also transmit these to their clients. Findings have revealed that both indigenes and non-indigenes patronise the prostitutes in Ago-Are, the former discreetly and the latter openly. Being away from their homes where social sanctions may have discouraged such behaviour, the non-indigenes do not feel any inhibitions about patronising the prostitutes. By contrast, the indigenes are discreet because patronising prostitutes is a socially disapproved behaviour in Ago-Are. Besides, there is lack of anonymity for the indigenes in the community. It is not surprising therefore, that indigenes limit their visits to the hotel to the night time only when it is difficult to detect them.

However, whether their patronage is done discreetly or openly, the clients are at risk of contracting HIV since the prostitutes are likely to be the major reservoir of STDs in Ago-Are. Studies have shown that the risk of contracting HIV from female prostitutes is influenced by frequency of sexual contact (Cameron et

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al, 1989; Clumeck et al, 1985). Regular clients of prostitutes in Ago-Are are therefore more likely than occasional clients to be at higher risk of contracting HIV.

In Ago-Are, the married clients of the prostitutes represent a potential bridge through which AIDS may be disseminated into the general population. If the married clients contract HIV from a prostitute, they may infect their wives who in turn may transmit the virus to their offspring and this may accelerate its spread in the community. The same is true for married clients who are non-indigene.

Human mobility may aid the spread of AIDS in Ago-Are. Since STDS travel with their hosts (Brokensha et al, 1987) human mobility represents another potential conduit through which HIV may be introduced into and exported from the community. As findings indicate, different mobility patterns exist in Ago-Are. The mobility pattern among prostitutes is both urban-rural and rural-rural. The former is illustrated by prostitutes who have previously sold sexual services to clients in Lagos, Ibadan and Oyo while the latter is illustrated by those of them who previously sold sexual

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services to clients in Saki, Irawo and Tede before moving to Ago-Are. Frequent mobility among the prostitutes represents a means through which HIV may be imported into the community and further disseminated to other neighbouring areas.

The frequent mobility pattern among prostitutes in Ago-Are is similar to those found among prostitutes in Sabo area of Ibadan, Nigeria (Cohen, 1969). According to Cohen (1969), the explanation for the frequent mobility of prostitutes lies in the fact that the institution of prostitution frees women from two social ties which render women immobile namely, marriage and natal ties.

Casual Sexual Activity

Another practice which may have far reaching implications for the spread of AIDS into the community is the casual sexual activities that occur among the indigenes returning from cities to celebrate during festive periods on one hand and between those living permanently in Ago-Are and those returning on the other. Casual sexual activity among the latter may facilitate the rapid spread of HIV from the urban centres to the rural community. This is likely to be

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the case since, at present, HIV prevalence in Nigeria is limited to only the urban centres (Mohammed et al, 1988).

Lowe-Morna (1989) pointed out the role that urban-rural movement could play in the spread of AIDS. The author attributed the rapid spread of AIDS from the urban to the rural areas of Zambia to city dwellers who maintained a foothold in their traditional home areas. This suggests that human mobility may play a crucial role in the rapid spread of AIDS in the country.

Furthermore, the frequent mobility of farm labourers and pastoralists also favour casual sexual activity in Ago-Are. The nature of the economic activities of these groups suggest that their mobility pattern is rural-rural. Since casual sexual activities among farm labourers and pastoralists occur mainly with the prostitutes, the former may help disseminate the virus to other rural communities in Nigeria.

The explanation for why these two groups patronise mainly prostitutes in Ago-Are lies in the very nature of their mobility. Frequent mobility limits their chances of developing stable relationships with female

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indigenes in Ago-Are. It is not surprising therefore, that these groups resort to prostitutes for sexual relief during their stay in the community. Infact, Cohen (1969) has emphasised the importance of prostitution as an institution that supplies migrant men with sexual pleasures in foreign lands.

Extra-Marital Sexual Relationships

Assuming HIV is introduced into the community through any of the potential routes aforementioned, its spread into the general population will be influenced by other sexual practices that exist in Ago-Are. One of such practices is extra-marital sexual relationships. Although extra-marital sexual relationships may occur at any time it is more common in Ago-Are during post partum. As findings showed, married men may engage in extra--marital sexual relationships while their wives are expected to abstain during post partum. The risk involved in patronising prostitutes by married men has already been discussed. There is also risk involved in extra-marital sexual relationship with other persons.

Because abstinence rule does not apply to men in Ago-Are, they may be at risk since they have more

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opportunities than women to engage in extra-marital sexual relationship during post partum.

The demand of childbearing coupled with other time consuming household chores leave a married woman with little opportunity to engage in extra-marital relationships during post partum. The men, on the other hand, are traditionally freed from these time consuming activities and consequently have ample opportunity to engage in exta-marital sexual relationships during this period if they so desire.

Furthermore, the practice of abstinence as a means of child spacing among married couples in Ago-Are suggests that sex is meant for human reproduction only and not an act to be enjoyed for it own sake. Thus, women abstain from sex after delivery and resume normal sexual activities with their husbands only after the child has fully grown, in other words, when they are ready to have another baby. However, this concept of sex is applicable to only the women since abstinence rule does not apply to men. In Ago-Are, men may either marry a new wife or engage in extra-marital relationships while their wives abstain at post partum.

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It is in this sense that the sex act can be said to be a pleasurable activity for men in Ago-Are.

This dual definition of the function of sex reflects one aspect of the double standard of morality among the Yorubas in general. As Olusanya (1969) observed, Yoruba sexual norms favour sexual licence for the men and sexual asceticism for the women. Whereas, the wife is expected to be absolutely faithful to her husband and remain at home to mind household chores, the man could gad about. Another aspect of double standard relates to who can and who cannot sue for divorce on grounds of adultery. Whereas, under customary marriage, men could sue for divorce on grounds of adultery on the part of their wives, women may not do the same. This is so because customary marriage permit polygyny (Ekundare, 1969) and men who engage in adulterous relationships can easily defend themselves by pleading that they intend to marry the other woman. Moreover, since polyandry (a union of a woman to more than one husband) does not exist among Yorubas, women cannot plead adultery as cause of divorce (Ekundare, 1969).

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The result of this double standard of morality is that Yoruba men married under customary laws are more likely than women to indulge in extra-marital sexual relationships which increase their chance of exposure to STDs including HIV which can be easily transmitted to their wives. Findings from Elemile's (1984) study on the epidemiology of STDs in a rural Yoruba community lead credence to this speculation. Results of the study showed that majority of all the female respondents who had STDs contracted these from spouses. Of the 17 female respondents who had trichomonal infections, 16 contracted it from husbands while all the 18 female respondents with candida infections also contracted it from husbands.

Pre-Marital Sexual Activity

Findings have shown that pre-marital sexual activity is a common practice in Ago-Are. This agrees with the findings of Nichols et al (1986) in their study of sexual behaviour of unmarried persons, aged 14 - 25 years who were working or attending school in Ibadan, Nigeria. Results of the study revealed that a significant proportion of the respondents, ranging from

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28 percent of female secondary school students to 76 percent of males not enrolled in school, were sexually active.

Young unmarried persons who are sexually active are at risk because with increase frequency of changing sexual partners their chances of exposure to STDS and AIDS is high. In fact, STDS are a major reproductive health problem among young people in both the developed and the developing countries (Liskin et al. 1985). That adolescents and young persons in Ago-Are are sexually active may be a recent development since Yoruba traditional sexual norms discourage pre-marital sexual activity (Fadipe, 1970). This social change may be a result of the deterioration of the traditional constraints on sexuality in Ago-Are. Other explanations that have been proposed to explain the sexually active behaviour of young unmarried persons in Nigeria include earlier onset of menarche among females, earlier initiation of sexual activity and the influence of urbanization and the mass media (Liskin et al, 1985).

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Marriage and Divorce Practices

Polygyny

Polygyny is a socially approved custom among the Yorubas (Fadipe, 1970). Both Moslem and customary marriage are potentially polygynous in the sense that Moslem and customary Laws allow a man to marry more than one wife (Ekundare, 1969). Ideally, polygyny as a form of marriage should help check men's extra-marital impulses in the sense that they can turn to other wives if one of them is abstaining. Yet, polygyny may not be a perfect solution in Ago-Are because, in the absence of modern contraceptives, all wives in a polygynous union may become pregnant within a few months from each other and consequently, abstain at the same time. Thus enough room may be left for the husband to engage in extra-marital sexual relationships.

The results of Caldwell and Coldwell's (1977) study on the relationship between marital sexual abstinence and fertility exemplifies this point. Results of the study revealed that 4 percent of Yoruba husbands in polygynous marriages engage in extra-marital sexual relationships during post partum because all the wives

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were abstaining, 8 percent abstained while 88 percent had sexual relationships with other wives. If men in polygynous unions become infected with HIV as a result of extra-marital sexual relationships, they could transmit the virus to other wives in the union. It is in this sense therefore, that polygyny becomes a potential route through which AIDS may spread in Ago-Are. It is important to stress that polygyny per se does not carry any risk of spreading AIDS so long as spouses in polygynous union are mutually faithful. It may become a route for the spread of AIDS if any of the spouses in a polygynous union engage in extra-marital sexual activity and contracts the AIDS virus.

However, men in monogamous marriages may be more at risk than men in polygynous marriages, of contracting STDS and AIDS in the sense that the former are more likely than the latter to engage in extra-marital sexual relationships during post partum. As Caldwell and Caldwell's (1977) study further revealed, whereas, 31 percent of husbands in monogamous marriages abstained from intercourse, the remaining 69 percent indulged in extra-marital sexual relationships during post partum.

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It is likely that polygyny as an institution is currently on the decline in Ago-Are. As was pointed out during group discussions, the practice is no longer fashionable because of the economic responsibilities that go along with it. If economic factors influence the practice, it is likely that the economic problems currently experienced in Nigeria will check men's polygynous inclinations. In addition, the results of Van Driessen's (1972) study on the prevalence of polygyny in Ife Division in Nigeria buttresses this point. The study revealed that polygyny had declined in the area because of economic considerations rather than education or religion.

Divorce Practices

Divorce may also contribute to the spread of STDS in general and HIV in particular. As Olusanya (1971) pointed out, frequent divorce increases a woman's chance of exposure to STDS through frequent change of sexual partners. Since divorce action by women in Ago-Are is often an outcome of previous extra-marital relationship, it represents another potential route through which AIDS may be spread in the community.

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The refund of the bride wealth at divorce facilitates the circulation of women among men which increases women's chance of exposure to STDS. Apart from the risk of exposure to STDS, there are other social problems which may result from frequent divorce. As Sofoluwe (1965) pointed out, children of mothers who frequently change husbands are likely to suffer from meternal deprivation, due to the children being left with their fathers before they are aged three years.

Findings have shown that lack of care is the main reason often cited by women taking divorce action. This is not surprising since in Ago-Are, men systematically neglect wives in whom they are no longer interested.

Compared with results of previous studies on Yoruba divorce practices by Lloyd (1968); Sofoluwe, (1965) and Okediji and Okediji (1965), the incidence of divorce in Ago-Are is low (see Fig. 2). Findings of this study however agree with that of previous studies in a number of ways. First, women initiate divorce action more often than men. Secondly, women tend to initiate divorce on civil grounds with lack of care being the major cause.

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Given the low incidence of divorce in Ago-Are, can one conclude that customary marraiges are more stable these days than in the past? Divorce itself is not the best indicator of marital stability in the sense that a marriage might be practically ended but not legally so by the separation of the spouses (Lloyd, 1968). The "Adalemosus" in Ago-Are, who have not taken any formal divorce action but are already separated from their husbands and living a sexual lifestyle of single women exemplifies this viewpoint. Secondly, as some participants at group discussions observed, the low incidence of divorce in Ago-Are may actually reflect the ascendancy of the "moving-in" type of marriage (Odesanya et al, 1984) over the full fledged marriage. The "moving-in" type of marriage involves no formalised arrangement, the woman merely cohabits with the man. When such union breaks up, as they often do, they are not mentioned in the court register since they were not formalised in the first place. In any case, the "Adalemosus" as well as other women who frequently change husbands are at risk of contracting STDS because such behaviour exposes them to such diseases.

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Blood Contact Practices

Circumcision

Findings of this study indicate that male and female circumcision are carried out under unhygienic conditions. Many of the surgeon's pre-and post-operation procedures may be a source of infection for the child. For example, use of a dirty cloth to tie the circumcised penis, inserting a paste of "osun" and native black soap into the vagina as well as use of dirty and unwashed fingers during operations expose the child to infections.

The potential risk of HIV transmission during circumcision stems from two possibilities, namely, exposure to blood and use of unsterilised knife.

The surgeon is exposed to the blood of his clients since he uses neither a glove nor other protective materials that would have limited the chances of exposure. Chance contact with HIV may occur among infants who are aged under five years and other clients aged 15 years and above. This is likely to be the case since AIDS is uncommon among the 5 - 15 year age group on the African continent (Dawson, 1988).

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However, for viral dissemination to occur through exposre to blood during circumcision, a pathway for an infected blood must exist either in form of cuts or other ulcerations on the body (Hrdy, 1987). Since the incidence of accidental cuts of the surgeon's fingers during circumcision cannot be completely ruled out, exposure to blood is a possible route of HIV transmission.

The use of one unsterilised knife for cirumcision also carries some risks of transmitting HIV. The knife was not sterilised before or in-between use. Merely ringing it in cold water after surgery does not make it sterilised (Liskin et al, 1986). The risk of viral transfer through an unsterilised knife in-between use may be high since HIV is considered capable of remaining infectious for hours or even days if kept at body temperature (Jefferies, 1988; Liskin et al, 1986). This is likely to be the case of circumcisions that were performed in rapid succession. However, HIV can be easily inactivated by solutions like alcohol and other detergents (WHO, 1988; Jefferies, 1988).

The "Sunna" type of female circumcision (Oduntan and Onadeko, 1984), is practised in Ago-Are. Despite

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its adverse health consequences, including septicaemia, urinary tract infections and haemorrhage (Ebomoyi, 1985), female circumcision has persisted in many parts of Yorubaland (Ebomoyi, 1985; Afelumo et al, 1985; Oduntan and Onadeko, 1984). It is interesting to note that the main reason why female circumcision is practised in Ago-Are is to prevent promiscuity. Yet, Sayed's (1982) study among prostitutes in Sudan suggests that circumcision may not in any way be related to promiscuity. Of the 200 prostitutes surveyed, 170 have pharaonic circumcision, 22 sunna and 8 were not circumcised.

The issue of female circumcision and its potential risk of transmitting HIV in Africa has generated a heated debate among scholars. On one hand, some scholars have speculated that the practice increases the likelihood of HIV transmitted via exposure to blood in the vaginal canal as a result of mucosa friability. In addition, such scholars have also argued that in areas where pharaonic circumcision is practised, vaginal intercourse is associated with tissue damage, tears and bleeding. As a result, anal intercourse becomes a common recourse for heterosexual

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partners (Johnson and Pond, 1988). On theother hand, other scholars, like Hrdy (1987), for example, have argued that female circumcision does not play any major role in AIDS transmission. Hrdy's argument is based on the premise that the distribution of pharaonic circumcision in Africa does not overlap with the so called "AIDS area" on the continent. The author concluded that:

> ... If female circumcision is an important determinant of AIDS transmission, it is difficult to understand why parts of Central Africa where levels of AIDS are highest and where AIDS was first described do not practice female circumcision.

It can be reasonably said that to the extent that female circumcision renders the genital area friable thus increasing the chance of occurrence of lessions during intercourse, it carries some risks even if these are minimal. Ironically, an intact foreskin in males has been shown to significantly increase the chance of contracting sexually transmitted HIV (Cameron et al, 1989; Simonson et al, 1988). According to Cameron et al (1989) the foreskin increase susceptibility to HIV

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because the prepuce is capable of trapping infected vaginal secretions thereby facilitating viral infection.

Scarifications

The risks involved in facial and body scarification (enu abe) are similar to those discussed under circumcision. These relate to exposure of the surgeon to blood of his clients and use of unsterilised knife for scarification. Post operation procedures like the use of soot from the roof of a lantern may expose recipients to infections.

The risks involved in body scarification in which people sympathise with infants who are either scarified or circumcised is high in the sense that the practice facilitates viral transfer among clients since the "olola" uses only one knife for all operations. On the other hand, the practice increases the rate at which the "olola" is exposed to client's blood. Consequently, the more the number of people who sympathise with the infant the higher is the risk of viral transmission.

The risk involved in medicinal scarification (gbere) may be minimal. The fact that new and disposable instruments are ritually employed for scarifica-

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tion eliminates the risk of viral transfer through unsterilised instruments. In addition, compared to other scarifications, the cuts of (gbeere) are superficial which involves negligible exposure to blood. Except the operator has accidental cuts with the instruments used, the chance of viral transfer through this route is low.

Ear Piercing

The risk of viral transfer through ear piercing is low. Although unsterilised needle was used for piercing, the considerable time interval of between weeks and months means the virus even if present on the needle would have been destroyed before it is reused. The risk of exposure to blood is also minimal since negligible quantity of blood is shed during the operation. However, the use of unsterilised needle may be a source of other infection for the girl.

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IMPLICATIONS FOR HEALTH EDUCATION PLANNING

The major purpose of education about AIDS is to prevent the transmission of HIV and the spread of AIDS by influencing the risk behaviours that increase the exposure of individuals to HIV. The findings of this study have shown that there is a wide range of sexual and blood contact behaviours that may favour the transmission of HIV and the spread of AIDS in the community. Since these behaviours involved varying degrees of risks and resources for health education interventions are presumably limited. It is imperative that the behaviours be prioritised according to the degree of risk involved in them so that resources are not spread out too thinly.

Green et al (1980) have recommended the use of a guideline for the selection of important behaviours that contribute to a particular health problem. This approach facilitates the development of intervention priorities to solve the health problem. According to the guideline, behaviours are considered most important to a health problem if:

a. Data are available that clearly link the behaviour to the health problem;

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b. They occur frequently.

On the other hand, behaviours are considered less important when they are:

a. tenuosly linked or indirectly related to a health problem and desired outcome and

b. they are rare.

Using this framework, prostitution becomes the first priority behaviour for health education interventions because it has been implicated in HIV transmission (Cameron et al, 1989; Ngugi et al, 1988; Kreiss et al, 1986). It is through sexual contact with prostitutes that many groups in Ago-Are are linked up in a common sex pool. According to De Gruttola et al (1986) prevention interventions launched through this route is likely to enhance overall effectiveness of the control programme.

Various health education strategies can be used to educate the prostitutes in Ago-Are. Mann (1987) has suggested that in order to enhance the effective delivery of health interventions, preventive efforts that are aimed at controlling the spread of AIDS should be integrated into the existing primary health care programmes in various communities. In addition, care

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education about AIDS need to be integrated into the primary health care programmes since health education about prevailing health problems is one of the components of primary health care services (WHO, 1978).

Since such an approach is likely to enhance the effectiveness of preventive efforts and produce the desired change in behaviour, the health education strategies suggested in subsequent discussions should be carried out within the existing primary health care framework at the local government levels.

To reach the prostitutes, the support and cooperation of the owner of Idera Hotel as well as the landlords of the houses in which prostitutes reside may be enlisted. A combination of group discussion and individual counselling may be appropriate to educate the women. Perceiving themselves as being at risk of contracting gonorrhea is a good starting point of health education diagnosis. During individual counselling health messages should emphasise the risks involved in prostitution as well as the methods each prostitute can take to reduce her risk of exposure to STDs especially HIV. Some of the options the women may consider adopting are, [illegible] either they quit

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prostitution and take up a different occupation, or two, that women insist that their clients use a condom during each sexual encounter.

In addition, the women need to be informed about the risk involved in frequent mobility coupled with the sale of sexual services since these behaviours increase their risk of exposure to HIV. In short, the emphasis of the educational activities should be to encourage the women to make informed decisions that will limit their chance of HIV infection. And once the women take such protective actions, they will indirectly also protect their clients from HIV infection and consequently limit the risk of the spread of AIDS in Ago-Are. The educational activity targeted at the Prostitutes should be planned and delivered in a way that will sufficiently motivate women who cannot quit prostitution to make condoms available to clients and insist on their use during each sexual episode.

The next priority behaviour that emerges from this study is frequent sexual contact of clients with prostitutes. Frequent contact with prostitutes has been linked to HIV transmission and spread of AIDS (Cameron et al, 1989; Clumeck et al, 1985). An interpersonal

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communication approach may be used to reach the clients of the prostitutes in Ago-Are. The personalized communication approach is favoured because it is more likely than mass media to reach the clients and positively influence them.

To reach the non-indigenes, it may be necessary to enlist the support and cooperation of their leaders. These leaders may be trained as lay educators for members of their own group since members of the different groups in Ago-Are fraternise and have informal associations. Their training programme should focus on the various routes of HIV transmission with special emphasis on the risks involved in sexual contact with prostitutes.

In addition, the importance of the use of condom during each sexual episode with a prostitute as well as how to correctly use it may be incorporated into the programme for lay educators. This is necessary since it may be difficult to make clients of prostitutes use condoms if they are not aware of the risk involved in unprotected sexual contact with a prostitute.

It may be difficult to reach the specific groups of clients of prostitutes among indigenes of Ago-Are

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since their identities are not clearly known. An indirect way of reaching them may be to train all the key informants and other influential religious leaders in Ago-Are as lay educators with the hope that health messages will get to them. The use of key informants as lay educators on AIDS is aimed at achieving two objectives.

In the first place, it is an attempt aimed at ensuring community participation which is likely to facilitate the success of the AIDS education programme in Ago-Are. Secondly, being opinion leaders with considerable influence on other people, health education about AIDS from them is likely to have high credibility and hence likely to positively influence risk behaviours. The health messages to be disseminated through lay educators should be simple enough so that they are easily understood by the people. Such messages should also emphasise the need for mutual faithfulness among married couples and the risk involved in patronising prostitutes. The various associations that exist in Ago-Are may serve as the fora through which health education messages are disseminated.

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The next priority behaviour is the sexually active behaviour of young persons especially secondary school students in Ago-Are. This behaviour should take the next priority because AIDS is a selective disease that affects mainly young people around the world. According to the WHO (1989a), at least half of those infected with HIV worldwide are under the age of 25 years and about 20 percent of all people who have AIDS are in their twenties thus making AIDS a major concern affecting the youths of today. The school is one viable medium of reaching young people in Ago-Are. To this end, it is suggested that AIDS Education be infused into the School Health Education Curricular. Students need to be educated about the risk of contracting STDS including AIDS through active, unprotected sexual intercourse and frequent change of sexual partners.

Teachers have a crucial role to play in educating students about AIDS. Yet, the results of a recent survey in Ibadan, Nigeria, show that teachers' level of knowledge on AIDS is low (Osundare, 1990). Teachers need to be well educated to be able to adequately educate students about AIDS. To equip the teachers with basic information, an AIDS Workshop can

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be organised for teachers of health sciences and related subjects on a local government basis. As Sherr (1989) suggested such workshops should use group discussion methods where questions and misunderstanding can be dealth with, information and experiences shared, and personal involvement and commitment can be encouraged. A workshop on AIDS is appropriate because studies have shown that it is an effective method of raising lay person's level of knowledge on AIDS and an effective means of fostering in the minds of participants a positive attitude towards AIDS prevention and control programmes (Chirwa and Sivile, 1989).

Female circumcision has not been linked to HIV transmission, yet, its potential for transmission of the virus is high. Besides, there are many adverse health consequences associated with the practice (Ebomoyi, 1985; Oduntan and Onadeko, 1984). For these reasons, female circumcision becomes the next priority behaviour to be targeted in Ago-Are. As findings have shown, female circumcision is a deeply rooted practice in Ago-Are and educational efforts to eradicate it will take a pretty long time to accomplish. Both long

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and short term educational strategies may be needed to overcome the practice.

For the short term, the support and cooperation of lay educators may be enlisted and in fact the risks involved in female circumcision may be incorporated into the training programme for key informants and others. In addition, it is suggested that the "olola" be trained too. However, the format for the training of the "olola" should be different from that of other lay educators. The "olola's" training should focus on methods of basic hygiene, and simple sterilisation procedures using locally available alcohol and possibly the native black soap. Finally, it should also emphasise the risks involved in exposure to the blood of clients and the possible ways of limiting this.

For the long term, educational activities that discourage female circumcision should start in the secondary schools. To achieve this objective, the support of teachers may be enlisted. Health messages on female circumcision that are disseminated in schools are likely to foster negative attitude to the

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practice in the minds of the adolescents who are future parents. This is likely to be the case since members of the school age group are still in their formative and most impressionable years when ideas are still very fluid and amenable to change(Ademuwagun and Oduntan, 1986).

AIDS was discussed in only three of the twelve group discussions and only pre-marital sexual activity and prostitution were said to be capable of spreading the disease. Knowledge about AIDS as a disease condition and its route of transmission is low. This level of awareness on AIDS is to be expected since AIDS is, after all, a new disease in the country and no effective health eduation intervention has so far been launched to stem its spread into the general polulation. What currently exist in Nigerio are sporadic spot announcements in the print and electronic media many of which are beyond the reach of many rural dwellers in the country.

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LIMITATIONS OF THE STUDY

Not all the persons approached for information concerning sexual and blood contact practices in Ago-Are volunteer such information. For example, the woman who performs uvulectomy, one of the blood contact practices common in Ago-Are, did not answer questions posed by the investigator let alone allow him to observe the conditions under which uvulectomy was carried out. Instead, she referred the investigator to the man who trained her to collect such information. Unfortunately, the man no longer lives in Ago-Are. With holding such information placed some limitations on this study especially on the data on blood contact practices.

Although male and female circumcision are done at the local government maternity in Ago-Are, records of such procedures are not kept. According to the staff at the maternity, the local government authorities do not permit them to circumcise hence records of circumcision are not kept. Such record could have been used as a yardstick for comparing the number of circumcision done at the maternity vis-a-vis those done by the "olola" so as to determine the pattern of patronage of both services.

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Furthermore, anonymity among individuals who participated in group discussions could not be achieved because of their close acquaintance. Thus close association among the participants may have limited the degree of self revelation during such discussions.

In Ago-Are, five of the nine female prostitutes lived in a hotel while the remaining four lived in two separate locations. Systematic observations could only be made of the activities of prostitutes living in the hotel since it is a public place. On the other hand, the activities of the other prostitutes could not be observed because they live in family compounds which are not public places. When approached for interview none of them entertained questions from the investigator. Therefore, the inability of the investigator to observe the activities of all the prostitutes soliciting in Ago-Are coupled with non-cooperation from some of them placed some limitations on the data collected on sexual practices.

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CONCLUSION AND RECOMMENDATIONS

The study was designed to identify socio-cultural practices that may favour the transmission of HIV and the spread of AIDS in a rural community with a view to determining primary prevention strategies that may influence the practices.

The findings of the study showed that there is a broad range of sexual, marriage and divorce and blood contact practices that may favour the transmission of HIV and consequently accelerate the spread of AIDS in the community. The behaviours that carry a high potential for transmitting HIV are prostitution, frequent sexual contact of male clients with prostitutes, casual and premarital sexual activities.

Since AIDS has not been reported in any rural community in Nigeria (Mohammed et al, 1988), human mobility, especially the urban-rural movement of female prostitutes is likely to play a crucial role in the spread of the disease into rural communities.

If AIDS is introduced into these areas through mobility, its spread into the general population will be facilitated by existing sexual practices especially extra-marital relationships that involve frequent

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sexual contact with prostitutes and possibly through blood contact practices like female circumcision.

A culturally relevant health education intervention designed and delivered within the framework of existing primary health care at the local government areas may go a long way in controlling the spread of AIDS into rural communities.

The priority behaviours to be targeted in prevention and control efforts are prostitution, frequent sexual contact of male clients with prostitutes, premarital sexual activity and female circumcision. A Personalized communication approach may be used to positively influence these behaviours.

Finally, it is hoped that the findings of this study will be useful in developing effective programmes aimed at controlling the spread of AIDS in Nigeria.

The findings of this study have implications for further reaearches on other practices that may favour the spread of AIDS in Ago-Are. The following recommendations are therefore suggested:

- Since the activities of patent medicine sellers who administer intra-muscular injections to their clients may contribute

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to the spread of AIDS in Ago-Are, it is suggested that more qualitative studies are conducted to assess the level of risks involved in the practice.

- Secondly, more studies may be needed to determine the factors that may facilitate the quick acceptance of modern family planning methods among married couples in Ago-Are. This action will be aimed at providing couples an alternative to abstinence at post partum which appears to be the dominant birth spacing method in Ago-Are at present. If modern family planning methods are accepted this is likely to discourage extra-marital relationships during post partum and consequently reduce the couples' risks of exposure to HIV.
- Thirdly, it is suggested that the local government authorities should provide the necessary wherewithal needed to successfully implement the health education strategies suggested in this text.

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- Finally, to ascertain whether or not the health education strategies are effective in influencing potential risk behaviours, it is suggested that the health education programme be evaluated at periodic intervals.

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APPENDIX I

BIOGRAPHIES OF KEY INFORMANTS

IYA EGBE

Name:	Rebecca Adebayo
Sex:	Female
Age:	42 years
Marital Status:	Married with children
Type of Marriage:	Polygynous. Her husband has two other wives.
Religion:	Christianity. She belongs to the Baptist denomination and attends First Baptist Church, Ago-Are.
Occupation:	Farming. She plants maize, groundnut and beans.
Educational Status	No formal education.
Home Town:	Ago-Are
Name of Compound:	Akewe Compound in Ago-Are
Length of stay in In the community:	About 26 years. She has been living in Ago-Are Since 1969 when she returned from Ghana following the expulsion of Nigerians from that country.

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Status/Position occupied in Ago-Are:	The Iya Egbe (Leader of Egbe Omowumi, an association consisting of about 40 married women. She is also a member of the Executive Committee of the Ifedapo Co-operative and Thrift Society, Ago-Are chapter.
Association to which Informant belong:	1. Egbe Omowumi 2. Egbe Ina Oluwa n tan (a Christian religious association).
Justification for selection:	She was selected as a key informant because of the leadership position she occupies. She is the leader of the largest female association in Ago-Are.

MOSLEM LEADER

Name:	Buseri Adedigba
Sex:	Male
Age:	About 70 years
Marital Status:	Married with children
Type of Marraige:	Polygynous. He has two wives.
Religion:	Islam. He is an Alhaji. He worships at the Central Mosque in Ago-Are.

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Occupation:	Farming and trading. He is a large scale farmer. By local standard, he is wealthy. At present, he trades mainly in agricultural products like maize, yams and yam flour.
Educational Status:	No formal education
Home Town:	Ago-Are
Name of Compound:	Jogun omi, Ago-Are
Length of stay In Ago-Are:	Since birth.
Status/Position In Ago-Are:	1. Baale of Jogunomi Compound. 2. Treasurer of the following associations: Ifedapo Transport Owners Association; Ifedapo Co-operative and Thrift Society; Former Treasurer of Ago-Are Ifelodun Union (1970 - 1978). Alhaji Adedigba is an influential opinion leader among members of the moslem community in Ago-Are. His views and opinions are well respected.

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Associations to which Informant belong: 1. "Egbe Oredegbe" (a moslem religious association of elderly persons).

Justification for choice: He was selected as a key informant because of the leadership position he occupies in Ago-Are.

THE CHAIRMAN

Name: Michael Adepoju Adekambi

Sex: Male

Age: 47 years

Marital Status: Married with children

Type of Marriage: Monogamy.

Religion: Christianity. He attends First Baptist Church, Ago-Are.

Occupation: Teaching. He teaches at the Baptist Secondary Grammar School, Ago-Are. He is a part time farmer.

Educational Status: Holder of the Teachers Grade II Certificate obtained in 1973 as well as the Nigerian Certificate of Education (NCE) obtained in 1981.

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Home Town:	Ago-Are
Name of Compound:	Maye
Length of Stay in Ago-Are:	Except for brief period while in school he has always lived in Ago-Are.
Status/Position occupied in Ago-Are:	Current chairman of Ago-Are Ifelodun Union, a position he has held since 1986. He has previously been the Secretary General of the same union from 1976 to 1979.
Associations to which informant belong:	1. Egbe Moboluwa Duro (a christian religious association).
Justification for choice:	He was chosen because of the influencial position he occupies in Ago-Are. The Ago-Are Ifelodun Union was founded in the early 1960s to initiate self help projects that will promote the social and economic development of Ago-Are. All indigenes of the town are dejure members of the union. Being an influential position, the post of the chairman is often

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keenly contested for. The Chairman is the spokesperson for the community at all public functions and represents the community during official transactions. Being the chairman, Mr. Adekambi was considered a likely source of information about the community.

BABA EGBE

Name:	Jonathan Isola Anifowose
Sex:	Male
Age:	About 49 years
Marital Status:	Married with children
Type of Marriage:	Monogamous
Religion:	Christianity
Occupation:	Tailoring. He has been a tailor in Ago-Are since 1958.
Educational Status:	No formal education
Home Town:	Ago-Are
Name of Compound:	Agoro onile nla
Length of stay in Ago-Are	About 38 years

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Status/Position occupied in Ago-Are:	Baba Egbe (Leader) of "Egbe Iwa bi Olorun" (canvival association comprising of about 50 young married men. He started the association in 1957. Mr. Anifowose is an influential informal leader among young adults in Ago-Are. His shop, located in a strategic point in the town, is a popular meeting place for relaxation for many youths in the evenings.
Association to which Informant belong:	Egbe Iwa bi Olorun
Justification of choice:	Mr. Anifowose was selected as a key informant because he is the leader of the largest male association in Ago-Are.

THE AREOJE

Name:	Babatunde Areoje
Sex:	Male
Age:	About 61 years
Marital Status:	Married with children

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Type of Marriage: Polygynous. He has two wives.

Religion: Traditional

Occupation: Traditional healer and a night watchman at Baptist Secondary Grammar School. He hunts during his leisure hours. He is also a part time farmer.

Educational Status: No formal education

Home Town: Ago-Are

Name of Compound: Areoje

Length of stay In Ago-Are: About 17 years. Following his retirement from the Nigerian Army at the end of the Nigerian Civil War in 1971, Pa Babatunde returned to Ago-Are where he has been living ever since.

Status/position occupied: The Areoje, leader of all the adherents of African traditional religion in Ago-Are. Pa Babatunde is also a successful traditional healer who enjoys wide patronage from indigenes.

Association to which Informant belong: Egbe Orente (a canvival association of elderly person in Ago-Are).

Justification for choice: Pa Babatunde was selected as a key informant because he is the leader of adherents of African traditional religion in Ago-Are.

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CHRISTIAN LEADER

Name:	James Adesokan
Sex:	Male
Age:	About 72 years
Marital status:	Married with children
Type of marriage:	Polygynous. He has three wives
Religion:	Christianity. He attends First Baptist Church in Ago-Are regularly.
Occupation:	Farming. He is a large scale farmer. He plants mainly food crops like maize, yams and groundnut. By local standards he is wealthy.
Educational status:	No formal education
Home town:	Ago-Are
Name of compound:	Balode
Length of stay in Ago-Are:	Since birth
Status/Position occupied in Ago-Are:	He is an influential opinion leader among members of the christian community, the Vice-chairman of the Ago-Are Ifelodun Union.

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Justification for choice: Pa Adesokan was selected as a key informant because of the leadership position he occupies among christians in Ago-Are.

THE FIRST "OLOLA"

Name: Ademola Salawudeen Adetayo

Sex: Male

Age: About 45 years

Marital status: Married with children

Type of marriage: Monogamous

Religion: Islam

Educational Status: No formal education

Home town: Tede (neigbouring town located about 3 kilometres east of Ago-Are)

Name of Compound: Olola Compound

Occupation: Olola. A hereditary occupation passed on to him by his father many years ago. He is also a part time farmer.

Type of training: Through opprenticeship. He was opprenticed to his father for many

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years before be become proficient as "olola." As an apprentice he used to accompany and assist his father on business trips to neigbouring towns and villages.

Job Experience: About 25 years experience. The operation he has performed in the past include body and facial (tribal marks) scarification of different patterns,- male and female circumcision. He has offered services to clients in places like Ago-Are, Saki, Aha, Okeho and Igbojaiye.

Instrument used for operations: He uses a knife designed by him and fabricated by a local blacksmith. He currently has only one knife. According to him, he used to have more than one knife, but these were lost during a return trip back to Tede. He plans to make new sets of knife in the future. When not being used, the knife is kept in

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brown leather bag which he takes along with him on business trips.

Method of services: Clients in need of his services send for him. Some clients go to his compound. He visits Ago-Are every Sunday morning to provide services to people in the area.

Association to which informant belongs: Egbe Arikewusola (a moslem reli- association of young married men).

Justification for choice: He was selected as key informants because he possess specialised information on blood contact practices.

THE "IYALODE"

Name: Janet Arinlade Ojo

Sex: Female

Age: About 50 years

Marital status: Polygynous. Her husband has one other wife.

Religion: Christianity

Occupation: Business woman. She owns a licenced beer parlour in Ago-Are.

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Education status:	Primary school education.
Home Town:	Ago-Are
Name of compound:	Akewe
Length of stay in Ago-Are:	About 21 years. She has been living in Ago-Are since 1969 when she returned from Ghana following the expulsion of Nigerians from that country.
Status/Position occupied in Ago-Are:	The Iyalode (leader of women groups in Ago-Are). She is one of the presiding officers of the Grade C Customary Court. In addition, she is one of the coordinators of the Better Life for Rural Women programme in Ifedapo Local Government area. Finally, she is a matron of the National Patent Medicine Sellers Association of Nigeria, Ifedapo chapter.
Association to which informant belongs:	Egbe Omo Ogun Kristi (a christian religion association of married persons).

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Justification for choice: As the Iyalode, Chief Arinlade Ojo was considered likely to be knowledgable about prevailing norms in the community. Being a presiding officer at the Customary Office, she was considered likely to provide insight into divorce and remarriage practices in Ago-Are.

THE COURT CLERK

Name: Elikanah Oladokun Oparinde

Sex: Male

Age: About 45 years

Marital status: Married with children

Type of marriage: Polygynous. He has two wives

Religion: Christianity

Educational status: Primary school education

Occupation: Civil servant. He is the court clerk of the Grade C Customary Court in Ago-Are, Tede, Aha and Sepeteri. He has held this position since 1978. He hunts during his leisure hours.

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Home town:	Irawo (a neighbouring town located about 10 kilometers West of Ago-Are).
Name of compound:	Ago-Ige Irawo. At present, he lives in Tede.
Training and experience:	Mr. Oparinde began his career in the civil service in 1974 as a road labourer with the then Western State Government. In 1976, he was seconded to the Ministry of Justice as a court messenger. Through the dint of hard work, he rose from the ranks and was appointed first as clerical officer in 1977. In 1978, he was appointed as a court clerk of the customary courts in Ago-Are, Tede, Aha and Sepeteri. He has attended series of training and course related to court procedures.
Association to which Informant belongs:	Egbe Bolorunduro (a christian religious association of young married men at the Baptist Church in Tede).

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Afojeseye Elite Club (a convival association of married men in Irawo).

Justification for choice: He was selected as key informant because he has specialised information on Yoruba divorce practices.

THE SECOND "OLOLA"

Name: Daniel Ojo

Age: About 70 years

Sex: Male

Marital status: Married with children

Type of marriage: Monogamous

Religion: Christianity

Educational status: No formal education

Home town: Tede

Name of compound: Olola Compound. (Note that there are more than one Olola families in Tede).

Occupation: He is also part time farmer.

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Type of training: He was an apprentice under his father for many years before he became proficient as "olola." He used to accompany his father on business trips to neighbouring towns and villages.

Job experience: About 40 years experience. He has provided services in the past to clients in Aha, Sepeteri, Ilero Sabe, Saki and Ago-Are.

Instruments used for operations: He has four different types of knives each used exclusively for different operations. One is used for facial scarification, two for male and female circumcision and the fourth for body scarification. He inherited one of the knives from his later father. When not being used, the knives are kept in a piece of woven cloth and wrapped up.

Method of service delivery: He used to be an itinerant "olola" touring all the areas already

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mentioned providing services to clients. But these days, owing to his old age, he limits his business trips to neighbouring town of Ago-Are and Aha. Usually clients send for him when they need his service. Others go to his house for surgical services. He has already trained one of his sons, who will take over from him in the future.

Association to which Informant belongs: Egbe alala (a christian religious association of elderly persons at the Baptist Church in Tede).

Justification of choice: He was selected because he has specialised information on blood contact practices.

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APPENDIX II

Clinical Definition of AIDS in Africa

1. Clinical signs commonly seen in adults AIDS patients in Africa and the % of adults patients who have them.*

Definitive signs:
- (a) aggressive Kaposis sarcoma (6 - 17%)
- (b) cryptoccocal meningitis (3 - 12%)

Major signs:
- (a) weight loss 1% of body weight (90%)
- (b) chronic diarrhoea 1 month (40 - 48%)

Minor signs:
- (a) persistent cough for 1 month (36 - 59%)
- (b) generalized pruritic skin rash (22 - 40%)
- (c) oral candidiasis (30 - 80%)
- (d) chronic herpes simplex, orzoster (10 - 15%)
- (e) generalized lymphadenopathy (14 - 76%)

2. Clinical signs commonly seen in paediatric patients in Africa.*

Major signs:
- (a) weight loss or abnormally slow growth

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(b) chronic diarrhoea 1 month

(c) prolonged fever 1 month

Minor signs: (a) generalized lymphadenopathy

(b) oral candidiasis

(c) repeated common infections (otitis, phayngitis,...)

(d) persistent cough

(e) generalized rash

(f) confirmed maternal HIV infection

*Source Johnson, B.K. and Pond, R.S. (1988): AIDS in Africa: A Review of medical, public health, social science and popular literature. A report prepare under contract for Misereor Acher, West Germany.

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APPENDIX III

INTERVIEW AND OBSERVATION GUIDE

Interview Guide for Key Informants

Blood contact practices:

1. Identification of practices that involves use of skin piercing instruments common in the study area.
2. Origin of each of the ones identified.
3. The level of prevalence of the practices.
4. Who carry out the operation of practices.
5. Factors influencing the practice in the community.

Marriage practices:

1. Identification of marriage practices that involves having more than one sexual partner.
2. Origin of the practice in Yorubaland.
3. The factors influencing the practices in the community.
4. The prevalence of the practice in the community.

Sexual practices:

1. What are the Yoruba traditional norms on marital and premarital sex as its affects males and females.
2. What are the Yoruba traditional norms on marital and extra-marital sex as it relates to married men and women.

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3. What are the sanction if any of that are imposed on men and women who indulge in extra-marital sexual relationship.

Interview Guide for the "olola"

1. Identification of the kinds of operators he performs in the community.
2. Instruments used for operations.
3. List of materials used for operation and the functions each of these material perform.
4. Who provides the materials
5. Ideal time for operation and reasons why.
6. Pre and post operation procedures for each practice.
7. Fees charged for operation.
8. Who pay the fees
9. Methods of sterilisation of instruments before use, in-between used and after use.
10. Description of the methods used.

Interview Guide for the Court Clerk

1. Description of the process involved in contracting Yoruba customary marriage.
2. Rights of husband and wife regarding divorce under Yoruba customary marriage.

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3. The process of or procedures for taking divorce action.
4. The grounds for taking divorce action as it relates to a male or a female.
5. Trends in divorce cases in Ago-Are.
6. Reasons most frequently cited for divorce action.
7. Factors considered for determining who takes custody of children.

Interview Guide for persons whose divorce pleas were heard at the Customary Court from February to April, 1989

1. Sex
2. Occupation
3. Age
4. History of previous marriage
5. Type of current and prospective marriage
6. Reasons for divorce
7. Number of children born into the union
8. Refund of bride wealth

Observation Guide for Operation of Blood Contact Practices

1. Type of operation
2. Who carry out operation
3. Part of the body on which operation is made.

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4. Instruments used for operation

5. Conditions of instruments before use:

   (a) sterilised before use

   (b) not sterilised before use

6. If sterilised, what are the procedures of sterilisation.

7. Duration of sterilisation procedures

8. Pre-operation procedures

9. Surgical procedures

10. Materials used for operation

11. Post operation procedures

12. Chance of blood contact between operator and client during operation

    (a) high (b) low

13. Condition of instruments in-between use

    (a) sterilised before re-use

    (b) not sterilised be re-use

14. Who make decision about operation

15. Time taken to complete operation

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APPENDIX IV

Guide for Focus Group Discussion

Introduction

Good day and welcome to this group discussion. We have invited people with similar experiences to share their ideas and perceptions on certain practices in Ago-Are. You have been selected because you all have certain things in common which are of particular interest to us. The aim of the discussion is to gather more information on these practices which will be used for research purposes. We are not interested in what is right or what is wrong, all that is needed is your own opinion. Your views are confidential. Thank you.

1. What is your attitude toward male and female circumcision?
2. Why do people in Ago-Are prefer the service of the "olola" to that of the health staff at the maternity.

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3. It has been observed that young unmarried persons in Ago-Are are sexually active. Comment on this observation using your own experiences in this community.
4. What are the factors influencing this pattern of behaviour in this community?
5. How common is extra-marital sexual relationship in Ago-Are today?
6. Among which groups of peoples is the practice most common?
7. What are the factors influencing the practices in Ago-Are?
8. Who are the people who patronise the prostitutes' in Ago-Are?
9. What are the factors influencing this pattern of patronage?
10. Among which group of people is polygyny common in Ago-Are?
11. What are the factors influencing frequent divorce are remarriage in Ago-Are.
12. Are there risks involved in any of the practices already discussed?
13. Mention the risk involved in them.

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