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Sexually transmitted diseases in Ethiopia

Social factors contributing to their spread and implications for developing countries

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SUMMARY Sexually transmitted diseases in developing countries are causing concern to those responsible for their control and eradication. To gain a better understanding of the problems involved in a country struggling with development, the economic and psychosocial factors influencing the spread of STD in Ethiopia have been studied. Increased migration and urbanisation and the changing role of women have led to a rise in prostitution. Thus changes in the social structure—particularly in relation to the education and employment of women—and improved medical services are essential for the long-term control of STD.

Introduction

Sexually transmitted diseases (STD) in developing countries are causing concern to those responsible for their control and eradication. To gain a better understanding of the issues involved, Ethiopia was selected for an in-depth study because of the high prevalence of all types of STD, including syphilis, gonorrhoea, chancroid, lymphogranuloma venereum, and granuloma inguinale.

No reliable statistics are presently available on the actual extent of STD in Ethiopia, but Guthe[1] reported that syphilis was the most frequent disease being treated. Field studies carried out in various provinces showed that the prevalence of positive seroreactors was between 32% and 70%. Schaller[2] estimated the annual incidence as 150 000 new infections.

Reports of STD in Ethiopia deal almost exclusively with the medical aspects of the problem. Because an understanding of the social factors contributing to the spread of these diseases is extremely important in order to devise strategies for their long-term control, this paper analyses these aspects and, in particular, their implications for women. The rationale for this approach is threefold. Firstly, Ethiopian women, particularly prostitutes, are one of the major reservoirs of STDs and are responsible for their high prevalence.[1-5] Secondly, Ethiopian women who have STD are a danger to themselves, their families, and their communities. Most are unaware of their risks and delay seeking help; this delay may lead to pelvic inflammation, fallopian tube scarring, and possible sterility. Larsson[6] reported that of all pregnant women and their babies admitted to a maternal and child health centre in Addis Ababa during a six-month period slightly more than 15% had positive serological test results for syphilis; 21% of their live-born children had clinical signs of congenital syphilis. Stillbirths and abortions among the sero-positive women were twice the average in the general population of pregnant women attending the centre. Infected women are a danger to their communities because, unknowingly, they act as carriers and may transmit these diseases to others. Thirdly, Ethiopian women hold a perilous position in their own society; because increasing numbers are contributing to the spread of STD, they are becoming identified by Ethiopians and non-Ethiopians as evil and promiscuous persons unworthy of respect (D Plorde, unpublished data; T G Kidan, personal communication, 1976).

An analytical approach described by Jeanneret[7] has been used to identify psychosocial factors in the Ethiopian culture—related to migration, urbanisation, and sexual behaviour—which might interact in such a way as to result in an increase in STD. These factors have been examined primarily in relation to the Amhara people, who represent approximately 30% of the Ethiopian population and live in the central highlands.

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Social factors

MIGRATION AND URBANISATION

Jeanneret[9] states that factors such as land, population, economics, marriage customs, and the status of women are causally related to migration and urbanisation. Because increases in the latter lead to weakened family and community relationships and to sexual promiscuity the incidence of STD is likely to rise.

LAND

Before 1975, the majority of Amhara lived as tenants on fertile farmland owned by a small number of feudal landlords or by the Ethiopian Orthodox Church. Life for the tenant farmer and his family has always been marginal at best; at worst, famines occur, such as those in the 1970s. To supplement incomes seasonal migrations of men were common; of necessity, women and children were usually left behind. Often these temporary migrations became permanent, especially if opportunities for better employment were available. Messing[4] reported that in the south-western town of Hosaina, approximately 30% of the heads of the households were women abandoned by their husbands.

In 1975 long-awaited land reform took place when the Provisional Military Council, which had earlier seized control of the government from Emperor Haile Selassie, announced that all land throughout the country was to be nationalised.[8] Many farmers, disillusioned by the disruptive effects of the sudden nationalisation process, left the land and did not return (T G Kidan, personal communication, 1976). These conditions have forced wives, especially those permanently deserted with children to support, to seek new partners or employment, which puts them at high risk of contracting and spreading STD.

POPULATION

In 1974 the estimated population of Ethiopia was 28 millions, with 56% under 20 years of age.[9] Between 90% and 95% of the Amharas live on the highland plateaux in scattered rural hamlets and villages. A demographic survey by Russell[10] describes the distribution of a small population of all 23 villages in two sub-provinces in North-eastern Ethiopia (table I). These data are characteristic of the highland Amhara people, who represent approximately 30% of the Ethiopian population.

TABLE I *Village population according to type and sex*[12]

Village type	*No of villages*	*Population range*	*Men*	*Women*	*Excess women*
Countryside	15	30-271	657	676	19
Roadside	4	169-1003	807	935	128
Market	4	125-722	568	841	273
Total	23	4484	2032	2452	420

Countryside villages are remote farming communities some distance away from the major roads and vary in size from 30 to 271 inhabitants. Roadside villages are located on traffic routes and cater for buses and lorries passing en route to and from major cities. People gather in market villages to trade and exchange goods. In the whole area there were 420 more women than men, mainly in the roadside and market villages; of these, 390 were between the ages of 15 and 54 years. It is unlikely that this imbalance is a consequence of major disasters, since these would affect both men and women. It could, however, reflect the extent of seasonal migration of men from these villages at the time of the survey. It may, on the other hand, be the result of migration of men and women from countryside villages over a period of time, with the men moving first to roadside and market villages. This latter explanation appears plausible in the light of the relative balance of men and women in the countryside villages. Regardless of the causes, it is noteworthy that a sizeable difference does occur.

Because of the greater number of women in both roadside and market villages there are numerous opportunities for men travelling through or bringing their goods to market to spend time with them and thus risk contracting and spreading STD.

ECONOMICS

The Ethiopian economy is based primarily on subsistence agriculture; only 0·2% of the total population are employed in manufacturing industries. The yearly income per head is approximately $80.00.[11]

Efforts to develop the country's economy have met with mixed results. Before the twentieth century the concept of villages or towns was relatively unknown in the Amhara culture; they gradually came into being as an outgrowth of weekly markets when traders would wander in, set up shop, and service the peasants and their chiefs. With improved road conditions, especially during the Italian occupation in the late 1930s, these market towns and roadside villages became more permanent (S D Messing, unpublished data, 1957).

According to the traditional culture a woman had two opportunities to improve her economic situation. She could marry, knowing that if she divorced half of the couple's moveable possessions would become hers. Her second opportunity, if single, was to brew and sell alcoholic beverages in the village drinking houses and act as a "temporary wife" to travellers (S D Messing, unpublished data, 1957). While both of these opportunities allowed a

woman to accumulate capital and so become influential in the community, the second option placed her at risk of contracting and spreading STD.

MARRIAGE CUSTOMS

The age at which Amhara women get married appears to depend on whether they live in a rural or urban community. Marriage arrangements for Amhara women in rural areas are made between the ages of 3 and 4; the girl actually goes to her husband between the ages of 9 and 12 (S D Messing, unpublished data, 1957). Rendel-Short,[12] in a study of 140 pregnant urban women attending an Addis Ababa health clinic, reported that women were between 9 and 20 years of age at the time of marriage; 32% married between 12 and 14 years and 42% between 15 and 17 years.

In preparation for marriage virtually all Amhara women are circumcised either shortly after birth or before the age of 15. This is done to assure the prospective bridegroom that his spouse will not be oversexed and subsequently unfaithful to him.[4]

Three forms of marriage exist among the Amhara. The first and simplest is a temporary one and consists of a ceremonial meal eaten by the two spouses. Since it is temporary, dissolution is by mutual agreement. In the second, that of a bond wife, the marriage procedure is similar to the first, but requires the blessing of a priest. Divorce, which occurs frequently in this type of marriage, is easily obtained by both men and women. In the third form of marriage, the contracting parties take the sacrament and wear golden church mantles and crowns. Such a marriage is indissoluble and entered into by very few (S D Messing, unpublished data, 1957).

The vast majority of Amhara adopt the first two types of marriage, which provide them with maximum flexibility in adjusting to unpredictable environmental circumstances. Thus, numerous transient sexual liaisons and opportunities for contracting and spreading STD are the result for women.

STATUS OF WOMEN

The Amhara culture makes a sharp distinction between the roles of "noblewomen" and the "commoner" women. Noblewomen are granted almost all of the prerogatives of noblemen while the commoner women, who constitute 95% of the female population, are thought to need protection and tribal discipline because of "psychological weakness" (S D Messing, unpublished data, 1957). This ascribed weakness largely determines the roles assigned to women in the traditional Amhara society. Table II shows the division of labour by sex as characterised by Messing (unpublished data, 1957).

TABLE II *Division of occupation by sex*[14]

Men	*Women*	*Either sex*
Farmers, hunters, cattle raisers	Grain preparers, kitchen gardeners, family gardeners	Traders, retailers
Porters, charcoal-makers	Fetchers of water, dung, firewood	Servants
Weavers, smiths, leather- and horn-workers	Spinners, pottery-makers, tattooers, hairdressers	
Military	Restaurateur-prostitute	
Clergy, scribes, healers, church-painters	Nun (in old age), manual labourers for church	Musicians, singers
Civil administrators, teachers, judges		

In the first three categories, the quality and the quantity of labour is comparable in both sexes. In the last three categories, male job responsibilities are varied, prestigious, and challenging; there is an indication of literacy, status, and respect. Female job responsibilities, by comparison, are routine, drudge-like, and menial; there are no equivalent roles for women, unless being a prostitute or nun is considered an equivalent.

A major determining force in the repression of women is the attitude of the Ethiopian Orthodox Church. Common women are thought to be unclean and hence allowed to do only manual labour for the church. They are not allowed entrance into the church until old age when, if respectable, they may be considered for the nunnery (S D Messing, unpublished data, 1957).

Many women are unhappy with their tasks of fetching water, dung, and firewood and aspire to move upward. Especially attractive to the dissatisfied women of the countryside are the comparative luxuries enjoyed by the brewers and sellers of alcoholic beverages (T G Kidan, personal communication, 1976; D S Plorde, unpublished data).

In summary, these complex inter-related factors appear to be contributing to an increase in country-to-city migration in Ethiopia.[4 5 10] This, in turn, is resulting in weakened family and community relationships and an increase in promiscuity. Unfortunately, few demographic data are available, and the actual net migration from rural to urban areas is unknown. The limited data available on the distribution of STD in Ethiopia suggest that venereal disease is predominantly an urban problem. Guthe[1] states that 60% of the cases reported by the Ethiopian Ministry of Health in 1949 were in the capital city of Addis Ababa. These data need to be

interpreted with caution as the reporting practices in provincial Ethiopia vary markedly.

SEXUAL BEHAVIOUR

Professional and personal beliefs

Until Larsson's[6] study, health professionals believed congenital syphilis to be rare in Ethiopia. This was because of the difficulty of diagnosing a disease with symptoms similar to other highly prevalent diseases, busy schedules, and lack of funds for serological testing. A belief commonly held by mid-level health workers is that penicillin is an effective cure, and hence they use it liberally.

Commonly held personal beliefs, as identified by Torrey,[13] include: "Gonorrhoea is caused by urinating on a hot stone"; "Syphilis can be cured by having lots of sexual contacts, which weakens the disease"; and "Rashes and lesions can easily be cured by an injection." In general, people believe that STD are trivial infections compared with other prevalent more debilitating infectious diseases such as malaria, tuberculosis, leprosy, rabies, and elephantiasis (T G Kidan, personal communication, 1976).[5]

Because of the beliefs held by both the health professionals and the general population women understand neither the transmission process, the serious nature of the problem, nor what to do should they contract STD.

Health care

FACILITIES

The government, which is the principal provider of health services, has a budget of 36 cents per person per year.[9] In 1974 there were 76 hospitals, 61 health centres, and 481 health stations in Ethiopia, all of which were considered poor by WHO standards, having little in the way of medical equipment or trained personnel. An STD control centre was established in Addis Ababa in 1952; limited STD services were further developed and extended to other facilities in 1956.[9]

PERSONNEL

Scientifically trained health personnel countrywide include 300 physicians, most of whom are located in the large cities, 120 public health officers, 600 nurses, and 2800 "dressers." Most of the treatment for STD is provided by relatively untrained dressers, while a few physicians in the STD control centre in Addis Ababa provide overall direction.[9]

DIAGNOSIS AND TREATMENT

Adequate treatment for STD is dependent on the availability of facilities, trained personnel, and adequate supplies. Because Ethiopia has serious deficits in all these areas, treatment is either inadequate or non-existent (T G Kidan, personal communication, 1976).[5] [14] Diagnoses are usually made on the results of vaginal smears in women or of the Venereal Disease Research Laboratory (VDRL) test in cases of syphilis; often no laboratory tests are performed at all (T G Kidan, personal communication, 1976; Perine, unpublished data). Unfortunately, the VDRL tests are often inaccurate because of the high rate of false-positive reactions. Vaginal smears are relatively technically complicated to examine and are therefore often inaccurate. Consequently, these two methods of detection are of questionable value.

The indiscriminate use of penicillin has led to a noticeable increase in resistance of the gonococcus to penicillin[14]; in certain places in Ethiopia it is among the highest in the world. Alternative antibiotics, if available, are so expensive that their use is precluded. Recent evidence indicates that these diseases in developing countries are being mismanaged to such an extent that more problems now exist than would have arisen if no treatment had been given.[15]

Education and occupations

Only 7% of Ethiopian children attend school; 85% are boys and 15% girls.[9] Educational opportunities are inextricably related to occupational opportunities, and for Ethiopian women both are severely limited. The extent of their occupational choices is described by Russell[10] in his survey of 23 rural Ethiopian villages (table I). Of the 2032 men, most had identifiable occupations such as farmers (493), policemen (149), traders (130), government officials (84), road builders (74), weavers (65), clergy (19), tailors (19), teachers (14) etc. In all, 31 occupational choices were available to men. Of the 2452 women, most were housewives (931) or brewers and sellers of alcohol (338); a few were servants (31), nuns (9), bread sellers (3), and waitresses (2). In all, six occupational choices were available to women. Of the 338 brewers and sellers of alcoholic beverages 198 lived in the roadside and 140 in the market villages.

A clarification of the role of the brewer and seller of alcohol in the Amhara culture is vital to understanding it as an occupational choice by so many Amhara women. Traditionally, the art of brewing and selling alcohol ("tej" and "talla") was a special skill taught to all young girls as part of their preparation for adulthood. Because of the early age of marriage for almost all girls, these skills were usually only performed for their immediate family. If however, a woman did not marry, or if she became single, it was acceptable for her to brew and sell these

beverages and to serve travellers and others as a "temporary wife." In the traditional society, "tej" and "talla" houses were an integral part of the social structure—a gathering place where people shared ideas, music, and entertainment. Indeed, the "tej" and "talla" sellers were respected by all members of their communities, female as well as male, for their unique entrepreneurial skills (S D Messing, unpublished data, 1957).

CHANGING PATTERNS IN PROSTITUTION

The status of the "tej" and "talla" brewers and sellers plays a critical part in the changing patterns in prostitution. As the rate of migration from countryside to roadside and market villages has increased, so too the number of single women becoming brewers and sellers of "tej" and "talla" has risen. It has become their means of earning a living while looking for a husband. Forty to sixty per cent are considered to be prostitutes rather than "temporary wives" and are no longer respected in their communities (T G Kidan, personal communication, 1976). With the emergence of "beer houses," where commercial bottled beer is sold and 100% of the women are prostitutes, respect for these women has been eroded even further. The Ethiopian Provisional Military Administrative Council[8] has expressed its view about the issue by declaring that "prostitution is one of the serious social evils still awaiting a lasting solution in the society."

The change in nomenclature, from "temporary wives" to "prostitutes," seems to accompany the ever-increasing numbers of women who are faced with the necessity of earning a living. With so few occupations open to women in the society, even for those who are educated, the single woman appears to choose beer selling and prostitution as a sure and quick way to earn an income. In Addis Ababa, the capital of Ethiopia, with a population of almost one million people, approximately 100 000-150 000 women are in the beer business (T G Kidan, personal communication, 1976).[5] This means 10-15% of the population of Addis Ababa may be prostitutes. There is reason to believe Ethiopia is not the only African nation, struggling with issues of political and economic development, which is failing to recognise the educational and occupational needs of its women.[16]

Discussion

Migration and urbanisation patterns, coupled with complex psychosocial factors, are interacting in such a way as to increase the transmission of STD in Ethiopia. Recent military movements within the country are yet another factor to be taken into consideration. The prevalence of STD in Ethiopia cannot be estimated at present, but it appears to be high in both urban and rural areas. These diseases can be substantially reduced, in some cases eradicated, if a strong programme, which considers both the medical and social aspects of the problem, is adopted.[17]

The following considerations will be critical to a long-term solution of the problem. Ethiopia will need to:

(1) Join other African countries in establishing data on census and disease prevalence to assess the extent of the problem accurately.
(2) Increase the availability of good health services and the number of trained personnel.
(3) Adopt appropriate health education strategies which will be integrated into their basic educational curriculum.
(4) Change the status of women by increasing their educational and occupational opportunities.

The first three requirements are basic to the control of STD as well as to numerous other diseases. They are expensive and, if implemented alone, are unlikely to solve the problem. Since the social structure contributes to the problem, a change in that structure will be necessary. Both education and employment are associated with improved health; therefore, the fourth consideration, that of changing the status of women, is essential to a long-term solution of the problem.

Ethiopia is presently struggling both internally and externally for its life as a nation. The Provisional Military Administrative Council is attempting to restructure major sectors of the society, including expansion of the educational system, development of small industries, provision of social and health services, and revision of its policies of land distribution.[8] They have recognised that national progress will require a healthy population and that STDs pose a serious threat to this process of development. For this reason, they have appointed a committee of experts to devise a plan for eradicating prostitution. This solution cannot, however, consist only of abolishing prostitution. It must take into account the fact that these women in becoming prostitutes traded their self-respect for their livelihood, because they saw no other means open to them. Educational programmes, both for these women and members of their communities, such as those carried out in China, will need to be developed and implemented. Furthermore, with the present degree of social dislocation ever-increasing numbers of women will need to find alternative ways of earning a living. Because the Ethiopian government is already reshaping major sectors of the society, now is the ideal time for the simultaneous development of educational and occupational opportunities to meet

the needs of women. This will enable them to contribute in a positive way to the economic development of their country.

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