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SOCIAL CHARACTERISTICS OF
PATIENTS SEEKING VENEREAL
DISEASE TREATMENT IN PUBLIC
HEALTH CENTRES

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ABSTRACT

Information for this paper was collected through interviews of 87 persons seeking treatment for venereal disease in public health centres in six different towns around Kenya. Data is presented on the subjects' social characteristics and their responses to questions about sexual behaviour and venereal disease. Judging from the sample population, it seems that venereal disease is more prevalent among the young and the single or divorced. The respondents' knowledge about the causes and prevention of venereal disease was found to be very limited. In conclusion, public education concerning these very common infectious diseases is urgently recommended.

INTRODUCTION

Venereal diseases are widespread among young people. Because they are sexually transmitted, they have a sociological dimension in addition to the medical one. As has been pointed out,¹ the number of people suffering from venereal disease is increasing in Kenya, yet in spite of the good intentions of public health personnel few people know anything about these diseases. Public education concerning the transmission, prevention and treatment of venereal disease is urgently needed.

The purpose of this paper is to present data on the social characteristics of patients who have sought treatment for venereal disease in Kenyan public health centres. In addition, the level of knowledge these patients have about venereal disease has been investigated. It is hoped that this data will show that more attention should be given to the problem of venereal disease.

Methodology

This study was conducted over a period of four weeks during 1973. Subjects were chosen randomly from the registers of the public health centre in Nairobi which specialises in skin diseases, the centre in Mombasa which caters for women working in public places, and general public health clinics in Nyeri, Machakos, Nakuru and Kitale. Interviews were conducted in private rooms without outside interruptions both before and after patients had seen the doctor. In all cases, the attending health personnel were asked to confirm the nature of the respondents' illness.

Using a questionnaire, the author interviewed 87 patients, 74 females and 13 males. Some of these patients were coming to be treated for the first time, and some were coming for additional treatment so that some respondents knew the nature of their illness and others did not. In fact 85 of the respondents were suffering from venereal disease and 2 from other ailments. The ages of the respondents ranged between 17 and 36, with the majority between 17 and 24.

¹ For a detailed discussion of venereal diseases and their historical development in Kenya, see 5.

SOCIAL CHARACTERISTICS OF THE RESPONDENTS

Age, Education and Marital Status

Although the sample is not large, it indicates that the majority of patients seeking treatment in public health centres for venereal disease are young. Thus 72% of the females and 77% of the males were under 24. It is also possible that the sample was skewed toward young people because they would be more likely to visit public centres being unable to afford private doctors.

Table 1. Age of patients seeking venereal disease treatment in public health centres.

AGE	MALE		FEMALE	
	No.	%	No.	%
17 - 18	-	-	4	5%
19 - 20	3	23%	16	22%
21 - 22	5	38%	17	23%
23 - 24	2	15%	16	22%
25 - 26	-	-	7	9%
27 - 28	1	8%	7	9%
29 - 30	-	-	5	7%
31+	2	15%	1	1%
Age not given	-	-	1	1%
Totals	13	99%	74	99%

Researchers in other parts of the world have also found that venereal disease occurs more frequently among young people. Nicholas J. Fiumara concluded that "gonorrhoea is the most prevalent disease of young people 10 to 19 years of age" (3, pp. 338-339), and A. Grimble found that "gonorrhoea is a disorder closely related to potency and will therefore always be common in the younger age groups". (10, p. 186)

Investigations within East Africa have also found that venereal diseases are common among younger people. In his study of social determinants of venereal diseases in East Africa, Bennet found that "71% of the cases were young men under the age of 30 and that 20% were under the age of 20". (2, p. 332)

If we use this classification, the figures in Table 1 show that 95% of our respondents seeking treatment were under the age of 30 while 26% were under the age of 20 years. The higher percentages in our study might indicate either that more people are being exposed to venereal disease at an earlier age or that detection of the disease among young people is improving. At any rate, there can be no doubt that a large proportion of those suffering from venereal disease in East Africa is young.

Most of the patients interviewed had only primary school education or none at all. As shown in Table 2, 12% had no education and 70% had from one to seven years. Only 17% of the respondents had more than primary education. In addition, one respondent refused to answer this question.

Table 2. Respondents' education.

EDUCATION	No.	%
No Education	10	12%
1 - 7 years	61	70%
8 or more	15	17%
Refused to Answer	1	1%
Totals	87	100%

The marital status of the respondents is shown in Table 3. As can be seen from the table, only a small number claimed to be married. It would seem that the majority of women who come to seek treatment for venereal disease in public clinics are either single (35% of our sample) or divorced (50%). Slightly more than half of the male respondents (54%) were also single, so that our sample suggests that most of those seeking treatment in public clinics for venereal disease are not married. Although it is difficult to generalise from a sample of this size, it has been shown that the level of promiscuity is high among young unmarried people in Kenya (see 4, 6 and 8), so that the chance for exposure to venereal disease would be high among this group. It seems reasonable that a relatively large

proportion of the young and unmarried might be suffering from venereal disease and thus seeking treatment.

Table 3. Respondents' marital status.

MARITAL STATUS	MALE		FEMALE		TOTAL	
	No.	%	No.	%	No.	%
Single	7	54%	26	35%	33	38%
Married	6	46%	6	8%	12	14%
Divorced	-	-	37	50%	37	43%
Widowed	-	-	5	7%	5	6%
Totals	13	100%	74	100%	87	101%

Religion

The respondents were asked their religious affiliation, but in considering their answers it must be borne in mind that these do not necessarily indicate active participation in a church group or strict adherence to religious teachings.

It seems from our investigation that Roman Catholics were seeking treatment for venereal disease in greater numbers than those professing other religions.

Since the Catholic Church is supposed to be quite strict in its teachings on sexual behaviour, it is curious that 40% of our sample of venereal disease patients, who might be considered more sexually promiscuous than the population as a whole, were Catholics. This 40% is significantly higher than the 28% of the total Kenyan population said to be Catholic based on mid-1972 population estimates. (12, p. 181) Perhaps the Catholic belief in the absolution of sin through confession alleviates the guilt feelings of this portion of the population, or perhaps more likely the teachings of the Catholic Church have had little impact on the actual behaviour of its African members. It seems in

Table 4. Respondents' religion.

RELIGION	MALE		FEMALE		TOTALS	
	No.	%	No.	%	No.	%
Catholic	5	38%	30	41%	35	40%
IPC	1	8%	5	7%	6	7%
Protestant	3	23%	18	24%	21	24%
Muslim	2	15%	17	23%	19	22%
Traditional	-	--	1	1%	1	1%
Methodist	1	8%	--	--	1	1%
CMS	-	--	1	1%	1	1%
Seventh Day Adventist	1	8%	2	3%	3	3%
Totals	13	100%	74	100%	87	99%

general that Western religions have been reinterpreted by Africans to suit local traditions and customs. A striking example of the deviation of Catholics in Kenya from the teaching of their church is their reported widespread approval of the use of contraceptives. (See 8.) Combining all the Protestant sects listed in Table 4, 37% of our sample of venereal disease patients were Protestant, compared with 38% of the national population. (12, p. 181) The Muslims were 19% of our sample, but they comprise only 6% of the population. (12, p. 181)

In Table 5 the respondents' religion is compared with their education level, and it is found that the Catholics are generally as well educated as other groups. Looking at marital status, one finds that the divorce rate is highest among Catholics: 43% of the Catholic respondents were divorced. The Muslims followed with 30% divorced, and finally 16% of the Protestants were divorced.

Table 5. Education compared with religion.

RELIGION	EDUCATION IN YEARS											
	up to 5		5 - 7		8 - 9		10 - 12		NONE		TOTALS	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Catholic	8	38.0%	16	40.0%	4	36.0%	2	50.0%	5	45.0%	35	40.0%
IPC	2	9.0%	3	7.5%	1	9.0%	-	-	-	-	6	7.0%
Protestant	-	-	11	27.5%	5	45.0%	2	50.0%	3	27.0%	21	24.0%
Muslim	9	43.0%	7	17.5%	-	-	-	-	3	27.0%	19	22.0%
Traditional	1	5.0%	-	-	-	-	-	-	-	-	1	1.0%
Methodist	-	-	1	2.5%	-	-	-	-	-	-	1	1.0%
CMS	1	5.0%	-	-	-	-	-	-	-	-	1	1.0%
Adventist	-	-	2	5.0%	1	9.0%	-	-	-	-	3	3.0%
TOTAL	21	100%	40	100%	11	100%	4	100%	11	100%	87	100%

Occupation and Income

The respondents in this study had either unskilled jobs or were casually employed. Most of the women were employed as beer sellers or waitresses, and the largest occupational group among the men was that of driver/mechanic.

Table 6. Occupations.

OCCUPATION	MALES		FEMALES		TOTAL	
	No.	%	No.	%	No.	%
Bargirl/waitress/barman	1	8%	45	61%	46	53%
Ayah/housemaid	-	-	6	8%	6	7%
Prostitute	-	-	6	8%	6	7%
Housewife/salesgirl/self employed	-	-	7	9%	7	8%
Trainee/student/clerk	4	31%	2	3%	6	7%
Driver/mechanic	6	46%	-	-	6	7%
Casual labour/self employed/general	2	15%	3	4%	5	6%
None	-	-	5	7%	5	6%
Total	13	100%	74	100%	87	100%

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Most of the jobs appearing in Table 6 are associated with low education and low incomes. As Table 7 shows, the income derived from these various occupations is small. Although incomes range from those who earn between zero and one hundred shillings a month to those whose incomes were at least five hundred shillings a month, the largest group of respondents (47%) earned between one and two hundred shillings.

Table 7. Income per month, in Kenya Shillings.

INCOME	MALE		FEMALE		TOTAL	
	No.	%	No.	%	No.	%
No income or no response	3	23%	9	12%	12	14%
1 - 100	-	-	5	7%	5	6%
101 - 200	1	8%	40	54%	41	47%
201 - 250	2	15%	11	15%	13	15%
251 - 300	1	8%	3	4%	4	5%
301 - 400	3	23%	3	4%	6	7%
401 - 500	2	15%	2	3%	4	5%
501 and over	1	8%	1	1%	2	2%
Total	13	100%	74	100%	87	101%

In order to better understand the real significance of these statistics on income, the respondents were asked how many children they had in school, for whom they would have to pay school fees, and how many children they were actually supporting. Although 76% of the respondents had children (53% had one or two children and 23% from three to six), the large majority (72%) had no children in school. The average number of children for each respondent was 1.4.

The question concerning how many children the respondents were supporting included any children supported, not just the respondents' own biological children. However, 97% of those interviewed were supporting no children. An explanation for this might be that children would be considered a burden by these generally young and unmarried people living in urban areas, and so the children might have been sent home to their

grandparents. This practise is especially common with African girls who find themselves with a baby but no husband.

Although reported incomes are low, they should be adequate for the respondents' needs since almost none of them are supporting children. An interesting comparison can be made with the monthly incomes recommended by the ILO Mission to Kenya. The ILO Mission, using 1971 prices, suggests that "suitable targets might be as follows: for rural households, 120 shs. by 1978 and 180 shs. by 1985, and for urban households 200 shs. and 250 shs. respectively". (11, p. 109) It must be remembered that the ILO Mission is projecting household incomes, whereas we are reporting on individual incomes. Since almost all of our respondents are only supporting themselves, their incomes as reported in Table 6 might be said to exceed the ILO recommendations. Although many of our respondents, especially the large number of women working as waitresses and bargirls, might be tempted to supplement their low incomes by working as prostitutes, it does not seem likely that they are being forced into this out of economic necessity.

REASONS FOR VISITING TREATMENT CENTRES

The respondents were asked why they had come to the clinic, and 23% of the men and 47% of the women said they were coming for treatment, which meant that this was not their first visit. The rest of the men (77%) and 28% of the women said they were visiting the centres for the first time and had come because they were sick. The other women gave such reasons as "to be checked" or "to fill up health cards", in the case of those living in municipalities where they have to have health cards in order to work in public places.

When respondents were asked if they thought they were suffering from any diseases, 100% of the men and 77% of the women answered in the affirmative. More specifically, 85% of the men and 50% of the women said they thought they were suffering from gonorrhoea, and a further 8% of the women thought they were suffering from syphilis. Many of these diseases were clinically verified after investigation. Responses to this question are shown in Table 8.

Table 8. What type of disease do you think you are suffering from?

DISEASE	MALE		FEMALE	
	No.	%	No.	%
Gonorrhoea	11	85%	44	59%
Syphillis	-	-	6	8%
Other non-specific				
Urethritis	1	8%	7	9%
Bilharzia	1	8%	-	-
Don't know	-	-	16	22%
No reply	-	-	1	1%

The respondents were asked why they suspected that they were suffering from these diseases, and the symptoms they reported are given in Table 9.

Table 9. How do you know that you are suffering from the above illness?

SYMPTOMS	MALE		FEMALE	
	No.	%	No.	%
Discharge	1	8%	20	27%
Stomach Pain	3	23%	17	23%
Been Told	-	-	21	28%
Scratching	1	8%	5	7%
Pain when Urinating	6	46%	1	1%
Soreness	-	-	1	1%
Miscarriage	-	-	1	1%
Physical signs	1	8%	1	1%
Had it before	-	-	1	1%
Don't know	1	8%	-	-
No reply	-	-	16	22%

Note: Percentages may add up to more than 100 because multiple responses were allowed.

Many of the respondents had been referred to the venereal disease clinic by the staff of other health centres which could not diagnose or treat these diseases adequately. These would be respondents in Nairobi and Mombasa where interviews were conducted in specialised clinics. Specifically, 26.4% of all respondents had been referred by dispensary staff, a nurse or a doctor.² Of all those interviewed, 44% claimed to have come on their own, and of these 77% were men. This may indicate the fact that gonorrhoea is easier to detect in males than in females. Of the men, 15% had learned about the nature of their illness from friends, but only one of the women had learned from this source. Of the women, 5.7% had learned of their illness from boyfriends, husbands or former husbands.

SEXUAL BEHAVIOUR AND PRACTISES

Nearly all of the respondents had had sexual experience by the time they had reached the age of sixteen. The majority had their first experience between the ages of fourteen and sixteen, as is shown in Table 10.

Table 10. How old were you when you had your first sexual intercourse?

AGE AT FIRST INTERCOURSE	MALE		FEMALE	
	No.	%	No.	%
10 years and under	1	8%	2	3%
11 - 13 years	5	38%	31	42%
14 - 16 years	6	46%	38	51%
17 and over	1	8%	1	1%
Don't know	-	-	2	3%

This table indicates that by the age of 20 virtually every young person has had sexual experience.³ The majority of our sample, 68% of the men and 88% of the women, had their first sexual experience with an older person.⁴ Only 31% of the men and 11% of the women had their first sexual experience with a person younger than themselves.

². To many people, especially in rural areas, a doctor is any man who works in a health centre, clinic, hospital or a related service. Thus a dispensary dresser or orderly will often be referred to as a doctor. This confusion is not simply an indication of ignorance, but rather a sign of the great respect many Kenyans have for the medical profession.

³. For a more detailed discussion on the sexual attitudes and practises of young people in Kenya see 4, 6 and 8.

⁴. For a detailed analysis on how both boys and girls are introduced to sexual activities see 7.

The frequency with which our respondents reported having sexual intercourse varied considerably. Fifteen percent of the women and twelve per cent of the men said they had sexual intercourse once a week. The majority (62% of the men and 51% of the women) said they had intercourse between two and four times a week. Among the women, 15% said they had intercourse more than five times a week, and another 18% said they had sex daily.

The respondents were further asked if they always had intercourse with the same person.

Table 11. Do you have sex with the same person every time?

	MALE		FEMALE	
	No.	%	No.	%
Yes	2	15%	15	20%
No	11	85%	58	78%
No reply	-	-	1	1%

As shown in this table, a large majority of both sexes indicated that they do not always have sexual intercourse with the same person. This response pattern would seem to indicate a high level of candour on the part of the respondents. It also probably indicates a certain level of promiscuity, considering also the fact that 87% of the sample were not married, Table 3 showed that 7% of the female respondents admitted that they were prostitutes, but the high level of sexual activity with more than one partner indicated by a much larger portion of the women interviewed may indicate that a larger number of them are engaged in some form of prostitution.

The respondents who stated that they had sexual intercourse with only one person were asked what their relationship was with that person. Among the women who have intercourse with one person only, 46% said that their regular sexual partner was their boyfriend, 37% said their husband, and the rest refused to answer.

All those who said that they do not always have intercourse with the same person were asked where they meet their sexual partners. The results are shown in Table 12. Percentages add up to more than 100 because multiple responses were allowed.

Table 12. Where do you meet your sexual partners?

	MALES (%)	FEMALES (%)
At bars and parties	68%	84%
In the street	34%	34%
At dancing halls and night clubs	8%	24%
Partners are old friends	23%	19%
In my own room	8%	18%

This information combined with the frequency of sexual intercourse indicates that many of these women are at least part-time prostitutes, although they may have other occupations as well.

It would seem then that we are dealing with a rather special group, making it difficult to generalise from our sample to the Kenyan population as a whole. It seems likely that these respondents have been exposed to venereal disease more frequently than most Kenyans, and it might be expected that they know more than the average Kenyan about venereal disease, the way it is spread and how it is prevented and cured. The respondents' knowledge about venereal disease will be discussed in the next section.

KNOWLEDGE AND BELIEFS ABOUT VENEREAL DISEASE

The respondents were asked whether they had ever heard about the possibility of being infected with a venereal disease. Of the total sample, 56.3% had heard about this possibility, 33.3% had not and the rest refused to answer. It is disturbing that such a large portion of the sample population had not heard about venereal disease prior to their present ailment. Although the incidence of venereal disease is increasing in Kenya (see 5), there is very little public education on the subject. Nearly half of the women (47%) did not say they had heard about venereal disease, and nearly one fourth (23%) of the men.

Those who had heard about venereal disease were asked about the sources of their information and multiple responses were allowed. It was expected that health personnel would be a major source of information on venereal and other communicable diseases, but in fact only one respondent had received information from health personnel. Of the others, 40.2% had heard from their friends, and of the women 5% had received information from the radio, and 7% from newspapers and books. In addition, 6.8% of men and women had heard about venereal disease from a variety of sources such as folklore, teachers, husbands, lecturers and other people.

The respondents who admitted that they were suffering from venereal disease were asked how they felt about it, and the largest group (41.4%) said that they felt sad or depressed. A further 24% said that they were uncomfortable or in pain; 6% were embarrassed, 5% were annoyed, angry or disappointed, 3% were indifferent, and 8% refused to answer.

How Venereal Disease is Spread

The patients were asked if they knew how they had been infected. One of the women said that the source of her illness was the hotel, but it turned out that she meant she had had sexual intercourse in a hotel room. Of the women, 51% said that their infections had come from men or sailors, 11% identified boyfriends as the source of infection, and 4% identified husbands. One woman stated that she had been infected by prostitutes, but on further questioning it turned out that she meant that she had become infected due to her being a prostitute. The other women (31%) did not know the source.

Two of the thirteen male respondents said they had been infected by water, and it was later clinically verified that they were suffering from bilharzia. Seven men claimed they became infected from women, bargirls or prostitutes; one from sailors (!); one from a boyfriend (!); and the two others did not know the source. The responses to this question indicate that the majority of the sample population realise that venereal diseases are transmitted sexually.

Even among those respondents who knew how venereal disease is transmitted, many continued to have sexual intercourse after they realised that they had been exposed and before seeking treatment. From the total sample, 46% of the men and 74% of the women continued to have sexual intercourse although they knew they had been exposed. Furthermore, 38% of the men and 43% of the women had suffered from similar infections before, although only 28% of the men and 39% of the women claimed that their earlier infections had been cured.

Respondents were asked whether they could remember when and where they were exposed to venereal disease. While most of them could not remember the precise dates, 77% of the men and 49% of the women remembered the place where they thought they were exposed. Thus 31% of the men and 34% of the women thought they were exposed in their own rooms, and 46% of the men and 15% of the women thought they were exposed in hotel rooms.

Effective treatment and control of venereal disease depends on the cooperation of patients in informing their sexual partners about their illness or informing health authorities about their sexual partners so that they can be contacted and if necessary treated before the disease is spread further. Respondents were therefore asked if they had informed anyone after realising that they were suffering from venereal disease.

Table 13. After you realised that you had venereal disease, did you inform anyone?

	Number	%
Yes	24	27.58%
No	57	65.51%
No reply	6	6.89%

Only slightly more than a fourth admitted talking with anyone about their illness, and well over half had not spoken to anyone. Only very few of the respondents had informed either their sexual partners or a public health worker: 16% of the men and 2% of the women talked with their brothers; 31% of the men and 14% of the women talked with their closest friend. Among the women, 5% had told their husbands, and one woman had told a physician and two had told public health nurses.

A person suffering from venereal disease could have one of two motivations in informing someone else, either to seek help for himself or to enable the other person to seek help if he has been exposed. The respondents in this sample who informed another person about their infection apparently were seeking help for themselves. Of those who did confide in another person, only 25% of the women and 31% of the men received sympathetic advice. In most cases the respondents were told by their confidants that they should seek medical attention as quickly as possible. One man and one woman said that their confidants had said nothing, and one other woman who had confided in her husband said that since he had infected her he said nothing.

Very few of the respondents would admit that they had passed on venereal disease to someone else, although as was stated earlier 46% of the men and 74% of the women had sexual intercourse when they knew they had been exposed to the disease.

Table 14. Do you think you have passed your ailment to anybody?

	MALE		FEMALE	
	No.	%	No.	%
Yes	-	-	7	9%
No	5	38%	7	9%
No answer	-	-	1	1%
Don't know	8	62%	59	80%

By far the majority of respondents, while not denying that they passed the disease on, simply said that they did not know. Of the seven women who admitted infecting someone else, three said they had infected their boyfriends, another three said they had infected many men and one said she had infected her husband.

The respondents were asked if they knew of other people who were suffering from venereal disease. Only three women and none of the men were willing to admit that they knew others with venereal disease. One woman said that she knew three people, another woman knew nine and the third knew more than nine. However, when respondents were asked if they believed many people were suffering from venereal disease, a large majority (69% of the men and 80% of the women) answered in the affirmative.

This apparent discrepancy can only be explained in psychological terms. Since this sample was made up almost entirely of people who were actually suffering from venereal disease themselves, and since venereal disease is widely associated with sexual promiscuity and is thus a source of embarrassment and shame, these people felt less guilty and more comfortable if they could believe that many others had the same problem.

Table 15. Who do you think has the disease more often and in greater number than the other - men or women?

	MALE		FEMALE	
	No.	%	No.	%
Men	2	15%	38	51%
Women	11	85%	23	31%
Don't know	-	-	13	18%

As might be expected, men and women accuse each other of spreading the disease. Thus 85% of the women and 51% of the men said that the opposite sex had venereal disease more often. These accusations seem almost inevitable since venereal disease is transmitted sexually and so men usually become infected from women and women from men.

How Venereal Disease is Controlled and Cured

Respondents were asked if they had tried to treat their ailments themselves before coming to the treatment centres, and 23% of both the men and the women had attempted treatment before coming to the clinics. Of those who had attempted prior treatment, 15% of the men and 9% of the women had used "local medicines and herbs", and 8% of the men and 18% of the women had used "drugs".⁵ Some of the patients had sought help from "witch-doctors" because they thought someone "had cursed them", while others sought help from friends and chemists.

⁵. In Kenya's urban areas, particularly at bus stops and bars, a phenomenon has grown up which someone has jokingly called "the trade of the travelling chemists". This involves selling illegal, though fortunately often harmless, drugs to travellers. The people involved claim that they have several drugs which can cure almost any type of illness. For those coming from rural areas, the name "capsule" is used and understood to mean a wonder drug for any ailment. For the more sophisticated group from the urban areas, the name "suta capsule" is used and is often supposed to be a form of antibiotic effective against venereal disease. The sellers of these pills claim that if one is taken just before or after intercourse, it will effectively prevent any kind of venereal disease.

In addition, the patients interviewed were asked about the prevention of venereal disease.

Table 16. Is there anything that one can do to prevent venereal disease?

	MALE		FEMALE	
	No.	%	No.	%
Yes	7	54%	37	50%
No	6	46%	36	49%
Don't know	-	-	1	1%

About half of the men and the women felt that there is some way to prevent venereal disease. This group was asked further about preventative measures, and 38% of the men and 39% of the women mentioned the condom (durex). "Drugs and medicines as well as herbs" were mentioned by 15% of the men and 18% of the women, while 4% of the women said one "should wash after sex," and 3% of the women said that "one should abstain from sex". One woman claimed that there is a "control oil" which can be used, and another woman said that the only way to avoid venereal disease is "to avoid sex with strangers".

Respondents were asked whether they felt anything could be done on a national basis to control and cure venereal diseases, and 37% of the total sample answered affirmatively and 2% negatively. This left a significant majority (61%) who did not know. Breaking down the responses by sex, one learns that 54% of the men and 34% of the women believed that something could be done. It is interesting that a much higher proportion of the women felt that venereal disease could be controlled on an individual level (50%) than on a national level (34%).

Those who replied that they thought something could be done on a national basis were asked what measures could be taken. The need for a national education programme on venereal diseases was mentioned by 23% of the men and 15% of the women. One man and one woman also claimed that there would be no more venereal disease if prostitution were eliminated.

The others cited measures which are really applicable to individuals rather than on a national level. Thus 6% said that one should use drugs and/or get treatment immediately; 2% said that "all men should be examined"; 7% said that either people should have regular checkups, abstain from sex, be careful or finally that they should be warned.

When the respondents were asked who should actually take the measures they had suggested, 14% mentioned the police and public health personnel, 9% thought the responsibility lay with the individuals concerned, 6% mentioned teachers, 3.4% mentioned parents, one person mentioned husbands, and another person thought that venereal disease control is the responsibility of everyone who understands the problem. The others (63%) either had not mentioned any measures to be carried out or did not know.

CONCLUSION

The social characteristics of a sample of patients seeking checkups or treatment for venereal disease have been presented along with some indications of the knowledge and beliefs of the sample population concerning venereal disease. Although the size of the sample is small, a few generalisations can be put forward tentatively based on the information collected.

Firstly, venereal diseases appear largely to afflict young people and those who are single or divorced. Secondly, among those afflicted with venereal disease there seems to be widespread promiscuity. Thirdly, people seeking treatment in public health centres seem to be generally in the low economic and occupational groups and have little or no education.

It is clear that, while many of the respondents had some general knowledge about venereal disease and the way it is transmitted, accurate information about prevention and cure was scanty. The respondents seem to have received little or no information from public health personnel or other government sources. Furthermore, it is possible that Kenyans living in rural areas have even less knowledge of venereal disease than this urban-based sample.

The need for public education on the subject of these very common infectious diseases is clear. The challenge to public health authorities will have to be met with determination and urgency.

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