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"Because it's not as if one is promiscuous": Investigating Culture and STI Care in Africa

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Abstract

This study explores the implications of culture for Sexually Transmitted Infections (STI) health care delivery in Africa. A purposive sampling of 20 audio-taped doctor-patient interactions in selected STI and HIV clinics in south west Nigeria, was done. The interactions were transcribed and screened for instances of cultural influences. Insights from Conversation Analysis and the common ground theory were adopted for the analysis. The study found that culture has both positive implications and negative implications for STI care in Africa. The African culture of respect, illustrated through greetings and the use of honorifics constitute positive impacts to STI care delivery, while the cultural practices of stigmatisation of STI patients, taboos, indirect reference to certain parts of the body and the tendency for patriarchal STI deresponsibilisation, were found to be very inimical to STI care in Africa, and Nigeria especially. The study concludes that the positive aspects of culture should be deployed in achieving better health care delivery in STI cases; the negative aspects, some of which have been identified above, should be addressed corrected for better results in the societal conceptualisation, interpretation and treatment of STIs in Africa.

Keywords: Culture, STI care in Africa, Stigmatisation, Conversation Analysis, Common ground

Introduction

Culture can be conceived as the lens through which a society views the world, including issues of health. For instance, "the culture of a society about sex related issues plays an important role in the prevention and treatment of sexually transmitted diseases" (Praharaj 2011:1).

Culture has been defined as the "characteristics and knowledge of a particular group of people, encompassing language, religion, cuisine, social habits, music and arts" (Zimmermann 2017). Culture thrives on communication and socialisation. The core of culture is formed by values and these values reflect broad tendencies for certain state of affairs- right or wrong, right or

evil, natural or unnatural. Culture is further hypothesised as a collection of shared values, beliefs, and practices that are contained within a clearly defined community (Ulrey & Amason, 2001; Brislin & Yoshida, 1994). These values, beliefs, and practices are conceptualised as variables, and the goal of the health communicator is to identify those underlying cultural cues that may be incorporated into the delivery of the health message. (Kadiri, Ahmad, Mustaffa 2014)

Research has shown that "socio-cultural influences, traditional lifestyles, societal norms and traditions have some influence on sexually transmitted infections (henceforth, STIs), including HIV/AIDS" (Praharaj 2011:2). According to Meyer- Weitz (1998:3), an essential step in curtailing the spread of STIs in South Africa is to understand how the cause, spread and prevention of STIs are conceptualised by STI patients themselves and how these representations influence their behaviour.

A sexually transmitted infection is an infection passed from one person to another person through sexual contact. While some STIs can be cured, some cannot be cured, but can be medically managed. STIs continue to pose severe risk to public health and the consequences can be quite lethal, if left untreated. Common STIs include - gonorrhea, syphilis, chlamydia, genital herpes, HIV/AIDS, hepatitis (A, B, C, D, E), bacterial vaginosis, crabs or pubic lice, genital warts, vaginal thrush (female candidiasis), Trichomonas, Molluscum contagiosum, etc.

Previous Studies on Culture and STI

Since the predominant way of contracting STIs is through sexual intercourse, it becomes pertinent to examine the cultural interpretations of the relationship between sex and STIs and the implications this cultural conceptualisations bear for STI care. Culture is discussed under the variables below, in relation to STI:

Norms and Taboos

In some cultures, especially Africa, sexual relationships are enmeshed in different cultural beliefs, with regulations placed by different norms and taboos, which include various sexual taboos such as having sex with a widow, having sex with a woman who has had a miscarriage or an abortion. These taboos reflect the widespread belief in Africa that death is a mystically polluting force that can negatively affect health (Green et al., 1995).

Other sexual taboos that are believed to result in ill health are having sex with a woman during menstruation or with another man's wife (Green, 1992; Green et al., 1995; Scott & Mercer, 1994). It is believed that in instances where these sexual taboos are ignored or transgressed, that a traditional disease such as an STI will result. Diseases are considered as either naturally caused or spiritually caused (Green, 1992).

In Africa, most diseases that are transmitted by sexual intercourse are considered as traditional diseases, thus spiritually caused (Green, 1992; Green et al., 1995). It is therefore believed that these diseases are best diagnosed and treated by traditional practitioners and medicines or through consultation with multiple healers (Green, 1992).

Polygamy and STI

Polygamy, the practice whereby a man marries more than one wife, is entrenched in the African culture. Culturally, the practice of polygamy is premised on the belief that a large family and many wives translate to wealth, affluence, and influence. The primordial African man was assessed for affluence by the number of wives under his control and care. Furthermore, polygamy is also popular for other economic reasons like benefits such as cheap labour for farming etc. However, today, for both economic and religious reasons, monogamy is more popular, especially in urban areas, but multiple sexual encounters, either with regular partners or with sex workers, remain.

Consensual unions, often between a man and more than one woman also occur relatively frequently. Polygamy and concubinage are still accepted as normal cultural practices among Africans in spite of the effect of modern life on many tribal customs (Mokhobo, 1989).

All these translate to more freedom to engage in sexual relations with more than one person at a time, thus expanding the risks of contracting STIs.

Gender Roles and STI

In many societies in Africa, Men's social roles are characterised by the expectations of male dominance and sexual prowess, while women are expected to be subordinate and submissive to male dominance and sexual desires. The subordinate status assigned to women in general in combination with male dominance and sexual prowess place women in a very vulnerable position, making it virtually impossible for them to negotiate for safer sex or to claim monogamy from their partners. This seriously compromises their risks for STI infection and their ability to protect themselves.

Methodology

A purposive sampling of 20 audio-taped doctor-patient interactions in selected STI and HIV clinics in south west Nigeria, gathered between 2012 and 2015, make up the data for the study. The interactions were transcribed and screened for instances of cultural influences. Only five interactions were selected for analysis for the study. The analysis was done using insights from Conversation Analysis and the common ground theory.

Theoretical Insights

Common ground

Common ground is a concept that is attributed to Herbert Clark and Susan Brennan (1991). The theory is situated explicitly in the tradition of Conversation Analysis though with a mentalist flavour different from Conversation Analysis.

They propose that the context that a listener requires to understand what a speaker means at a particular speech event is the common ground that is believed to mutually exist between them (Clark and Carlson 1981:319). Common ground is defined as "mutual knowledge, mutual beliefs, and mutual suppositions" between two people (Clark and Carlson 1981:321). The idea here is that it is not sufficient for the two people involved in an interaction to believe or know certain things. Each of them must know and believe that he knows and believe those things, know that the other person shares the same belief and knowledge, and that the other person knows that he holds similar beliefs and knowledge and so on (Schiffer 1972). All joint activities thrive on the accumulation of the participants' common ground (Clark and Brennan 1991:127; Clark 1996:38). The process by which interactants build their common ground is called "grounding", a term that has been defined by Clark and Brennan (1991:129) as "… a collective process by which the participants try to reach [their] mutual belief. It is generally understood that mutual belief can never be perfect. As such, there is a need for a "moment by moment" updating of common ground through grounding.

Three major types of evidence that signal what is common ground between two interactants as identified by Clark and Marshall (1981) are: physical co-presence, linguistic co presence and community membership. Physical co-presence refers to the possibility of two people sharing a similar experience which could be by sight, smell or touch, within the same space and time. Linguistic co presence involves all the utterances being uttered in the course of the interaction including the current one being considered by participants while community membership refers to knowledge shared by participants by virtue of their group affiliations which could be by age, race, social class, technical know-how, religion, profession and the likes.

Data Analysis

The Culture of Respect and STI Health Care

The culture of respect is deeply engrained in the Africa society, especially in the South west region where the Yoruba tribe is settled and where the data for this study were got. One of the fundamental ways through which people show respect, especially in formal settings, is through greetings. This phatic communion is also expected to be reciprocated as failure to return a greeting could be damaging to the public self- image of the affected individual (Brown and Levinson 1987). Another way through which the culture of respect is demonstrated in the hospital setting is through the use of honorific expressions, to show deference to an older person or to express respect for an

individual's social status, even in cases where the referent of the honorific expression is younger than the one expressing the honorific.

With this background knowledge, the doctors and other health workers sometimes feel the moral obligation to lighten the burden of the patients by building a common ground for solidarity. One of the ways through which health care providers lighten the stigmatisation of visiting an STI or HIV clinic is by the cultural practice of greeting and respect, sometimes through the use of reciprocated honorifics, as reflected in the interactions below.

Interaction 1

1. P: **good morning ma**
2. D: **how are you?**
3. P: fine
4. D: do you have any complaint?
5. P: no
6. D: what's your CD4 result?
7. P: ()
8. D: where did you do it?
9. P: ()

Interaction 2

1. **D: good morning ma**
2. **P: good morning**
3. D: how are you?
4. P: I'm alright
5. D: how is work?
6. P: fine
7. D: you've done your viral load?
8. P: yes
9. D: any complaint?
10. P: I just use to have this pain in my joints

The interactions above occurred in an HIV clinic. In the first interaction, the patient who is younger greets the doctor while in the second interaction, it is the doctor that expresses her respect for the older patient by greeting her first, as the culture demands among the Yoruba tribe in Nigeria. This cultural disposition supersedes the social power that positions the doctor as possessor of expert knowledge and the care giver- a socially superior position over the patient who is a beneficiary of the expertise of the doctor and the care receiver. Similarly, in both interactions

above, the use of honorific term "ma" (Nigerian English variant of the contracted form, ma'am) is employed alongside the greeting by the younger participant, to show deference to the older.

This culture of greeting and use of honorific expressions in STI health care delivery has the positive implication of creating a friendly atmosphere for the medical business. Especially, they address what Brown and Levinson (1987) call the positive face of STI patients, thereby lessening the moral burden of having to visit an STI clinic for a diagnosis or treatment.

The Culture of STI Stigmatisation and STI Health Care

Stigmatisation stems from the cultural belief that STI is a corollary of an undisciplined sexual lifestyle or promiscuity. The implication is a negative effect on the willingness of STI patients to seek treatment. The reality in most STI and HIV clinics in Nigeria is an unusually low patronage by patients, compared to other clinics. Many patients would rather bring up issues of STI symptoms alongside other general health complaints, at other clinics, rather than visit a designated STI clinic.

Usually, HIV patients, because of the seriousness of their health condition, and the fear of stigmatisation, have an air of reserve around them. Most times, they dread people finding out the truth about their health status. As such, in the HIV departments in the hospitals where some of the data were collected, most of the patients stealthily went into the place hoping people, especially non- reactive persons would not recognise them. As a matter of fact, most of the patients are compelled to attend clinics because of the nature of their condition (the need for follow ups checks on their immunity level).

The interaction below occurred in an HIV clinic and we see the patient express the cultural belief that HIV is a consequence of promiscuity (. Earlier in the data, she also expresses regret for delaying her decision to seek medical care the moment she observed she was losing much weight. This is one of the grave implications of stigmatisation in STI care in Africa.

Interaction 3

D: there is nothing if you are not infected you will be affected
P: since I heard I have been happy because kin se pe eeyan n se agbere kiri
(Not that person is doing adultery about)
(It's not as if one is promiscuous)
D: kin se ori agbere nikan leyan tin ri
(Not that on adultery alone person can see it)
(One can get it through other means aside sex)
P: mo mo, igba ti mo gbo awon idanileko yin, o ti ye mi
(I know, when I heard the teachings your, it has understood me)

(I know, ever since I heard your teachings, I have been enlightened)
D: to ba je bi odun mewa seyin bayii, ti won ba ni eyan ku tori HIV, a gbo. Sugbon, niisin iru e o ye ko waye mo
(If it is like 10 yrs back now, if they say someone died because of HIV, we'll hear, but, now such should not happen again)
(If it were some 10 yrs ago, and someone dies of HIV, it's understandable, but such should not happen now)
P: unh

Taboos and Indirect Reference to the Genitals

STI and HIV interactions involve symptomatic descriptions that require the mentioning of private parts of the body that are considered taboos, again in the cultural context of many societies in Nigeria and Africa. Thus, in order to save face, patients engage in pragmatic acts of hedging to insist on their moral sanctity against the socio-cultural beliefs of the Nigerian society.

Consider the interaction below.

Interaction 4

Doc: er…
Pt: I said I'm having scratch inside my private part
Doc: okay↓
Pt: as I'm scratching it, the thing will be paining me,
Pt: peppering me
Doc: emm
Pt: and then I still have malaria ( )
((noise))
Doc: (.) sorry. You said, you have toilet disease. How do you know you have toilet disease?
Pt: =even when .eh because I travelled home then
Doc: =Is it because you travelled home?
Pt: =No, it has been affecting me before.
Pat: I used to scratch my private part.
Pat: It will be scratching me (It will be itching me)
Doc: =do you have any discharge?
Pt: =no

In line 10, the patient adds to her prior turn "no" (15) with "the thing the body is paining me" (17) where further reference is made to the private part through metaphors such as "*the thing" and "the body"* which share the same referent. The metaphors become significant as one

gains insight into the Nigerian socio-cultural belief where it is regarded as a taboo to refer to the male and female genitals using their biological names.

The cultural restriction on direct reference on these private body parts in the public (known as taboos), makes STI and HIV medical interactions quite discomforting. This indirect reference could also result in ambiguity.

However, the taboo is more binding on patients who have to navigate their explanations with indirect references. Doctors are trained to be blunt and direct. However, our data reveal more adherences to these taboos by doctors.

Patriarchy and STI Deresponsibilisation

The culture in Africa is obviously patriarchal as asymmetrical gender roles obtain between the male and female. While a man is allowed to marry more than one wife and engage in extra marital affairs with more women at the same time, it is absolutely shameful and unacceptable for a woman to do so. Also, the woman is more often than not blamed for infecting the man with an STI infection. In the literature and in our data, it is common for a man to boldly claim, "I started having this itching after I had sex with one girl like that". There is an interesting instance in the interaction below.

Interaction 5

122. Dr: the only question that I want to ask i:;s when you urinate, do you feel anything?
123. Pt: = no
124. Dr: so when you have ehm fun, do you feel anything?
125. PT: hmmnnn as in to pain someone?
126. Dr: either pain or stomach pain during intercourse
127. Pt: no
128. Dr: so you will go for test
129. Pat: except that ehn::: ti nba ni fun nigba mii, ehn::: mo ,maa weak and then iyen I think it's associated with my health status /
130. pat: except that ehn::: when I have fun sometimes (Material process), I feel weak (mental) ,
131. Pt: ehn;;; I think that is associated with [I think my health status] (Mental????)
132. Dr: [it's normal]
133. Dr: alright, alright no problem
134. Pt: because I am diabetic (Relational)
135. Dr: no problem

The background information of the interaction above reveals that a married man in his fifties visits the STI clinic of a hospital in south west Nigeria on the request of the health provider, as his wife had previously come for the diagnosis of an STI. Thus, the health provider (HP) had counseled that the husband be invited for diagnosis and treatment as a better therapy plan for the couple. But then, the man demonstrates very evasive and uncooperative attitudes to most of the inquiries by the HP on likely symptoms of an STI. From the point at which the interaction is captured above, it is evident that patient's response to most questions by the doctor is in the negative. Thus, later in the interaction, doctor proposes a medical line of action to verify patient's claim of absence of STI symptoms- going for a test.

At this point, patient decides to give some information, prefaced with "except", which in a way betrays the hoarding of necessary and helpful information, previously.

In fact, his first increment (an expanded turn) above (line 129/130) is a direct uptake to an earlier interrogation by the HP in line 124. Thus, in line 131, patient associates his weakness during sexual intercourse with his diabetic condition (ehn;;; I think that is associated with [I think my health status]). Thus, he exonerates himself from STI symptoms and an achieves an indirect blaming of his wife for the symptoms.

It must be understood that there is a socio-cultural disposition to sexually transmitted infections in the Nigerian context that stigmatises infected people as being sexually undisciplined and of infidelity in marriage. This shared cultural knowledge is revealed in the interaction (in full transcript) as HP had earlier hinted that most men are wont of such evasive behaviours to STI diagnosis.

Findings and Implications of Culture for STI Care

There are varying implications that culture bear for STI care. Some are positive and others negative, with the negative outweighing the positive.

One of the positive implications is the culture of respect (the culture of omoluabi- cultural respect for elders and the general good behaviour an individual is expected to demonstrate). Respect plays out in STI care through mutual phatic communion and the use of honorifics among participants. This is helpful to STI care as it helps to lessen the intrinsic face -threatening nature of the interactions (Amusa 2016), by making patients feel relaxed and welcome.

However, the negative implications of cultural indices of stigmatisation of STI patients, taboos, indirect reference to certain parts of the body and the tendency for patriarchal STI deresponsibilisation, are very inimical to STI care as discussed above. They have adverse

implications for the conceptualisation of STIs by patients and the society at large. They also affect the willingness of patients to seek treatment for their STI conditions.

Recommendations and Conclusion

It is recommended that the appropriate governmental bodies, NGOs and medical bodies increase their education, awareness and enlightenment of the populace to correct the cultural misconceptions on the perception and interpretation of STIs and those infected by them. The society should be sensitised to stop stigmatisation; efforts should be made to educate the people that absence of symptom is not the same as nonexistence of the infections. Safe sex practices should be encouraged and the African cultural heritage of virginity among the youth should also be promoted.

In conclusion, culture has very serious implications for STI care in our context. While the positive aspects of culture should be deployed in achieving better health care delivery in STI cases, the negative aspects, some of which have been identified above, should be addressed, and corrected, in order to achieve better results in societal conceptualisation, interpretation and treatment of STIs in Africa.

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