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Social construction and cultural meanings of STI/HIV-related terminology among Nguni-speaking inmates and warders in four South African correctional facilities

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Abstract

Cultural sensitivity is increasingly recognized as a means to enhance the effectiveness of health promotion programmes all over the world. Sociocultural meanings and terminology of diseases are important in understanding how different groups perceive and interpret illness. This study was conducted as part of the process of developing and adapting a sexually transmitted infection (STI)/HIV peer led health education intervention for soon-to-be-released inmates who were predominantly Nguni speakers in South Africa. Two focus group discussions (FGDs) were conducted with prison inmates in each of four facilities. Additionally, one FGD was conducted in each prison with non-health trained (custodial) personnel who were Nguni speakers from the same community ($n = 27$). The data revealed unique terminology and meanings attached to several biomedically defined STIs. These sociocultural constructions were not limited to inmates as findings from warders' discussions showed a similar pattern. Moreover, we found the existence of a number of traditional 'folk' STIs and culture-specific prevention methods. These conceptualizations influence reported health-care-seeking behaviour, where dual consultation of traditional healers and biomedical remedies is widely practiced. The research has biopsychological as well as cultural implications for the development and adaptation of contextually relevant health promotion interventions.

Introduction

In health promotion, cultural sensitivity can be defined as the extent to which ethnic/cultural (and linguistic) characteristics, experiences, norms, values, behavioural patterns and beliefs of a selected population as well as relevant historical, environmental and social forces are incorporated in the design, delivery and evaluation of targeted health promotion materials and programmes [1]. Kagawa-Singer and Kassim-Lakka [2] address this issue appropriately by saying, 'every culture defines what health is for its members, determines the aetiology of disease, establishes the parameters within which distress is defined and signalled, and prescribes the appropriate means to treat the disorder both medically and socially' (p. 578). This observation cannot be more relevant in sexually related conditions and behaviour change programmes where the complex issue of sexuality and long-term expectations of adopting certain behaviours brings extra dynamics into the cultural and language issues.

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There appears to be an uncomfortable coexistence of Western defined diseases and so-called folk illnesses, found in most non-Western societies. Folk illnesses have been defined as 'syndromes from which members of a particular group claim to suffer and for which their culture provides aetiology, diagnosis, preventative measures and regiments of healing' (p. 86) [3]. These so-called descriptions of illness draw largely from the repertoire of language, idioms, metaphors, imagery and myths from that cultural context. The differences in illness representations among different cultural groups have been widely documented in the interpretation and description of symptoms and illness in psychiatric conditions [4, 5]. There are distinct cultural-based, learnt patterns and interpretations of how individuals experience and explain illness which ultimately dictates how they manage them [6].

The subject of culture and local meanings attributed to sexual behaviour and sexual infections is a relatively underdeveloped area in HIV/AIDS intervention research, due to the almost exclusive focus on descriptive data that are often viewed as high-priority information that could lead to quick preventative measures [7]. The tendency to give little focus on the sociocultural and linguistic factors that shape sexual experience has been detrimental in the long-term management of sexually transmitted infections (STIs) and HIV/AIDS [8]. Additionally, Parker [7] emphasizes that seeking more comprehensive measures should go beyond the frequency of certain behaviours to include the 'subjective and interjective' social, cultural and linguistic meaning associated with sexually transmitted diseases in order to gain a deeper understanding of these issues in different sociocultural contexts. It is therefore essential to engage in an in-depth exploration of these issues to facilitate participatory development of tailored HIV/STI interventions which are culturally sensitive and linguistically appropriate and appealing to target populations [9].

This paper reports on data gathered from a qualitative study, conducted as one of the components of a larger study, which developed, implemented and evaluated a health education intervention targeting soon-to-be-released inmates. An in-depth exploration of the contextual issues was expected to enable the research team to ensure that the eventual health education intervention targeting inmates would convey all the deeper meanings and other culturally relevant issues, as opposed to conducting a superficial cross-translation of English written and Western-based educational materials.

The study was carried out in the provinces of KwaZulu-Natal (KZN) and Mpumalanga (MP) in South Africa. These two provinces lie adjacent to each other and share a common heritage in terms of language and culture. The general population living in this area are mainly Nguni speaking (isiZulu, siSwati and isiNdebele). The research team comprised indigenous Nguni speakers who were originally from these communities and therefore demonstrated both an understanding and sensitivity to the community being researched. The team members were all full-time research assistants who were college graduates and had a clear understanding of the biomedical meanings of STIs, HIV and AIDS. Additionally, the first author who is fluent in all the Nguni dialects spoken in these regions was responsible for monitoring the entire process of instrument development and data gathering.

South Africa carries a large burden of sexually transmitted diseases where it has been reported that over 50% of antenatal clinic attendees are infected with at least one or more of the prevailing STIs in the country [10–12]. The risk of contracting HIV in people with untreated STIs is up to five times higher due to STIs being a significant cofactor in the transmission of HIV [13, 14]. Prison populations worldwide have been known to have a high prevalence of STIs as they are likely to engage in risky sexual behaviour, including multiple sexual partners and transactional sex frequently associated with alcohol and drug use [15, 16]. Furthermore, most prisoners, due to poor socio-economic conditions and constant trouble with law enforcement authorities, are unlikely to receive medical attention even when they are outside of prison.

Prison facilities represent a microcosm of the community with almost every health problem in the 'outside world' experienced on an even larger scale

on the inside [17]. This has been due largely to a number of factors, but chief among them has been the historical lack of intervention and prevention programmes for inmates before and after incarceration. The time spent in prison has been identified as one of the few opportunities through which inmates can acquire skills and knowledge about health-related information, more especially programmes on STI and HIV prevention [15, 18]. Employing a participatory intervention development approach will ensure that the programmes targeted at inmates will engage and fully address the challenges that face participants in their sociocultural context.

Methods

Setting

The provinces of KZN and MP are two of the nine provinces which make up the Republic of South Africa. Research conducted by the Department of Health through the national antenatal surveys has consistently indicated that the two provinces have the highest HIV seroprevalence rates in the country, namely 30% for KZN and 28% in MP [12]. An exploration of the dynamics of risk behaviours in prisons in these two provinces was a good opportunity to gain insight into a group of people who are transiently moving in and out of the general population under the prevailing HIV conditions. Prisoners being a subgroup who are generally exposed to higher sexual risk behaviours than the general population therefore warranted special enquiry as part of a comprehensive approach to HIV prevention in these provinces and the country as a whole.

Sampling and data collection

Two focus group discussions (FGDs) were conducted in each of the four selected prisons in KZN and MP. All the selected prisons were either located in a small town or a semirural area which is the general characteristic of most prisons in the country. Each focus group consisted of between six and eight African black male inmates ranging from 18 to 35 years of age. All the participants were first-language Nguni speakers who had a low level of education with an average of about 3 years of formal education. This meant that they had extremely poor command of English in both its written or spoken form. The FGDs were conducted using discussion guides containing themes and constructs based on a literature search as well as a pilot focus group conducted among inmates during the initial phase of the study.

Additionally, four FGDs were conducted with general custodial staff (non-health personnel) members in the same prisons, with one focus group per prison. All the general staff members who were selected for the focus groups were African black Nguni-speaking males from the same communities as the inmates. Custodial staff members are usually moderately educated individuals who have an average of Grade 10 (junior high school) education. General staff members were chosen as key informants because they spend more time interacting with prisoners in their everyday life and they are involved in most decisions about and movements of inmates within the prison facility. Since the study was not targeting a prison-specific phenomena, but rather the everyday cultural and linguistic meanings of life and living, the general staff members provided valuable information as most of them came from the communities around the prison from where study participants came.

Interview schedule

Pre-prepared FGD guides were developed based on theories on sociocultural illness representation. The interview schedule consisted of detailed open-ended questions which explored themes such as knowledge of STIs, including commonly used terminology and their meanings, causes of STIs as well as transmission and prevention. Additional probes explored themes such as health-care-seeking behaviour as well as traditional culturally based prevention practices. The study instruments were pre-tested among prison inmates and staff members in one prison in KZN, prior to implementation at the four study sites.

Data collection procedures

The FGDs were recorded on audiotape and the facilitators also kept field notes during the discussions.

All FGDs were conducted in isiZulu by a team of trained isiZulu-speaking facilitators who were also responsible for the overall data management. The discussions were then transcribed by the same team and then translated into English. To ensure accuracy the transcripts were back-translated into isiZulu by another team of isiZulu-speaking research assistants, originally from the areas where the research was being conducted, and therefore familiar with local dialects.

Data analysis

The qualitative data management software Kwalitan version 5 was utilized for coding the collected data. The discussion guides had been prepared with a list of pre-determined themes in order to focus the discussions into a specific area of content. Based on the pre-determined tree of themes from the FGD guides and interview schedules the data were then coded into major themes with new emerging themes and patterns continuously added during coding. The main themes explored included issues such as biomedical terminology and its meaning, prevention and health-care-seeking behaviour. Additional themes that emerged encompassed cultural meanings and definitions of STI, traditional folk STIs and other sex-related conditions that are not necessarily acquired through sexual contact. Initially, data were analysed to explore findings among the inmates' focus groups and staff focus groups independently. During the next stage, themes that were common to both inmates' FGDs and staff FGDs were generated and examined. The emerging themes were then grouped into concepts that are derived from the theories of sociocultural illness representation [3, 5]

Results

Common terminology and descriptions of sexually transmitted diseases

A variety of local words and phrases emerged during the discussion with both inmates and prison warder participants. *idrop* was one of the most popular STI terms used by Nguni speakers based on their observation of drops of discharge that the patient usually experiences in presentation of syphilis. In men they explain that this discharge forms 'drops' which exudes from the penis. This presentation of symptoms has resulted in *idrop* being seen as a male STI.

> When you wake up in the morning you have a burning urine. Huh—and maybe during the day it blocks and you urinate a white urine and it is painful, it is this disease, a drop which makes your penis to be swollen and there is dirt coming out your penis. (Inmate respondent)

> I know that if you have a 'drop' you develop lumps and there is a discharge in your penis. (Warder respondent)

> I think it is a disease like drop. You get it when you sleep with a woman, and you find that you get injured in your manhood. (Inmate respondent)

Syphilis is also referred to as *ugcunsula*. The respondents explained that this word is not symptom related. Furthermore, they clarified that *ugcunsula* is widely understood across different age groups, and will therefore be commonly used as the diagnosis when consulting with traditional healers.

Cauliflower (genital warts), is an English word that is used to describe another common type of STI. This descriptive term for genital warts is derived from the actual changes that occur on the male sexual organ after an advanced progression of the disease. A prison warder upon probing described cauliflower as 'something like a tree', or 'a flesh tree'. This could indicate that some people may wait until the formation of 'cauliflower-like swellings', which is an advanced disease stage before they realize that they are infected and then seek appropriate health care.

Intwala zengulube (pubic lice), when translated into English literally means 'pig lice', which could indicate that other people may believe that pubic lice could be spread by contact with pigs as opposed to getting it through sexual contact with an infected person:

> You just have itching on your private parts. When you scratch you can pick them up or

> sometimes they run around to your face and head. (Inmate respondent)

Ukuvuvuka kwezimbilapho sometimes referred to simply as *imbilapho* refers to swollen glands. The participants explained that swollen glands that usually accompany a number of STIs are regarded as an independent infection and that they did not associate it with other STIs. This often means that the individual may be seeking remedies for the treatment of the swollen glands as the presenting diseases as opposed to finding the root cause of the symptoms, which is a sexually transmitted one.

Ibuba is known in the biomedical world as gonorrhoea. This was a unique finding and was mainly mentioned by a few older participants in the focus groups. Some of the younger participants were not familiar with this term.

Ingculaza is a term, together with a multitude of others, that is generally used to refer to both HIV and AIDS. It creates the impression that both are often perceived as being one and the same thing, even though some people try to differentiate by referring to HIV as *igciwane lengculaza* (AIDS virus).

> I don't know exactly what HIV means, but it's something to do with soldiers protecting the body. It kills the soldiers of the body. (Warder respondent)

> Yes its like that, first is HIV then after six months it becomes AIDS. (Inmate respondents)

The terms *Z3* and *amagama amathathu* (three letters) is another popular description that emerged, derived from the three letter abbreviation of HIV as opposed to AIDS but is widely used to refer to people who are considered to be sick and showing symptoms of the disease.

Isipatsholo is the term widely used to describe herpes based on the presentation of blisters that usually occur in the genitals when someone is infected with the disease. They explained that the blisters have to be visible on the outside of the organ to fit the description of this condition.

> Your private part gets swollen with itchy rash or blisters. (Warder respondent)

> The symptoms in private parts, you get some discharges. Sometimes you experience pains when you go to urinate or some blockage in the bladder. (Inmate respondent)

Beliefs and explanations of causes of STIs

Participants from inmates and warder discussion groups viewed the female body as a powerful mystical entity, which is associated with 'bad blood' or 'dirty blood'. The dirty blood can be passed on if sexual activity takes place for instance between a man and a woman during the menstrual period.

> I can say you can get a drop if you sleep with a menstruating woman. (Inmate respondent)

> If a woman loses her husband they take certain herbs, should you sleep with that woman you get a disease. This also happens when you sleep with a woman who has lost a young baby. (Warder respondent)

Generally accepted biomedical methods of family planning such as the birth control pill and the injection were also explained by the respondents as possible causes of sexually transmitted diseases being transmitted from women to men.

> These contraceptives for the women, injections can also cause some sickness, I can't remember but it was on televisions... (Warder respondent)

> Females are the ones who use contraceptives and you find that she sleeps with you the same day and that thing will then give you a disease. (Inmate respondent)

Some inmate participants indicated that they believed that poor hygienic practices may lead to the transmission of STI between two partners, as the infections are generally associated with being 'dirty'.

> I think the cause of the disease, if the female is not washing herself, her private parts, then the disease can stay there and during sex you get it. (Inmate respondent)

> When you sleep with a girl and you don't wash, the dirt is left inside you, that is why one suffers from these diseases. (Inmate participant)

Traditional 'folk' STIs and prevention methods

Both inmates and warders elucidated explanations, which resulted in a special category of STIs, namely traditional folk sexual illnesses. These conditions seemed to have no biomedical equivalents but were categorized as being sexually transmitted by both inmate and warder participants. They explained that most traditional sexual illnesses were strongly linked to the issues of fidelity and prevention of potential and suspected cheating by a spouse or sexual partner.

The participants outlined two conditions called *ilumbo* and *ikhubalo*. They explained that the two conditions are closely related and sometimes the names can be used interchangeably. Both these conditions were understood to affect people who have slept with a woman who had a 'trap' set by her husband to ensure that no other man is able to be intimate with the wife.

> Like us men we set a trap in our wives so that she cannot sleep with other men. Some use muti (traditional potions) which turns into 'ilumbo' inside a woman, and when someone else sleeps with her he catches it, then it destroys your blood and if you don't get traditional help you will die eventually. (Inmate respondent)

> Sometimes in our culture we believe that you can get a disease on what we call a 'jump over' which is known as 'umeqo' (Inmate participant)

The explanations given by inmates were also supported by prison warders who reported believing in and using most of these cultural practices.

> For example I have a wife and I am working far away, she is left at our home. In order to protect her not to sleep around you set some muti in her private parts so when she sleeps with another man they will be tied up until they will be taken to an inyanga (traditional healer). I'll be doing that to catch them in the act. (Warder participant)

During discussions it emerged that these conditions are viewed mainly as a deterrent to discourage partners from sleeping with other people. Warders who were working far from home and inmates who had left partners outside strongly believed that these methods were effective in ensuring that their spouses would not cheat.

> A person decides how he wants to set a trap on his wife, so ikhubalo will be this trap and whoever sleeps with my wife will be scared away by anything, others they make ikhubalo to be a mamba (snake), so whenever you go to meet his wife you come across a mamba. (Inmate partcipant)

> Certain inyangas make use of a knife, so when you close a knife you have closed a wife. So when you come to meet with my wife, you come strong, but when you want to enter her you become powerless, you won't enter her, you won't have a sexual intercourse with her. (Warder respondent)

Both warder and inmate participants elaborated that these fidelity-based prevention measures can also be applied by females to ensure that their male partners do not engage in casual sex or extramarital relationships with other people.

> And even women too they use such things. If you're a man they know maybe you sleep around. They just put that 'muti' in the bottle and lie it down (horizontal). Your penis will be soft always. Then when she store it like this (upright), then you become strong (erect). (Warder participant)

Health-care-seeking practices

Both inmates and warder participants reported actively using the dual health system of traditional healers and clinics as a form of addressing presentations of STI-related symptoms. Treatment of STIs generally consisted of a combination of these two belief systems with a few participants also mentioning the use of spiritual healers.

> I told her (nurse) that I have something I don't understand when I urinate it's painful and I have

> a discharge in my penis. And at the clinic they said I did right by coming over and then they gave me condom and injection and I got well. (Inmate respondent)
>
> Lets take cauliflower for example, you get it through sex, it's a disease, you go to a nyanga and the nyanga cuts you or put muti (herbs) inside you through the anus with a spyt (douche). (Warder respondent)
>
> ...you also have to go to traditional healers for treatment of these diseases to get something to spyt with. (Inmate participant)

Despite the resistance and restriction of herbs and potions into prison, participants explained that they routinely use both biomedical treatments and traditional remedies while in prison as well as outside. Inmates reported a number of ways to smuggle herbs and potions into the prison through relatives or through inmates who go outside to work in the prison farming sections.

> ...there are nyangas (traditional healers) inside.... In fact we usually go and work outside, so a traditional healer knows the kinds of plants he needs so he digs them up and smuggles them inside. (Inmate participant)
>
> The department (prisons) tried to make away (ban) with traditional medicine. We have been sending herbs away when visitors bring them. (Warder participant)

Discussion

This paper explored the sociocultural meanings of STI/HIV-related information among male Nguni-speaking inmates who had relatively low levels of formal education and were between the ages of 18 and 35 years. Additionally, information was gathered from prison warders who were from a similar background and within the same age range as the inmates. By utilizing focus group information from both inmates and warders, we further explored whether these issues will only be specifically applicable to inmates or there was an overlap with non-imprisoned Nguni-speaking men. Without seeking to claim generalizability of these findings, this study highlighted the existence of a broad spectrum of beliefs and interpretations of STI-related information. This information is widely used in the interpretation of, and coping with, STIs among Nguni-speaking young men.

The data from the study suggest that Nguni speakers have a terminology, which forms part of their vocabulary when describing STIs and HIV. This information is a likely reflection of what exists in the larger population among speakers of these languages, as confirmed by the FGDs held with prison warders. The study participants were able to describe a range of terms and words related to STIs. These included words like *idrop*, which is based on symptom identification; *cauliflower*, which describes physical changes; and *ibuba*, which identifies an actual disease namely gonorrhoea. Significantly, some indigenous terms showed generational differences, whereby younger people were not familiar with words that older people used to describe certain conditions, for example *ibuba*, referring to gonorrhoea.

Words that are sometimes skimmed over as colloquial words in most studies [3] were found to be predominantly used by study participants to derive meaning of STIs. It is important to emphasize that health workers and researchers should avoid the temptation to assume that one single local term can be used across the board to describe illness among non-Western language groups. The reality is that in most traditional description-based illness meanings, there are usually a number of words that are used to describe similar, or the same, conditions and most of this terminology is continually evolving [19]. This is clearly demonstrated in the terminology associated with HIV and AIDS which appears to evolve over time and was described using a wide range of terms and descriptions. Similarly, syphilis was described using two terms *ugcunsula* and *idrop*.

The findings of this study are similar to earlier findings on STI-related descriptions in sub-Saharan

Africa [20], whereby it was found that local indigenous people have unique views and interpretations of STIs. In most cases diseases are not viewed as a simple causal route but more as a complex web of illness representations [3]. The cause of certain diseases is viewed using a wide range of understandings including both the biological and spiritual level of illness presentations. Participants reported that engaging in sexual intercourse with widows and women who had lost a child may cause STIs. The reference to dirty blood and poor hygiene levels among women as causes of STIs demonstrated a certain level of misinformation and myths on the biological manifestations of diseases. However, the association of the menstrual cycle with a potential transmission of sexual disease cannot be dismissed as a myth or lack of information as it is strongly embedded in the social and cultural practices that are traditionally based and provide meaning within the Nguni community.

This study clearly demonstrated the existence of traditional folk-based sexually transmitted or sexually related illnesses not recognized in biomedical definitions of STIs. Conditions such as *ikhubalo* and *ilumbo* lean strongly on a spiritual definition and interpretation of illness due to their links to the use of snakes and other animal imagery that are supposed to discourage infidelity among couples. There can be no denying of the fact that these diseases exist and are viewed with seriousness as indicated by the general agreement that proper consultation with traditional healers is required when you get 'infected' with these conditions.

The data demonstrate complex notions of prevention, which encompass spiritual, physical and culturally bound mythological practices [8]. These practices are wrapped in notions of fidelity in the context of cheating partners, i.e. women having extramarital sexual relations. On careful observation most of these prevention strategies seem to be based on men taking control over 'their women' by applying certain herbs and potions obtained from traditional healers. These methods are perceived as providing 'traps' for the prevention of extramarital sex which they explained results in acquiring disease. These methods appear to present a situation whereby men may absolve any responsibility of active participation in preventive measures as long as they have applied the traditional methods that safeguard them and their sexual partners. In contrast, mainstream preventive strategies rely and promote active engagement of individuals in the process of voluntary behaviour change and adopting preventive strategies such as condom use. This creates a potential conflict between traditional and mainstream prevention strategies due to the difference of one being more passive and the other relying on the active engagement of the individual in disease prevention.

Traditional prevention methods were highly perceived as being more efficacious and even easier to practice than mainstream methods such as taking personal responsibility for condom use. This was evident as both inmates and warders who were working away from their wives believed that applying traps was the best way to ensure that their partners stay faithful in their absence. Discarding these traditional methods as cultural myths and taboos is likely to perpetuate conflict between the traditional ideas on prevention and the mainstream evidence-based prevention approaches. Participatory intervention development therefore facilitates the sharing of ideas from both traditional and Western paradigms in programme development.

The study demonstrated that health-care-seeking behaviour among Nguni speakers almost always involves the consultation of the dual system of Western-based medicine and traditional healers who then provide herbal remedies, potions and spiritual counsel. It must be added that consultation involves both preventive and treatment practices. Even the adoption of prohibitive policies against traditional medicine in prisons has resulted in widespread smuggling of herbs and potions by inmates in order to address this need. As some illnesses are interpreted as being due to some contamination of the blood, the traditional methods will always be necessary as Western medication is viewed as not being adequate to address these conditions holistically [21, 22]. Striking a balance between the need for individuals to utilize these

two systems is an issue that health workers and researchers should grapple with respectfully.

The aim of the study was to explore the sociocultural meanings as a way to develop a health education intervention targeting male inmates. The issue of cultural dynamics is a much specialized subject and still requires more focused and in-depth exploration than was undertaken in the present study. The use of focus groups from a limited subgroup of the society is likely to have limited the completeness of the unique cultural dynamics that exist among Nguni-speaking populations. Nonetheless, it is extremely important for researchers to put more emphasis on eliciting and understanding local terminology as a critical step towards developing effective health education interventions.

The emerging differences such as divergent views on prevention highlight the need to avoid a 'carpet bomb' approach in the development of health education interventions. Participatory programme development is likely to lead to more effective and acceptable interventions that are sensitive to sociocultural variations in terminology and illness representations of STIs. This paper is part of a growing trend of studies that critically address the issue of language and meaning of diseases in a manner that seeks to integrate ethnomedical dynamics in intervention development as an existing reality as opposed to myths that need to be changed [7, 9, 23]. This sensitivity and acknowledgement of different sociocultural notions of disease and illness resulted in the design of a life skills intervention that provided a broader, more encompassing and participatory approach to STI and HIV prevention (S. Sifunda *et al*., submitted for publication).

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Conflict of interest statement

None declared.

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