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Culture and marriage: The dual barriers to condom use among health care providers in Tshwane, South Africa

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Abstract

The use of condom will provide men and women 100% protection against HIV and AIDS infection. However, the acceptability of condom use in sexual relations including marriage is confronted with culturally entrenched barriers. Health care providers as being socialised within the communities with specific cultures also experience barriers regarding condom use. The purpose of the study was to explore and describe culture and marriage as barriers regarding condom use among health care providers in Tshwane. A qualitative, focused ethnography design was used. Data collection was through semi-structured interviews using three research questions. The population included health care providers who were responsible for provision of HIV and AIDS programmes in selected health care settings in Tshwane. Purposive sampling was used and ethical principles were upheld. Trustworthiness was ensured. Results indicated that irrespective of health care providers being knowledgeable on condom use, when faced with condom use in their sexual relationships they are confronted by culturally entrenched barriers. Marriage becomes a barrier for condom use as it is culturally embedded. Norms and values determining men and women's behaviour in a relationship stipulate that men are decision makers. As such, health care providers' sexual partners refuse to use condoms. It is recommended that culturally sensitive programmes be developed and health care providers receive appropriate training to address culture and marriage as barriers regarding condom use in their sexual relationships.

Key words: Health care providers, condom use, barriers, culture and marriage.

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Introduction

Globally culture shapes the behaviour of individuals, families and communities. Through culture a heritage is build which is known as cultural capital (Abel, 2008). Cultural capital is a set of family, group and community-sanctioned norms and values prescribing acceptable behaviours among its members. Some of the sanctioned and acceptable behaviours within cultural capital promote gender power, which results in the socialisation of men as superior and women as men's subordinates (Poole & Gause, 2011). Socialisation that promotes gendered power further prescribes norms and values expected to shape and

sometimes dictate behaviours between adults and children as well as between men and women. Health care providers are part of communities with specific culture capital. They are being socialised into norms and values where males possess legitimate power, which by ascription provides males with gendered power (Poole & Gause, 2011). The gendered power positions males in a dominant position and as decision makers in the household, including decisions about sexual relations. Cordero-Coma & Breen (2012) state that as a result of socialisation it becomes difficult for women to challenge decisions made by men. These include, amongst other things, refusal to use either the male or the female condom. Therefore, health care providers are in a precarious position, as some of them experience resistance by their partners regarding condom use. Owing to failure to use condoms some of health care providers are living with HIV and AIDS, as reported in the study conducted in Tshwane by Mataboge et al. (2014), which attested to some health care providers being HIV positive. These health care providers even avoid the uptake of HIV counselling and testing (HCT), even though they know as women that they are at higher risk of contracting HIV than men are (Shisana et al., 2009). Hargreaves et al. (2009) confirm that even though culture continues to shape attitudes to and behaviour relating to reproductive behaviour during the democratic era in South Africa, not many implementation studies are in place to address barriers that originate in culture. This perpetuates women's exposure to unprotected sex practice; including health care providers, even though they are knowledgeable regarding the benefits of condom use.

Diverse factors are explained to determine condom use among women and men (Hargreaves et al., 2009). However, health care providers are expected to have solutions that will modify these factors and promote the use of condoms among women and men, including themselves. Factors that are reported as barriers to condom use are men's refusal to use condoms, the need to prove trust between partners and being in a stable relationship, such as long term relationship or being married (Bandali, 2011). Among reasons for the lack of prevention of HIV and AIDS is the trust that women have in their spouse, especially those in marriage or stable relationships. In addition the preparedness of women to show love and devotion in sexual relations results in their not insisting on condom use **(Lotfi et al., 2012; Exavery et al.,** 2013). Together with culture, marriage becomes a barrier to condom use. It becomes difficult sometimes to determine whether culture acts as a barrier more than marriage as they are integrated in most social contexts and become dual barriers. Marriage within most black societies is based on culture, where marriage is negotiated and men pay money to the woman's family during marriage negotiation among indigenous African culture (lobola) (Jewkes et al., 1999). As such, men are dominant as they possess the economic power that is determined by their ability to pay lobola as such some women especially the unemployed become economically dependent on their spouses (Maganja et al., 2007; PEPFAR, 2009). In some cultures which

promote women subordination it is even taboo for women to negotiate sexual intimacy therefore women are not free to even talk about sexual issues or feelings with their spouses, as they are expected to be naive. Within marriages that have been negotiated following some black cultures, married women are expected to listen and obey their husbands. Therefore, they avoid initiating a dialogue or an argument with their spouse, especially concerning sexual practices and including condom use. To do otherwise would risk the label of being promiscuous (Molla et al., 2008). It becomes more difficult for women to defy cultural practices and insist on condom use as in most instances women are younger than their marriage partners. This factor compels women to respect men as their seniors in a sexual relationship and marriage (Lucea et al., 2013).

One would be optimistic that health care providers would use condoms in a sustainable manner with their male sexual partners, as they are in a position to promote condom use in health care settings. Bandali (2011) and **Exavery et al. (2**013) report that there is no sustained condom use sometimes absolute non-use of condom in some sexual relationships that are promoting certain black cultures even though condom use is promoted for the prevention of STIs/HIV and AIDS as it provides 100% protection. The results of the current study are a testimony of health care providers'(in this study black women of South African origin) failure to use condoms, as some participants reported that males are not cooperating to use male condoms and it was assumed by the participants that males will accept the use of the female condom. However, the use of the female condom is also determined by male partners, as women plays a subordinate role and decisions on sexual issues in traditional relationships are made by men (Selikow et al., 2009; Mantell et al., 2011). Women of younger ages use condoms for dual protection if males agree, as they as partners do not plan to have a child. It becomes difficult at a later age when women are no more of child-bearing age and wish to initiate condom use for the prevention of HIV and AIDS, as this in conflict with the marriage norms (Cordero-Coma & Breen, 2012). In addition as condoms use has been minimal in sub-Saharan countries, it becomes difficult for women to negotiate and insist on its use in marriage when is not used as contraception (Maharaj et al., 2012). The health care providers (belonging to cultures that promote men domination) thus become trapped behind cultural barriers as women regarding condom use.

Research problem

The population of health care providers comprises largely women some of whom are married or are in stable relationships. These women are promoters of male and female condom use. However, they are unable to negotiate condom use in their sexual relationships or marriage. The number of health care providers who are diagnosed with HIV and AIDS are evidence of unprotected-sex practice (Mataboge et al., 2014). In a study conducted in Free State province of South

Africa it was found that among other variables for the non-use of condom the community-based social norms and marriage played a part (Chandran et al., 2012). Dual barriers (culture and marriage) regarding condom use render health care providers unable to negotiate or insist on condom use even when there are risks to contract HIV and AIDS as a result of the infidelity of male partners (Shisana et al., 2009).

This study was designed to explore and describe culture and marriage as barriers to the use of condoms among health care providers in Tshwane.

Methodology

A qualitative enquiry through the use of focused ethnography design was employed (Higginbottom, 2011). Focused ethnography was relevant, as a specific population with specific experiences within sexual relations that were determined by norms and values within culture and marriage was explored. This was a relevant design based on the sample size. The focus was specifically on condom use by health care providers in their natural setting, which was their sexual relations as determined by culture and marriage.

Context

The setting needed to be specific and have a particular cultural context (Pink 2009). The setting included health care facilities in Tshwane district, including those health facilities at primary health care level and district level. The health facilities included were two district hospitals, one in the city and one in a township; one wellness clinic for HIV and AIDS patients in the city; a gateway clinic of one district hospital; and three primary health care clinics one in an informal settlement one in the city and one in a township. The health care facilities were involved in HIV and AIDS prevention as integrated in care provision for all clients and mandated by the HCT policy to promote HIV testing and condom use among all clients (DoH, 2012-2016). An assumption was made by the researchers that health care providers were engaged in sexual relations with males and are therefore exposed to cultural norms regarding acceptable behaviours in sexual relationships regarding condom use.

Population and sampling

The population was health care providers who were allocated in health care settings where HIV and AIDS care is a major component of their daily activities. Males and females were eligible to take part in the study. However, participants were mainly females as they are more common than men as health care providers. Participation was voluntary. All categories of health care providers were included; that is, professional nurses, enrolled nurses, nursing assistants and

HCT providers. All health care providers were South African citizens and were socialised in an almost similar sub-cultural context as they were all blacks who were South African citizens and shared same norms and values (Higginbottom, 2011). Purposive sampling was used to include health care providers, as they belonged to a similar sub-culture and participation was voluntary. The sample comprised 26 health care providers, a small sample size as the study was focused on a context-specific problem and held specific ethnographical knowledge regarding culture and marriage as dual barriers against condom use (Higginbottom, 2011).

Data collection

Individual semi-structured interviews were conducted so that the participants could be probed to describe the cultural context within which condom use happens in their sexual relationships. The health care providers possessed knowledge about condom use as part of their daily responsibilities and were provided enough time to reflect on condom use as users. It was difficult for health care providers to depart from their roles as condom promoters when they reported on clients' experiences. However, the use of semi-structured interviews using the three questions which were: What are experiences of the health care providers regarding condom use? What are the barriers to condom use for health care providers? How does culture affect condom use by health care providers? The questions focused on condom use by health care providers with their male sexual partners in a non-transactional relationship, with the final question probing into culture as a factor influencing condom use.

Two participants were included in semi structured interviews which were conducted to pilot test the questions prior to conducting the study. Semi-structured interviews were conducted at the employment area during lunch time as had been arranged. Each interview lasted for 30 minutes, as focus ethnography does not need the researcher to engage with participants for a long time (Pink, 2009). There were no observations made as observations are not always compulsory when conducting focus ethnography study (Higginbottom, 2011). In addition, condoms are used in private and one has to rely on the participants' experiences as reported in the results.

Data analysis

Thematic data analysis was done and two themes and six sub-themes were identified (Merriam, 2009). The data analysis steps included analysing transcripts through familiarisation so as to get the general sense from data. Other steps were identifying a thematic framework, indexing, charting, mapping so as data with common meaning are grouped together and interpreting data to finalise themes and sub-themes.

Ethical principles

Permission to conduct the study was given by ethics committee of a university in Tshwane. The Tshwane district health managers for research, chief executives of hospitals and managers of clinics also approved the conducting of the study. The participants gave informed consent voluntarily after the objectives of study were explained to them. Confidentiality and anonymity were observed by not exposing the names of participants. Reporting on condom use based on culture might have upset some participants, however no participant was assessed presenting with emotional signs reported experiencing emotional symptoms during data collection.

Trustworthiness

The criteria for trustworthiness were upheld (Polit & Beck, 2012). Credibility was ensured through engagement with participants for the period sufficient to collect data which lasted for 30 minutes during semi-structured interviews. In addition, some of the participants were interviewed more than once, as after data analysis further probing was needed into their experiences to ensure conformability. An indigenous health care provider was given transcripts to analyse and she confirmed the themes that emerged as a step to ensure dependability. A thick and detailed description of research design, methods and results is presented to ensure transferability.

Results

Data confirmed the two barriers that determine whether health care providers will use or not use the female condom or male condom. The dual barriers were the two themes, which are: culture as a barrier for condom use and marriage as a barrier to use condom.

Culture as a barrier for condom use

The theme of culture as a barrier for condom use had three sub-themes: perpetuation of silence regarding condom use among females and males; need to reduce the subordination of women; and readiness by some males to use condom to prevent HIV and AIDS.

Perpetuation of silence regarding condom use among females and males

The participants were of the opinion that as HIV and AIDS is classified as a pandemic it was the time to transcend the culture of silence regarding sexual health as there is a need to socialise future health care providers within a cultural milieu where they can openly negotiate condom use without fear in their sexual

relationship. The health care providers related parenting and socialisation as being cornerstones regarding how children as future adults will behave. Cultural and health care experts need to work within families and break the silence among family members on sexual health issues. This was verbalised by participants who thought the way they as health care providers were brought up has an influenced their behaviour. One said:

'Culture? No, I think it is the way we are brought up. Educated families are open when talking to their children. They can talk about sex and health issues with their children, giving them reasons not to make unavoidable mistakes. With us, when a child makes a mistake, we first shout, hit the child and tell them not to do it again. That way it is easier for the child to commit the same mistake because they know they will just be shouted at and the matter is solved. We don't give ourselves time to explain health risks with our children; maybe because they were also not explained to us when we grew up. When the parents are uneducated, their children will grow up uneducated. So I believe the health promoters need to go from house to house and educate all the families about health issues.'

Another participant said:

'Yes I think so. The way women are being brought up, most of women will tell you that their husbands don't want to use the condom. And you find that they have STIs and are aware that they [their husbands] are cheating. But he refuses condom use in their houses. I think it's only civilised males who are also educated who agrees to use a condom. They even come for HIV counselling and testing, but our cultural men are being affected by culture. And if we give the women condoms, they fight them that they talk about their family issues at the clinic. Another method will be for both partners to come to the clinic for testing and counselling [for HIV].'

HIV and AIDS is a health challenge that confronts cultural practices and would lead to change in cultural practices changes such as men's acceptance of condom use, including the female condom. There was a departure from cultural practices by educated men, as evidenced by educated partners who agreed to use condoms and to HCT.

Need to reduce subordination of women

The health care providers acknowledged culture as having a negative influence on decision making regarding condom use. This did not involve female condom use alone but also the use of male condoms. Socialisation was again cited as a determining factor for women's subordination and education to mitigate this need to reduce subordination of women to be in place. Even though the health

care provider mentioned that women subordination is a mind-set, one could say it is a cultural practice.

The health care providers said:

'To improve the usage of the female condom is very difficult because it is the mind-set. We black women are very submissive; if my partner says I'm not going to use it, then I won't use. I know the fact that we can insert it hours before we go to bed but we still need their permission to do that. Even the liberated ones [women] still believe that men are superior to us. In order to win this battle, we need to get hold of men and work on changing their mind-set regarding the female condoms'.

The changes needed regarding female condom use would need collaboration between sexual partners, as men would need to be a part of the socialisation change that will be effected and how this will affect sexual health behaviour of women. Failure to do so will lead to resistance and non-acceptance by men, especially as they have been provided legitimate power through socialisation. The participant expressed her experiences as follows:

'Yes, I think so. Men are always saying, I will never marry a wife and use a condom in my own house. Yes, it is more of a barrier because it gives males more power on women. Condom use has never been part of our culture for both black and white. So negotiation on use is still greatly needed'.

Women cannot break barriers based on culture on their own. They need to be supported to transcend these cultural practices. In addition they need to be skilled to negotiate condom use as this will be a culture modification, as it would diffuse men's power over women and decision making on safe sexual practices.

Readiness by some men to use condoms to prevent HIV and AIDS

Reports on positive sexual health practices were noted, as participants reported that there was acceptance of the condom, including the female condom, by men. In fact some men especially immigrants accept condom use. As such they do not resist the female condom. Acceptance of female condoms by foreigners was reported by a 52-year-old divorced participant as follows:

'I got divorced and am currently staying with a foreign nation guy. I must confess they are very understanding when coming to condom use. He had no problem at all in using/trying [female condom] it. And it went well.'

When probing was done to ensure that the participant was referring to using a female condom with a sexual partner of foreign nationality the participant confirmed and repeated her experiences as follows:

'Like I have said earlier, my foreign partner had no problem accepting [female condom] it.
Another participant reported her experience of immigrant male partners' acceptance of the female condom in the following excerpt:

'Yes is true. I am seeing a lot of foreigners here and they are so very compliant with condom use. They don't have a problem at all. I don't know the reason why they are like this but they do comply. Our SA males, I don't know what will help them. But I still say it is the way they are being brought up'.

Some derogatory statements were made regarding South African women as the reason for immigrants to use condoms. Serial monogamy means that even though a person has one partner at a time, she or he changes sexual partners in a short time span. This is a concern that motivates foreigners to use a condom as a dual protection. The participant reported that:

'I think it is true. At the moment, the foreign national males call us South African women [prostitutes] because they say we jump from one relationship to the next in a short span of time. What I've observed with them, they have a lot of knowledge on safe sex and the use of condom. Whereas with us South Africans we still engage in unsafe sexual intercourse and we are moving from one relationship to the other.'

A high-risk sexual health situation that exposes South Africans to HIV and AIDS was reported as frequent change of sexual partners. In South Africa males are reported to refuse to use both male and female condoms and females in serial monogamous relationships thus expose their partners to HIV.

Marriage as a barrier to condom use

The theme had three sub-themes, which were: rationalising marriage as a protective factor against HIV and AIDS infection, unfaithful married partners and condom use and married health care providers' fear of being abandoned by partners.

Rationalising marriage as a protective factor against HIV and AIDS infection

Some married health care providers trusted their partners and reported that they never worried about the use of condoms. One married participant reported as follows:

'I am married now; I have been sterilised and have no reason to worry or even to use a condom'.

Another one stated:

'I was married. My husband and I never used condoms, and we never even considered them'.

Being not worried to use condoms in a way reveals the lack of health care providers' knowledge about the risks of contracting HIV and AIDS. This became a worrisome fact for the researchers, as health care providers should be promoting condom use and not using marriage as a protective tool against HIV and AIDS.

Unfaithful married male partners and condom use

It emerged that married health care providers were experiencing sexual partners' resistance to condom use; as such they were at risk of HIV and AIDS, as some partners were unfaithful. Marriage is used as a protective factor until there is evidence of unfaithfulness. Until such a time neither men nor women use condoms. Sometimes even if the male partner knows that he is unfaithful he does not use a condom, as this could disclose to the wife (health care provider) that he is involved with extra-marital sex. One participant reported:

'I don't know about the foreigners but I know that South African men do not like using condoms, especially the married ones. Even when he is cheating, he rather use the condom with the girlfriend but not with his wife.'

One of the participants said:

'When married there was no need for using a condom. I didn't see any reason to use the condom in marriage if both partners are committed to one another. But when the marriage start to sour up and one sees the signs of extra-marital affairs, then I would recommend condom use.'

Health care providers accepted infidelity practised by their husbands but trusted that they used condoms with the girlfriends. Some health care providers insist on condom use once infidelity is has been proven. It is apparent that health care providers are at risk of contracting HIV and AIDS, as they might miss the signs of an extra-marital affair from the partner.

Married health care providers fear of being abandoned by partners

Even though health care providers are knowledgeable and skilled regarding HIV and AIDS prevention they have difficulties in their own sexual relationships to negotiate and insist on condom use. They end up having unprotected sex and some reported that condom use was never considered in their marital relationships. The challenges were communicated as follows:
'I wouldn't say it's culture but as women we compromise our health because we are afraid we will lose partners. You find that the partner is refusing to use the condom and we do not have the will to force them to use it'.

Another participant indicated:

'Yes, in most cases the partner will force to have sex without condom and threaten to leave you when you do not want to [have unprotected sex]'.

Even though the participants were employed in different level as health care providers they felt the maintenance of the sexual relationship to be a priority above insisting on condom use as this will result in being abandoned by partner.

Discussion

The patriarchal system seems to be perpetuating women's' inferior status. It seems that no change is being initiated within cultural practices that determine the power relations between men and women. The South African Constitution (Act No.108 of 1996) entrenches equity between men and women. Men enjoy legitimate power where there are clear delineation of roles between men and women that are prescribed by the society and if obeyed might sustain the marriage. An unequal power relation that favours men according to culture widens the gap of the power imbalances that render women almost silent on HIV risks, especially within marriage even when evidence of one partner's risky sex behaviour has been discovered. (Bandali, 2011). Cordero-Coma and Breen (2012) reported that in fact it seems as if condom use in marriage is an undesirable and unacceptable act amidst the HIV and AIDS epidemic.

There will be 100% protection from HIV and AIDS when abstinence is practised and 99% when condoms are used (DoH, 2011). It appears that women health care providers are unable to negotiate the use of condom just as their clients are. Some health care providers rationalise that being married is the reason for non-condom use. Sometimes even when the men is involved in extra-marital relations which exposes to risks to contract HIV and AIDS infection condom negotiation would not be initiated by women. In some cultures, as in Nigeria, it is taken as a norm that extra-marital relationships exist and the girlfriend is sometimes known to the wife or relative (Ankomah et al., 2013). Men in a study conducted by

Bandali (2011) in Mozambique were comfortable not to use condoms in marriage under the pretext that their risks of contracting HIV from their wives was minimal because married women were considered well behaved in contrast to the single women with whom they used condoms. The subordination of married women was reflected in the results of a study by Exavery et al. (2013) that indeed most married women did not use condoms unlike their unmarried counterparts. The study conducted in Botswana and South Africa by Magadi (2011) indicated similar results as reported by health care providers in the current study that marriage in fact acted as a deterrent to HIV and AIDS prevention. The protection against HIV and AIDS was marked by minimal prevalence, especially in the case where partners were stable and were not unfaithful.

There is generally a lack of preparedness by women, especially young married women, to communicate about condom use with men (Lucea et al., 2013). Negotiation in order to pursue condom use becomes a problem for the young women, as in some marriages the age difference between men and women is up to 10 years. In such case, in addition to men bearing a dominant cultural status, age also adds to the barrier to initiate condom use (Magadi, 2011). Bandali (2011) explains that experience in a sexual relationship and fear of HIV risks act as a facilitator for condom negotiation and use. In the current study participants were experienced health care providers, as they had a year or more working as health care providers in areas providing care to HIV and AIDS patients. Health care workers ages ranged between 35-58 years, which also acted as a factor that facilitated condom negotiation and use by some women who reported to be using condoms (Lucea et al., 2013; Anglewicz & Clark, 2013). It seems that when a condom is used as prevention for pregnancy it is better accepted by partners. When the prevention of pregnancy is not at issue the condom is perceived as an intruder in marriage and this was experienced by some participants. As such it becomes difficult to negotiate its use for HIV prevention by some women, especially at an older age (Chimbiri, 2007). In marriage condom use is not practised, as most women are economically dependent on men and fear abandonment. However, the health care providers displayed similar fears of being abandoned by husbands even though health care providers, unlike economically disadvantaged women, had a sustained job and salary.

The acceptance and readiness of the male immigrants who use condoms is understood within HIV prevention, as Mozambique, Botswana and Tanzania have experienced high HIV and AIDS prevalence, which led to sustained condom use (Asamoah-Odei et al., 2004).The question is why did the same cause not have the same effect in South Africa among South Africans, as it is experiencing the highest prevalence of HIV and AIDS in the world? It would therefore be risky for immigrants not to use condoms to protect themselves. The results of failure to use condom are reported by Maharaja et al. (2012) who attest that about 60% of women in sub-Saharan countries are living with the HI virus.

What is positive is that condom use has generally increased as reported by women (Maharaja et al., 2012). The attainment of nationwide condom use will represent a positive step for HIV and AIDS prevention in South Africa and neighbouring countries.

Recommendations

There is a need to communicate with policy makers to inform health care providers and other women need interventions that would reduce the effect of the dual barriers of culture and marriage regarding condom use. This would improve acceptance and condom use by men. The programme developers need to review existing programmes regarding condom use and develop culturally sensitive programmes to support women, including health care providers regarding condoms in their relationships.

Conclusions

The use of condoms by some health care providers is reported to be not practiced by some, as the cultural norms entrenched in marriage and sexual relationships give men the dominant role of the decision maker. The knowledge the health care provider possesses as a sexual partner becomes redundant as she is in a culturally determined position of subordination. Her health knowledge to negotiate and convince partners to use condom fails her with her partner. Culture and marriage norms act as barriers to using condom by health care providers. As such, some consent to unprotected sex even where there are signs of risks to contract HIV and AIDS. Fear of contracting HIV and AIDS by some migrant men becomes a facilitator for condom use as they suspect most women in South Africa are living with HIV and AIDS.

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