CULTURAL SENSITIVITY IN COMMUNICATION CAMPAIGNS FOR THE PREVENTION OF SEXUALLY TRANSMITTED INFECTION IN NIGERIA

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Abstrak

Kepentingan peranan budaya dalam kempen pencegahan penyakit jangkitan kelamin (STI) adalah tidak dapat disangkal. Namun, pemahaman tentang bagaimana budaya harus berperananan dalam mereka bentuk dan pelaksanaan kempen tersebut kelihatan masih kurang di Nigeria. Berasaskan fenomena yang dinyatakan, kajian ini meneliti bagaimana budaya boleh dikonsepsualisasikan untuk memperbaiki komunikasi kempen pencegahan STI di Nigeria. Data dikumpulkan melalui temubual mendalam terhadap 22 belia positif STI dan 19 negatif STI yang berusia dalam lingkungan 15 hingga 26 tahun di kawasan Selatan-Barat dan Utara-Tengah Nigeria. Data tersebut dianalisis melalui kaedah analisis tematik. Walaupun sebahagian daripada aspek budaya menyumbang secara positif, terdapat juga kesan negatif. Agama, nilai dan pantang larang, amalan budaya, dan ketamadunan didapati sebagai empat aspek utama menunjukkan pertalian dan pengaruh di antara budaya dan STI dalam komunikasi mesej STI di Nigeria. Bukti menunjukkan bahawa agama tidak menggalakkan belia terlibat dalam hubungan seks pra-perkahwinan dan luar nikah. Belia Nigeria mengakui nilai dan pantang larang sebagai mempunyai pengaruh kuat ke atas perkara berkaitan seksualiti. Walau bagaimanapun, masih terdapat beberapa amalan yang tidak menggalakkan tingkah laku seksual selamat seperti peranan kepatuhan wanita, poligami, berkhatan wanita dan menggunakan wanita muda untuk kepuasan seksual. Dapatan juga menunjukkan keperluan mesej STI dalam menangani isu-isu stigmasasi, penggunaan dialek tempatan, salah faham dalam ilmu STI, gambaran negatif STI, penggunaan maklumat semasa dan pendedahan status STI. Komunikasi pemasaran bersepadu dikenalpasti sebagai saluran berkesan kepada individu negatif STI. Walau bagaimanapun, individu positif STI lebih suka menggunakan komunikasi interpersonal dan radio. Kajian ini menyimpulkan bahawa peranan komunikasi kepekaan budaya adalah penting dan menjadi peneraju dalam intervensi tingkah laku sama ada sebagai agen mahupun pihak yang bermanfaat. Justeru itu, dua Model Kepekaan Budaya STI dikemukakan sebagai panduan berpotensi untuk menghasilkan penerimaan intervensi dalam kalangan pelbagai komuniti belia di Nigeria.

Katakunci: Kepekaan budaya, Komunikasi kempen kesihatan, Tingkahlaku seksual, Penyakit jangkitan kelamin, Belia

Abstract

The role of culture in sexually transmitted infections (STIs) prevention campaign has been crucial. However, a common vision on how culture ought to inform the design and implementation of the campaign appears to be lacking in Nigeria. Given this phenomenon, this study examined how culture can be conceptualized into improving STIs prevention communication campaign in Nigeria. Data was collected through in-depth interviews of 22 STIs positive and 19 STIs negative young people within the ages of 15 to 26 years in South-West and North-Central Nigeria. Data was analyzed through thematic analysis. While some of these cultural aspects help positively, others have negative impacts. Religion, values and taboos, cultural practices, and civilization were discovered to be the four major aspects where culture and STIs have nexus and influence communication of STIs messages in Nigeria. Evidence showed that religion discourage youths from pre-marital and extramarital sex. The Nigerian youths acknowledge values and taboos as having a powerful influence on matters of sexuality. However, there were still some local practices which discourage safe sexual behavior such as subservient roles of women, polygamy, female genital mutilation and using young females for sexual satisfaction. Findings indicate the need for STIs messages to address stigmatization, the use of local dialects, misconception in STIs knowledge, negative portrayal of STIs, usage of current information and disclosure of STIs status. It was discovered that integrated marketing communication channels will be effective to STIs negative individuals. However, the STIs positive individuals prefer the use of interpersonal communication and radio. The study concludes that a culturally sensitive communication intervention is crucial and should spearhead behavior interventions, both as agents and beneficiaries. Two STIs cultural sensitivity models were proposed as a potential guide in order to make the intervention gain acceptance among young people in various Nigerian communities.

Keywords: Cultural sensitivity, Health communication campaign, Sexual behavior, Sexually transmitted infections, Young people

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Kadiri Kehinde Kadijat

Dedication

I dedicate this work to my parents, Mr and Mrs W.A. Kadiri for their love, prayers and encouragement. In thick, thin, and when the going was getting tough they were a constant pillar of support. Thank you so much for the countless sacrifices that you made in order for me to achieve my dream. May Almighty Allah continue to bless you beyond your comprehension.

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List of Abbreviations

STIs	Sexually Transmitted Infections
UNICEF	United Nations Children's Fund
WHO	World Health Organisation
ARV	Anti-retroviral Drugs
HIV/AIDS	Human Immune Virus/ Acquired Immune Deficiency Syndrome
HSV-2	Herpes Simplex Virus type 2
PLWHA	People Living with HIV/AIDS

CHAPTER ONE

INTRODUCTION

1.1 An Overview

Sexually Transmitted Infections (STIs) constitute a major global health issue owing to the severity of its prevalence over the years and the target age group that they are ravaging. Going by the World Health Organisation's (WHO) reports, there is need for concerns regarding the plight of the youth who are at grave risk of contracting STIs. The WHO report of 2013 revealed that more than a million people acquire sexually transmitted infections (STIs) every day. The report further shows that an estimated 499 million new cases of curable STIs (gonorrhoea, chlamydia, syphilis and trichonomiasis) occur yearly. Furthermore, an approximately 536 million people are estimated to be living with incurable herpes simplex virus type 2 (HSV-2) infections. Approximately 291 million women have a human papillomavirus infection at a point in time (WHO, 2013).

The WHO reports of 2014 expounded that as at 2013, HIV/AIDS have claimed the lives of more than 39 million people since its inception. It was approximated that there are 35 million people living with HIV at the end of 2013 with 2.1 million people becoming newly infected with HIV in 2013 globally (WHO, 2014). Sub-Saharan Africa is the most affected region with 24.7 million people living with HIV in 2013. The data above further shows that about 70% of the global total of new HIV infection resides in the region. A 2014 WHO report on school and youth health further clarifies that in some countries (particularly in the developing countries) up to 60% of all new HIV infections occur

among 15-24 year olds. The youth represents a vital asset of any nation. Ironically, going by the WHO (2014) report, more than half of the fresh carriers of the HIV/AIDS virus fell within this age group. Unfortunately, it appeared that despite the enormous global efforts, the spectres of sexually transmitted diseases are on the increase (WHO, 2014)

This research probes the experiences of young people in Nigeria with regard to STIs. Nigeria has a massive young population; therefore this study explored the understanding of this vital asset of Africa's most populous nation's knowledge and awareness about STIs. The enquiry further permits an understanding of how the Nigerian diverse cultures can be strategically integrated into STIs preventive health communication design, conceptualization, theorization, and practice to achieve more effectiveness. The study holds the view that producing an effective culturally sensitive STIs preventive message requires the tailoring of such messages in a way that will be appealing to the young people within their specific cultural setting. It is believed that through the series of in-depth interviews with the informants – who are both STIs positive and negative – a door in reaching the heart of the Nigeria's young and sexually active generation through a culturally sensitive preventive health communication can be opened.

1.2 Research Background

Health is considered to be more than a mere absence of diseases. According to the WHO, health is a complete state of well-being. It connotes a comprehensive state of mental, physical and social fitness. Indeed, the WHO's *Ottawa Charter for Health*

Promotion reinforces the fact that health relates to the quality life available to the individual and the society (WHO, 1986; 2013), which necessitates taking into account the level of cultural, social, political and economic attainments of the society. These factors influence the state of well-being of the people whilst they (the factors) in turn are conditioned by the degree of health improvement recorded by members of the society. This mutually reinforcing existence between health and all these factors implies that adequate consideration would have to be given to the indicators if holistic progress is to be made in the health care development. Unlike in the West, where health is considered more from the individual perspective with the individual bearing the sole responsibility for his or her health care (Wass, 2000), the same is not for the developing economies, particularly African countries. In Africa, health care is seen largely as a social good, which the society owes the individual to provide. This therefore creates a big burden for many of the African countries in meeting the health needs of their people. The inadequacy of the required resources also infers the necessity for the developing countries to put the needed emphasis on preventive health care. It is what has made health communication an important component in meeting the heath care challenges in the developing countries.

STIs constitute health challenges where such preventive health communication can be of immense value. It is on fact that there exist more than 25 organisms transmitting different varieties of STIs with sexual contact remaining as the principal mode of transmission (Cafes & Dallabett, 1999; Ramana & Rani, 2015). It is also on record that the most vulnerable group at risk of exposure to STIs around the world (Nigeria

inclusive) are young individuals (between the ages of 15 and 24 years of age) because they indulge in unprotected sexual activities during their adolescent age (Imaledo, Peter-Kio, & Asuquo, 2013; Kadiri, Ahmad, & Mustaffa, 2015; Mbakwem-Aniebo, Ezekoye, & Okonko, 2012; Olakolu, Abioye-Kuteyi, & Oyegbade, 2011; Sambisa, Curtis, & Stokes, 2010; Widsmith, Schelar, Peterson & Manlove, 2010 and Yahaya, Jimoh, & Balogun, 2014.

Observations have also been made that STIs are on the ascendancy despite the well-diffused and well-acknowledged awareness promoting preventive measures including the use of condom (Ahmed et al., 2013; Arowojolu *et al.*, 2002; Olakolu, Abioye-Kuteyi, & Oyegbade, 2011; Olaseha *et al.*, 2004; Peltzer & Oladimeji, 2004; Smith, 2003; Ugoh, 2013). In the light of this, health communication has a unique role to play in the creation of better awareness and education so that the young people can take informed decision about their sexuality and sexual relationships.

Although there has been concerted efforts by health communication experts in ensuring that the right information with the appropriate contents concerning STIs are disseminated to people particularly the young people through the right channels, obviously increased attention is needed to design appropriate communication instruments that will have more effective impact. This requires looking towards combination of different communication strategies that can assist in changing young people's behaviour towards imbibing a healthier life-style (Freimuth, Edgar, &

Fitzpatrick, 1993; Stuckey & Nobel, 2010; Wakefield, Loken, & Hornik, 2010; Webb, Joseph, Yardley, & Michie, 2010).

Behaviour-change communication does not act in a vacuum. It requires being situated in the environment of the recipients if the messages are to make the required impact. The cultural context of the recipients and social appropriateness of codes must be factored-in to achieve the desired behavioural change. This also suggests the appropriateness of communicating in the indigenous language of a particular people. This approach has the capacity of significantly altering health risk behaviour to a positive response-level thereby leading to risk-reduction (Njikam nee Savage, 2005). In addition, message development works best when the peculiar unique qualities of the ethnic group's subgroups are also considered (Lesotho, 2008). Socio-cultural diversity which comprises of socio-economic status, educational level, acculturation level and place of residence are compelling interface in the effectiveness of behaviour-change communication (Johnson & Delgado, 1989; William & Flora, 1995).

For about forty years now, various mass media such as television, radio, newspapers, internet, mailings and other campaign materials have been used as channels for health communication with the objective of creating promotional and preventive messages (Ahmad & Harrison, 2010). In spite of these health campaign channels, it appears that there are still much left undone in incorporating the right strategic approach such as the culture of the targeted population. This approach has the likelihood of facilitating easy acceptance of the communication messages concerning the issue of STIs by the people.

For example, Freimuth (2004) indicated that the incorporation of cultural codes into health communication is as important as using an appropriate communication channel in the contemporary global context of health communication practice.

In recent times, the role of culture in health communication has been receiving unprecedented attention. For instance, scholars have incorporated culture into the conceptualization, theorization, and practice of health communication (Dutta, 2008). In the light of this, this study considers cultural factors to be very important-while designing information or a campaign concerning how to curb the prevalence of STIs among young people in Nigeria. Since people respect and hold their culture in high esteem, the use of cultural factors to create culturally sensitive messages has the tendency to contribute to a successful outcome in health promotion campaigns. For example, Geist-Martin, Sharf, and Ray (2003) noted that several array of disciplines such as communication, medical, anthropology, social work, sociology, literature, nursing, medical anthropology, allied health, public health and medicine have acknowledged that culture has a high influence on the perception that people have about health, their interaction and how they are treated.

Bird, Otero-Sabogal, Ha, and McPhee (1996) put the issue in the right perspective when they raised the need to take the basic background factors of the target population into consideration. Among the critical factors they direct attention to are the endogenous characteristics (e.g. knowledge, attitudes, beliefs, and cultural values), socio-structural factors, and environmental inequities (e.g., racism, poverty). It is the way to make

programs exhibit cultural sensitivity traits. Also, program personnel should be culturally competent, understand the imperative of working with community people, which is the grassroots people, who are familiar with the local culture. Morgan and Wabie (2012) contended that these factors are a necessity because each communal setting renders ineffective any attempt at mere duplication of a previous strategy or the application of a 'one-size-fits-all' solution. Hence, the way out to effectively use behaviour-change communication is to use an evidence-based approach, ensure its adaption to objective information gathered from a specific, population and locale.

There is little doubt that young people are appropriate target of culture-laden messages (Romer *et al.,* 1999). They are heavy users or consumers of the mass media. This experience has been buttressed, for instance, by the positive relationship found to have existed between mass media communications designed to address the specific culture and interest of African American youth's and their propensity to receive such messages (Grier & Briumbaugh, 1999; Grier & Deshpande, 2001). Hence, it is not controvertible that cultures do influence communications aiming at effecting change in behaviour; thus making it, that is, culture, an important component in health communication research.

1.3 Problem Statement

STIs constitute a major health burden for individuals who are not only sexually active but engage in risky sexual behaviour. Recently, there has been a global dimension to the diseases. On a global scale, approximately 499 million new cases of curable STIs occur annually (WHO, 2013). In Nigeria, the upsurge of STIs particularly, has been alarming.

This is in spite of the effort of the government that has witnessed the launching of communication campaign towards the creation of awareness among the people on the adverse consequences of contracting the infections. According to the latest data by NACA (2012), as at December 2011, on the side of HIV alone, there were 3,459,363 people living with the virus with estimated number of 1,449,166 requiring Anti-retroviral (ARV) drugs. That same year alone, 388,864 new infections were recorded while records show that 217,148 AIDS related deaths occurred in the country in the same year of 2011 (NACA, 2012). With an estimated population of 162,265,000 and as the most populated country in sub-Saharan Africa, Nigeria is obviously a big burden not only to West Africa region and African continent but to the World at large in terms of the burden of HIV/AIDS (NACA, 2012).

The most recent Nigerian HIV figure of about 3.5 million people infected with HIV ranked Nigeria second among the countries with the highest HIV/AIDS prevalence in the world, next to South Africa (NACA, 2012). In terms of the net effect of how the Nigerian situation can explode the health challenges of not just the region in which the country is situated, but extensively affect the world at large, it is important to see how Nigeria can be helped to reduce her current exponentially growing varieties of sexually transmitted diseases.

Undoubtedly, STIs remain growing diseases in Nigeria particularly among the youths (Ahmed *et al.,* 2013; Dixon-Mueller, 2009; Okereke, 2010; Shoveller *et al.,* 2004). Reported is the fact that youths in Nigeria within the age range of 15 – 24 years of age

represent the most affected group. Other studies affirm that Nigerian youths are not only sexually active but indulge in risky sexual behaviours (Imaledo, Peter-Kio, & Asuquo, 2013; Nwokoji, & Ajuwon, 2004; Oyeyemi, Abdulkarim, & Oyeyemi, 2011). In their study, Goldenberg, Shoveller, Ostry and Koehoorn (2008) noted that young people are the most vulnerable to STIs. The reasons are that apart from their uncontrollable sexual drive, they are in the habit of having multiple sexual partners and rarely use prophylactics. Hence showing their vulnerability to STIs compared to other segments of the population.

The evidence of sexual indulgence among the Nigerian youth is in fact overwhelming. A study conducted by Imaledo, Peter-Kio and Asuquo (2012) revealed that more than half of the respondents that were surveyed were in a sexually active relationship with the opposite sex. Among the sexually active respondents, 87% reportedly had more than one sexual partner in their lifetime and 32% used one form of protection during their last sexual activity. The attendant implications of these risky sexual behaviours are obviously grievous. In the first instance, it can lead to the transmission of HIV. At a lesser level, it surely can precipitate STIs, which, when later has metamorphosed can degenerate into other serious complications like infertility, pelvic inflammatory diseases, ectopic pregnancy, pregnancy loss and other various diseases such as gonorrhoea, chlamydia, staphylococcus, human papillomavirus to mention a few (Aliyu, 2004; Obidoa, M'Lan, & Schensul, 2012).

Incidentally, the high prevalence of STIs and its potential consequences have given the Nigerian government and the society at large a serious cause for concern. Quite evidently, the resources and efforts of the past towards salvaging the situation have not yielded positive results as expected (Erinosho, Isiugo-Abanihe, Joseph & Dike, 2012; Jappah, 2013). In the light of this, the Nigerian government, in the year 2000, developed a national reproductive health policy, part of which focused on reducing the risky sexual behaviours among adolescents. Expectedly, reducing the then increasing rates of STIs was one of the features of the policy (WHO & Joint United Programme on HIV/AIDS, 2001). The programme derived from the policy was hampered however by poor management stemming from utilisation of poor and inadequate data that manifested lack of information on the attitude, sexual knowledge, and behaviours of young people in Nigeria (Okereke, 2010). Unfortunately, it does not appear that a new policy or review of the existing one has been done. Yet, one of the leading Nigerian newspapers the *Punch,* on the 25th of June, 2013, had drawn attention to the fact that while several countries were experiencing considerable reduction in new STIs infections, Nigeria has been recording an increase. Another Nigerian leading newspaper, the *Vanguard*, also reported on July 2, 2013 that Nigeria has the world's slowest rate of declining HIV transmission among children and women of reproductive age. This critical situation of Nigeria suggests the need to take an urgent step towards having a holistic understanding of the factors driving people to cultivating risky sexual behaviours. Relatively, too, it has become compelling to find out why the health communication on STIs has had little or no impact on the Nigerian youth.

As a development issue, curtailing the rapidity at which STIs are growing in Nigeria and saving Nigerian youths from their scourges will continue to remain a major preoccupation of government and related professionals in Nigeria. It is therefore an effort in the right direction to explore in all ramifications how new vistas can be created for a successful implementation of STIs campaign. Nigeria has the potential of borrowing from the plethora of work that has been done in this area. Studies of Gerend and Magloire (2008); McManus and Dhar (2008); Sandfort and Pleasant (2009); Vega and Ghanem (2007); Wright, Fortune, Juzand and Bull, (2011) have shown that the possibility of increasing the knowledge and awareness level of young people concerning the STIs. What needs to be done is to nuance the content and context of the communication message within the socio-cultural characteristics of Nigeria and develop appropriate channels of communication to reach the target audience. That Nigeria needs this new opening is corroborated by several studies which shows that her young people need knowledge of STIs protective measures if they are to curtail their predisposition to risky sexual behaviours (Erinoso, Isiugo-Abanire, Joseph & Dike, 2012; Fawole, Ogunkan & Adegoke, 2011). In other words, a solution has to be found as to why Nigerian youths were not taking preventive measures into due consideration as found in studies and reports of health related organisations, agencies and professionals (NACA, 2012; Onoh, et al., 2004).

In the light of the above scenario, it becomes imperative for practitioners in health communication to disseminate culturally based messages to people from different cultural terrain. This can be achieved through the segmentation of audience based on

their cultural characteristics (Kreuter, Skinner & Steger-May, 2004), this is significantly important because of its ability to improve the accessibility, reception and salience of communication being presented (Kandula, Khurana, Makoul, Glass, & Baker, 2012). In a similar scenario, Sznitman *et al.*, (2011) argued that culturally appropriate strategy is the best approach to achieve cultural sensitivity in message design. This was also buttressed by de Anda (2002) that STIs cultural sensitivity in message design should attempt to explore the best strategy for effective implementation and successful campaign of the objective of STIs messages. Also, the need for adopting communication approaches/messages that are culturally sensitive has been argued to have the capability of sensitizing the people on behaviour change (Dutta, 2007) particularly the youth on the preventive measures of the STIs rampage in Nigeria. This development explains the importance of investigating the cultural strategies that are pungent in motivating audience which will lead to an improved and effective health promotion messages.

Since cultural norms and beliefs have a way of influencing people's behaviour, Reddy, Meyer-Weitz, Van den Norne and Kok (1999) argued that the cultural conditions and peculiarities of a community have a great impact on the sexual behaviour which later metamorphosed into the transmission and causes of STIs. Obioha (2008) explained that some aspects of cultural practices in some communities make the transmission of STIs to be conducive. Hence, he advocated that campaign planners need to explore and understand the cultural beliefs, values, norms and general attributes of their target groups in order to produce culture specific and focused STIs preventive control programs in Nigeria. Similarly, Acharya and Duta (2012) also emphasized on the need

for campaign materials (such as the media and messages) to harmonize with the cultural standards of the targeted group. It was suggested that for a campaign to be effective, there is a need for it to have accurate information about the cultural elements, identity and empowerment (e.g. cultural images, language and depiction of values, religion, beliefs, norms, customs and activities) and by considering the contextual and the environmental relevancy of the targeted group. As a result of this, Ityavyar (2010) argued that there is a strong feeling to incorporate the cultural practices and beliefs of the specific targeted group and environment in STIs' communication contents, adopted media and messages.

Connectively, in order to achieve effective and successful STIs campaign, there is a need for health communication practitioners to reposition and use different channels for disseminating health information. Also, the differences in the culture should determine the type of media channels that are used particularly when sensitive issues like sexual risk behaviour and STIs are involved. Therefore, there is a need to evaluate and refine the different ways of communicating not only culturally appropriate messages but also the use of strategic channels that the target audience will perceive as being culturally appropriate (Airhihenbuwa & Obregon, 2000; Kinney, Gammon, Coxworth, Simonsen, & Arce-Laretta, 2010; Sznitman, 2011).

According to Drysdale (2004) one of the foremost factors hampering the effectiveness of STIs campaign is the inappropriate selection of media that are used to transmit STIs preventive messages. This was also observed by Macdowall and Mitchell (2006) that the

peculiarity of cultural differences of a target group of people has a huge impact on the type of media channels that are used. Equally, Airhihenbuwa, Ford, and Iwelunmor (2013) reiterated that the cultural milieu of the people will determine the type of media that will be used to disseminate information to them. Logically, it is after understanding the media culture of the targeted audiences that any communication planner can have the confidence on how successful or effective their communication messages will be. This illustrate that culture plays a dominant role in the success of STIs preventive communication campaign both on the communication content and on the adopted media.

Considering the consequences of the rapid spread of STIs and the importance of its prevention among the young people, there is a strong rationale to examine the likely role of culture of information recipients in the tailoring of STIs preventive communication campaign. Although cultural sensitivity as a principle has been widely accepted among health communication and health behaviour researchers and practitioners (Dutta & Basu, 2007; Dutta, 2007; Geist-Martin, Sharf, & Ray, 2003; Kendall & Barnett, 2014; Palmer-Wackerly, Krok, Dailey, Kight, & Krieger, 2014) however studies which have focused attention on the use of cultural experience of STIs positive and negative young people for adaption in STIs communication are still rare.

There are many theories that have been used in health behaviour change studies such as Health Believe Model, Stages of Change (transtheorectical model), Social Learning/Social Cognitive Theory, Theory of Planned Behaviour, AIDS Risk Reduction Model, Ecological Approaches to mention a few. However, these theories apart from

being individual based models and theories, do not give attention to how culture in a particular geographical domain can influence the health behaviour of individuals. These factors maybe one of the reasons why STIs promotion program that were designed based these theories and models have not been effective as they are speculated to be. PEN-3 model captures the way of life of people in a particular geopraphical entity. The theory captures the psychological, organisational, cultural, physiological, community-level, political and policy-driven factors that influence health. Interventions that target unhealthy lifestyles by simultaneously focusing on multiple factors are more effective.

Furthermore, this research applied the Theory of Reasoned Action (TRA) and PEN-3 Model to examine cultural sensitivity in STIs communication among young people in Africa and Nigeria in particular are still rare (Garcia-Retamero & Cokely, 2011; Johnson-Mallard, Thomas, Kostas-Polston, Barta, Lengacher, & Rivers, 2012; Ortega, Huang, & Prado, 2012; Roberto, Krieger, Katz, Goei & Jain, 2011; Scarinci, Bandura, Hidalgo, & Cherrington, 2012; Sofolahan & Airhihenbuwa, 2013). Thus, the outcome of this study serve to strengthen the position of PEN 3 model which posit that culturally sensitive communications are crucial and that individual community should spearhead the behaviour change interventions which they themselves have developed and accepted as a community.

This study fills the gaps by providing a cultural sensitive communication contents/messages and the media that should be adopted by governmental agencies as one of the measures to quell the upsurge of STIs consequences among Nigerian youths.

This current study examined the perspective of the Nigerian youths towards the incorporation of their cultural perspective into STIs preventive communication messages. Thus, knowing the perspectives of the Nigerian youths over the role of cultural sensitivity in STIs' messages and channels would practically yield constructively in effectively addressing the STIs communication problem. Also, the study provides theoretically based solutions to the connection between cultural sensitivity and the success of health communication campaigns.

1.4 Research Questions

At the heart of this study, is to proffer answers to the following questions:

1. What are the elements of culture that can best contribute to effective health communication preventive messages on STIs in Nigeria?
2. What are the best message strategies underpinned by cultural sensitivity that can lead to achievement of cultural sensitive STIs message design in Nigeria?
3. What are the most culturally appropriate media for effective dissemination of STIs preventive messages for young people in Nigeria?
4. How does culturally based health communication influence the prevention of STIs among Nigerian youths?

1.5 Aims of the Study

The main aim of this study is to analyse the cultural sensitivity in sexually transmitted infection campaigns in Nigeria. In order to realize this broad aims, the secondary aims would also be pursued. They are:

1. To investigate the elements of culture that best contributes to effective health communication preventive messages on STIs in Nigeria.
2. To identify the best strategies suitable to cultural appropriateness in the achievement of cultural sensitivity in message design on STIs in Nigeria.
3. To explore the culturally appropriate media for effective dissemination of STIs preventive messages for young people in Nigeria.
4. To examine how culturally based health communication can affect STIs preventive communication.

1.6 Significance of the Study

The significance of this study is at three-dimensional level, namely: the practical, theoretical, and methodological perspectives that are introduced towards understanding STIs in Nigeria.

1.6.1 Theoretical Perspective

There are several theories in the area of health communication which are used to explain different phenomena of health situations. However, this study rests on two foundations – a theory and a model, which are combined to construct the perspective for the enquiry. While the "Theory of Reasoned Action (TRA)" provides the theoretical foundation for the study, the "Pen-3 Model" supplies the building blocks to erect the house. The theory and model were found indispensable tools because of the implications they have for finding solutions to Sexually Transmitted Infections in Nigeria.

The "Theory of Reasoned Action (TRA)" is a general theory pertaining to human behaviour. It deals with how components such as belief, attitudes and intention affect behaviour (Fishbein & Yzer, 2003). The theory, developed by Fishbein and Ajzen in 1967, is invaluable to developing a communication intervention project that has communication, information and education components (Fishbein *et al.,* 2001). Furthermore, the theory submits that the motivation of an individual to carry out a given behaviour depends on the attitude and subjective norms of that individual. Foundational to the theory is the assumption that all humans are rational beings who process information before having the motivation to take action (Fishbein & Yzer, 2003). For instance, if an individual has a positive attitude towards an issue, there is a great tendency that such a person will take action regarding the issue. Conversely, if he/she has negative attitude there is a high tendency of the individual not taking action.

The "PEN-3 Model" was developed by Collins Airhihenbuwa; a cultural approach protagonist. Airhihenbuwa is convinced that the model is the right choice for health education on STIs because it adheres to cultural sensitivity of the target communities (Airhihenbuwa, 1995). The model talks about the need for the cultural knowledge of the people to be integrated into healthcare interaction. The model's strength lies in the weight it gives to cultural meanings such as language, values, norms and beliefs attached to health behaviour. These attributes form the centre-piece of structuring people's interactions with health in the socio-cultural contexts (Airhihenbuwa *et al.,* 2009; Cowdery, Parker, & Thompson, 2012; Scarinci, Bandura, Hidalgo, & Cherrington, 2012).

This model provides an important reference for this present study as culture. The application of the theory and model permit a wide and deep understanding of young people's sexual behaviour that is necessary for the conceptualisation of future risk-reduction efforts. Also, it affords an assessment of existing prevention programs within the context of appraisal of each community needs and based on the local situation. The reason for this assertion is because preventive measures ought to be designed and facilitated by the unique needs of the community.

In parenthesis, it follows that extrapolation made from the prevailing culture will assist in the development and establishment of a culturally based health communication campaign capable of addressing the needs of youths in Nigeria. The data arising from this study has the potential of strengthening existing communication theoretical constructions and models geared at spearheading the behaviour change intervention communication programmes in Nigeria in particular as well as in similar communities with identical cultural structures.

In addition, the model and theory will significantly contribute to the study by identifying that there are some aspects of culture, message content and means of communication that are significantly unique in the Nigeria scenario. The findings of this study will strengthen or contribute to how TRA and PEN-3 model can be significantly and effectively used in the context of Nigeria.

1.6.2 Practical Perspective

Young people form a critical segment of the population with a peculiar idiosyncratic characteristic of being sexually active (Goldenberg, Shoveller, Ostry & Koehoorn, 2007; Nwokoji & Ajuwon, 2004; Tanton et al., 2015). Therefore, they are the most vulnerable group at the risk of diseases associated with STIs. The study looking into the perceptions of STIs positive and negative young people regarding preventive STIs communication in Nigeria, will give an objective appraisal of the reasons for – and otherwise – concerning the acceptance or rejection of the content of the STIs' preventive communication. Such outcome will provide valuable information to policymakers, health practitioners and communication specialists in planning and executing relevant and context-specific strategies aimed at changing the behaviour of the youths concerning the consequences and prevention of STIs. No less of importance, the result of this study can become a roadmap on how future STIs preventive communication campaign strategy can be nuanced in ways that attune to specific cultural and behavioural patterns of a specific cultural community.

Operating from the perspective that examined the most culturally appropriate media for effective dissemination of STIs preventive messages for young people, the study become a vital contribution to how selection of appropriate channels of communication for the effective dissemination of STIs message campaign. In large measure, it will be a knowledge gained on the influence and ways of utilising culturally appropriate media of communication to effect change among a specific group or cultural community.

1.6.3 Methodological Perspective

As a way of practically enriching knowledge, qualitative method becomes the third tripodal leg on which the study is hinged. This involves conducting in-depth interviews with both STIs positive and negative informants (young people). Through the interviews, they shared their lived experiences concerning STIs. The sharing of opinions and insights of both the afflicted and those not afflicted adds a new dimension to previous efforts because several previous researches conducted on STIs campaigns rarely consider sampling both STIs positive and negative young people. Yet, the fact remains that their perspectives have great influence on the potential for success and effectiveness of any preventive campaign. Furthermore, the use of qualitative method is invaluable because it exposes the researcher to pertinent and relevant responses on how STIs can be prevented.

Consequently, this study affords a better understanding through empirical evidence factors accounting for the spread of Sexually Transmitted Infections (STIs) within the cultural milieu of a country suffering from the health hazards. The problem is seen from the 'eyes' of those that are afflicted and affected by the affliction. It makes plain how cultural sensitivity in health communication in Nigeria has not received adequate significant focus. And to a reasonable extent, it offers an inroad to the perceptions of young people in Nigeria regarding the subject. Moreover, the use of in-depth interview brings to the fore a body of knowledge that adds to the stock of existing ones regarding how to address the methodological 'pitfalls' that have hitherto rendered previous attempts at preventive STIs communication ineffective.

1.7 Scope of the Study

STIs are infections that are mostly spread via sexual intercourse between two individuals (WHO, 2013). Presently, there are over 30 sexually transmitted bacteria, viruses and parasites that people are vulnerable to (WHO, 2013). Presently, Nigeria has the second largest people infected with STIs in the world. Therefore, the framework for this study is to investigate the STIs phenomenon from the lived experience of STIs positive and negative young people. However, the study restricts itself to STIs positive young people who are infected with gonorrhoea, chlamydia, syphilis, and HIV/AIDS. This is done with a view to using the knowledge gained to design an appropriate and strategic communication campaign that can benefit the young people. Undertaking sexually risky behaviour that exposes the individual to sexually transmitted infections is a serious public health issue with youths remaining the most vulnerable group. Hence, this study pays attention to the youths within the age bracket of 15-26 years.

There are two main categories of informants in the study. The first group are young patients within the age range of 15-26 years receiving treatment for STIs in four state-owned hospitals in the South-Western and North-Central parts of Nigeria. The patients were undergoing treatment for diseases such as gonorrhoea, chlamydia, syphilis, and trichonomiasis, and HIV/AIDS. Constituting the second category of informants are STIs negative young people. This group was purposively sampled from the same South-West and North-Central geographical location in Nigeria.

1.8 Nigeria in Perspective

Nigeria became a political entity in 1914 through the amalgamation of the Northern and Southern protectorates by the British colonialists. The legislative and executive powers of the then colony were vested in the Governor-General who was in charge of the colony. The name Nigeria, coined by Flora Shaw, who later married Lord Lugard, the British colonial administrator, was taken from the River Niger that ran through the country. On October 1, 1960, Nigeria became independent when the British voluntarily relinquished power. Since her independence, Nigeria has witnessed both civilian and military rule. The country from 1999 had been under the civil rule with Dr Ebele Jonathan who came to power in 2011 as the current President.

The country which is popularly referred to as "the Giant of Africa", is the most populous country in Africa and the seventh most populous country in the world. The country shares land borders with the Republic of Benin in the West, Chad and Cameroon in the East, and Niger in the North. Its coast in the South lies on the Gulf of Guinea on the Atlantic Ocean.

There are 36 states in the country with the federal capital territory located in Abuja. Seven states are located in the most populated North-West zone, South-West zone is the next most populated zone with six states. The South-South zone consists of six states while North-Central consists of seven states including Federal Capital Territory of Abuja. The North-East and South-East Zones consist of six and five states respectively. There are three main ethnic groups in Nigeria which are: Yoruba, Igbo and Hausa. The Yoruba people are predominantly in the South-West, Igbo in the South-East while the

Hausas and Fulani are in the North-West and North-Eastern parts of Nigeria. There are not less than 400 ethnic groups in Nigeria of which the three largest ethnic groups are the Hausa, Igbo and Yoruba (Chinenye & Ogbera, 2013). Other minority ethnic groups are Tiv, Ibibio, Ishan, Anang, Edo, Ijaw, Kanuri, Ebira, Nupe, Gwari, Ibibio, Efik, Igala, Ibira, Itsekiri, Jukun, Urhobo, and Idoma etc.

The diversity in ethnicity resulted in over 500 spoken languages in Nigeria because some ethnic groups speak more than one language. However, English language was chosen as the official language in Nigeria in order to encourage linguistic unity of the country. Though many people are not fluent in it, its use is mostly restricted to formal official level. Most people prefer to speak their mother tongue or "Pidgin English" during casual conversation, which is a combination of English and Nigerian local words.

Nigeria is home to different types of religions. However, the two major religions in the country are Islam and Christianity. These religions are spread across the country. This situation accentuates sectarian conflict amongst the population roughly divided into half Christians, who mostly live in the South-South and South-East, and Muslims concentrated mostly in the North-East and North-West. A combination of Muslims and Christians is to be found in the South-West while a small percentage of traditional religion worshippers are also found in Igbo and Yoruba areas. In most of the Northern states, which consist mainly of Hausa and Fulani, the vast majority of people are Muslims. The Hausa and Fulani have been Muslims for almost a thousand years, having been converted to Islam by Arab traders and merchants from the 10th century. On the

other hand, the British used Christianity as a tool to gain entrance into the lives of people in the South-West and South- East states. However, some people did not convert to Christian religion while some continued to practice their indigenous beliefs. Generally, Islamic religion is taken very seriously in the Northern part of Nigeria; women wear long flowing robes or traditional wears with headscarves, though few of them cover their faces. In the South, women dress more liberally wearing Western-style clothes as every day wear with an admixture of traditional attire if they so wish.

Other aspects of the Nigerian culture which gives the country a sense of dynamism is the different arts which include the ivory carving, grass weaving, wood carving, leather and calabash, pottery, painting, cloth weaving and glass, music, food, metal works etc. However, the core heart of Nigerian people's culture revolves around their beliefs, norms, values, religious practices and customs. These elements shape the daily life of the people and activities. The cultural norms and traditions dictate what the people can do and what they are not expected to indulge in. The violation of some of these cultural taboos and norms often attracts different sanctions from the society, which range from severe punishments to milder ones like social ostracization. An area where there are serious cultural expectations is sexual behaviour. A lot of social taboos and conventions surrounds sexual behaviour in virtually every culture in Nigeria; sexual excesses or indulgences are not only frowned upon but are attended with serious disapproval. In the traditional Nigeria community, violators of the social etiquette governing sexual conduct often become objects of ridicule in the community.

Figure 1.1: Map of Nigeria showing the 36 states and the Federal Capital Territory

1.9 Conceptual Definitions

1.9.1 Sexually Transmitted Infections

According to WHO (2011), STIs are infections that are mostly spread via sexual intercourse between two individuals. Presently, there are over 30 sexually transmitted bacteria, viruses and parasites that people are vulnerable to. STIs can facilitate the transmission of HIV with additional potential serious health complications like infertility, pelvic inflammatory disease, ectopic pregnancy, pregnancy loss and other multi-systemic diseases like gonorrhoea and chlamydia.

1.9.2 Cultural Sensitivity

This refers to the extent to which ethnic/cultural features, experiences, norms, behavioural patterns, values and beliefs of a target population as well as relevant environmental, social forces, and historical issues are incorporated into the packaging, design, delivery, and evaluation of health promotion materials and programs (Resnicow, Soler, Braithwaite, Ahluwalia, & Butler,2000).

1.9.3 Message Content

Message Content is the designed, tailored and packaged health information disseminated to a target group with aim of effecting behavioural change. The message should be able to support behaviour change and to clear up some misconceptions impeding behaviour change (Snyder & Hamilton, 2002).

1.9.4 Channels of Information

Channels of Information are the avenues through which young people are exposed to information on STIs. The sources range from people to books, files, films, tapes, radio, television, health practitioners etc. On the other hand, it can also mean the medium through which health communication is delivered to a target audience (Kreuter & McClure, 2004).

1.9.5 Elements of Culture

Culture is a complete way of life of a group of people. Therefore, the elements of culture are the specific attributes of culture which are unique to a particular group of people.

1.9.6 Health Communication

Health communication is the study and practice of communicating promotional health information, such as in public health campaigns and health education. The purpose of disseminating health information is to influence personal health choices by improving audience knowledge and awareness of a health issue, influence behaviors and attitudes towards a health issue, argue against misconceptions about health, increase demand or support for health services, demonstrate healthy practices, demonstrate the benefits of behavior changes to public health outcomes and advocate a position on a health issue or policy.

1.9.7 Message Strategies

This refers to how a message is creatively and persuasively communicated to a target audience. A message has to have an appeal- an idea that motivates an audience to respond. The message strategy must have a sound objectives that it wants to achieve,

have a good insight into the target audiences' attitudes and behaviour prior to determining on the most appropriate channels of communication to pass across the message to them.

1.10 Organization of the Study

The five fingers that combine to give this exercise a wholesome outlook begins with Chapter One which presents the introductory framework to the study. The chapter introduced the phenomenon of STIs in Nigeria, the segment of the Nigerian population found more vulnerable to the infection. Through the chapter, the foundation was laid as to the likely causes of the spread of the diseases among the youths, who were the most vulnerable group to STIs and the role that health communication could play in stemming the tide. The groundwork was laid as to the necessity of employing a culturally sensitive approach in the promotion of STIs communication messages if they were to record any useful impact. The chapter also contained the statement of the problems that the study intended to address through the research questions that it framed for itself to answer. The objective of the study, its significance, and finally, the scope of the study, all constituted areas of focus of Chapter One.

Chapter Two took off where the first chapter concluded by extensively reviewing relevant literature on the subject-matter. It further included review of approaches of researches into health communication; considered the issues of cultural sensitivity in message design, and wrapping up by drawing the curtain on health communication theories and models.

On the heels of the second chapter is Chapter Three where there is encounter with the methodology used in the study. Here the procedure employed in the collection of data was explained. Subsequently, Chapter Four presented the findings from the field research while Chapter Five dealt with extensive discussion on the findings while Chapter Six, the concluding chapter, apart from providing a summary and conclusion provided a number of recommendations which could assist in a further action-plan.

1.11 Chapter Summary

This chapter presents an introduction into the study of cultural sensitivity in STIs preventive communication campaign in Nigeria. The need for the study was established because of the necessity to produce an effective culturally sensitive STIs preventive message that is strictly tailored for young people in Nigeria. Based on the gaps noted, specific questions were formulated with the sole rationale of investigating how culture can be used to improve the existing STIs preventive communication campaign in Nigeria. Finally, some conceptual and operational definitions of terms as used in this study were also explained.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

A lot of explorations of the key subjects – health communication, communication, conception, design and dissemination of social messages, amongst others – have been done by the academics, professionals and scholars leaving a rich legacy of literature for the study to take-off. This chapter delves into a comprehensive review of some vital literature relating to its scope of study. Primarily, this involves probing into thoughts and thinking on issues such as cultural sensitivity in health communication, the implications of incorporating cultural elements like beliefs and values into health communication messages.

The take-off of the chapter is a review of the different perspectives in the field of health communication. The section terminates with a bird eye view on the current paradigm operating in the field. Thereafter, the idea of cultural sensitivity and its effect on health messages are also examined. Basic explanation of the various variables affecting STIs communication such as knowledge, awareness, message design in a culturally sensitive health communication, cultural sensitive channels of communication, the sources of information, the cultural beliefs, values, norms and myths is undertaken. In the end, the chapter puts forward the theory and model on which the study is based.

2.2 Health Communication: Definition and Evolution

Ratzan, Payne and Bishop (1996) gave one of the earlier concepts of health communication. They hold the view that health communication is a field that is concerned with not only human, physical, occupational and intellectual endeavours alone but is interested in their emotional feelings and others that combine to ensure optimum well-being of an individual. Thomas (2006) buttressed the point by adding that health communication is a powerful tool for the conveyance of impactful messages on the quality of life to the general populace and the policy makers as well. Similarly, The National Cancer Institute (NCI) (2007) extends the frontier further by stating that health communication value lies in the creation of awareness on deadly and hazardous diseases through the education of the people on possible prevention methods apart from proffering solutions to contracting of diseases. Further, health communication is also said to play an important role as a mechanism of enlightening the masses as far as proper and timely use of medications is concerned.

In tandem with the above, Liu and Chen (2010) views health communication as a concept whose utility is in the prevention of diseases and promoting health; improving doctor-patient relation; creating public health awareness; and broadcasting health risk through various channels in order to influence audience attitude and encourage behaviours promoting a cautious healthy life. Liu and Chen (2010) argued further that effective health communication increases the awareness of the individual regarding the value of his/her health while also equipping him/her with optimum information regarding potential health challenges. Liu and Chen also advance the fact that viable health communication strategies should have the capacity to transform public health

besides being an advocate for change in public policies and programs when desirable. Crucial as well, to Liu and Chen is that an effective health communication should lead to enhancement of the public health care services, act as the conveyor and the certifier of the beliefs, social norms and values that will assist the growth and development of quality personal and communal healthy life.

From the above concepts and definitions, it can be deduced that health communication programme is aimed at improving awareness of and understanding about health related issues. Its goal is to deliver improvement in the health condition of an intended audience. Health communication aims at informing and influencing individuals and communities in taking rational healthy decisions regarding their health. The consequence of this is that health communication is an interdisciplinary field pooling together ideas from management and mass communications with the key objective of improving personal and public health (Wright, Sparks & Dan, 2012; Piotrow *et al.*, 1997). The relevance of health communication to individuals and societies cannot be over emphasized. It is the chief mechanism of promoting public health awareness and education through which prevention or minimization of diseases can be achieved.

Indeed, there are many ways that health communication can be useful. It can help to bridge the gap in interaction between health professionals and patients (Maibach & Parrott, 1995). Through it there can be provision of a convenient access to health information. Health communication can ensure that patients and consumers adhere strictly to medical instruction. Besides the over-worn use of health communication

assisting in the dissemination of vital health information to both the individual and the general population at large, it is also an invaluable means of disseminating health risk information to the populace (Maibach & Parrott, 1995).

On the side of the health system, health communication has led to the growth in demand of appropriate health services with a consequent decline for inappropriate ones. It has also improved accessibility to needed information by those charged with making complex decisions such as health plans for medical care and treatment (NCI, 2007). At the community level, health communication has been used as a tool to effect change, set the public agenda, advocate for new policies and programs, support positive changes in the socio-economic life of the people and physical environments they live (Piotrow *et al.*, 1997). No less has been its use to improve the delivery of public health care services and boost social customs benefit health and quality of life of the people (Piotrow *et al.*, 1997).

In stating the obvious, health communication is not the sole pre-occupation of the mass communication discipline or expert. It cuts across a number of disciplines, which has enabled it to record great impact. As evident in the efforts of the World Health Organisation (WHO) and UNICEF, when social and behavioural sciences are aligned, a lot is achieved in confronting issues requiring behavioural change. For example, the rise of HIV/AIDS and other infectious diseases such as Anthrax, Avian Influenza, Dengue, Tubercle Bacillus (TB) and the most recent Ebola Virus Disease (EVD) around the world has shown that there is a need for multidisciplinary approach to public health

communication (Ahmad & Harrison, 2010). The proviso however is that despite the use of the multidisciplinary approach in health communication – even with an efficient health promotion system at that – result can be a failure if essential cultural factors of the targeted people are not taken into due consideration (Alden, Friend, Schapira & Stiggelbout, 2014; Bryce *et al.*, 2003; Iwelunmor, Newsome & Airhihenbuwa, 2014; Zwarenstein, Schoeman, Vundule, Lombard & Tatley, 1998). The reason is that given that health communication's main goal is to achieve behavioural change, and in the light of the fact that to influence a community, cultural context is significant, it follows that health behaviour cannot be influenced or changed when communication lacks communal, contextual and culturally significant symbolisms. In other words, there cannot be universality in the approach to health communication. This dividing bridge plagues Africa and Europe in the face of the fact that African countries rely on contextual and cultural influences that differ from what obtains in most European countries (Airhihenbuwa & Webster, 2004). Hence, there is a huge need to investigate cultural factors intervening in the usage of culturally sensitive message in health communication.

The imperative of this is to see that the audience easily identifies and relates with the content and context of a health communication campaign (Airhihenbuwa, 1995; Obregon, 2000; Iwelunmor, Newsome & Airhihenbuwa, 2014). Audience understanding of the inherent message is of utmost importance if there is to be effective reception especially against the backdrop of people's cultural values, beliefs, and practices that usually put people at risk of health problems. Hence, communication researchers have

the bounden duty of integrating the culture of the target audience in their health campaigns in such a way that the message they are purveying makes a remarkable impact on their communication recipients.

The current paradigm in health communication research today has shown the inadequacy of resolving African countries health crisis through Westernized intervention strategies. Apparently, universally accepted approaches have been empirically proven to be inappropriate necessitating the need to think out of the box constraining reliance on the extant traditional model of "one-cap-fits-all" international health communication approach (Airhihenbuwa & Webster, 2004). What is called for is a more localized culturally sensitive approach. Good enough, scores of behaviourist researchers are discovering the value of employing a new approach that is attuned to employing culturally sensitive campaigns that offer promise of altering the behaviours putting Africans including Nigerians at risk from various controllable attitudes (Airhihenbuwa & Webster, 2004). This new perspective of health communication certainly will strategically improve health status of most African countries (Freimuth, Edgar, & Fitzpatrick, 1993; Glanz, Rimer, Lewis, 2002; Haider, 2005; Jackson & Waters, 2005; Makoul, 1991; Ratzan, Payne, & Bishop, 1996; Rogers, 1996).

2.3 Issues of Cultural Sensitivity in Health Communication

In the 1980s, culture started receiving attention in health communication owing to the upsurge in the mobility of people from different cultures and because of failure of individualistic targeted health intervention campaigns (Dutta, 2008). Mazrui (1986)

referred to culture as interrelated values that are influentially active in terms of familiarizing societal perceptions, judgements, communications and behaviours. Airhihenbuwa (1995) sees health as one of the cultural construct, where cultural symbols and meanings constitute intervening variables. Human culture, obviously, embodies the entire social gamut of health beliefs, conventions, norms, socio-economic features, education, religion and the demographic characteristics of a particular people. Todd and Baldwin (2006) argue that all cultures are suffused with health beliefs that explain what causes illness and how to manage such afflictions and the type of people that should be involved in the process. They added further that an individual's cultural background shapes the way s/he perceives or deals with health and illness.

With respect to the many misconceptions surrounding culture, Dutta (2007) assists greatly through a detailed explanation that helps clarify such apprehensions. As Dutta states, an individual's tradition mirrors the person's behavioural standards with influence coming from demographic diversities such as age, gender and some other socio-economic features. Diverse are therefore those factors that mingle together to give people or community their traditions. Such factors witness the interplay of endogenous characteristics, socio-structural factors, and structural underpinnings. These factors lead to the differentiation in cultural elements like prevailing beliefs, norms, and practices. Thus, culture besides being an important phenomenon that identifies a society, it is also a dynamic and adaptive symbolism. It dictates relationships, identifies roles, and prescribes roles and obligations within the society. Culture also constrains individual behaviour while it shares meanings and understanding that become the foundation for

the individual member's beliefs and interpretation of social relations. Therefore, cultural identity is an immeasurable tool in promoting the interests of a specific group particularly on health issues.

Lupton (1994) asserts that it might be fruitful for medical professionals to pay attention to cultural influences when undertaking treatment rather than concentrating solely on physical manifestations alone in the course of effecting treatment of a patient. Similarly, Dutta (2008) expressed that cultural belief system of an individual has a huge impact on the individual's social roles and relationships when he/she falls sick. Based on these arguments Airhihenbuwa *et al.*(2009) and Trommsdorff (2009) concluded that culture, irrespective, of country or nationality, has a universal concept of being amenable to transmission of values, norms, practices, symbolization, interpretations and ways of life from one generation to the next including some other social properties delivered through learning and sharing. To these scholars, there is a great nexus between the influence of societal culture and treatment as well as management of illness; the implication of which is to also make more evident that language can be used to improve the understanding of illness concepts. These assertions emphasize that in order to ensure an effective health communication, such an intervention must take all the cultural factors into consideration. This study, thus, argues that culture as a complete way of life – the way we think, do things and feel about things – equally determines people's attitude to health and treatment.

Therefore, culture should be a decisive factor if not the centre point in the planning, evaluation, and implementation of health communication and health promotion programmes in general especially in tacking sexually-related infections where it has been found that culture plays a significant role in determining and defining people's sexual behaviour. In many of the cases, reactions to, activities pertaining to, and behaviour concerning sex that predispose people to sexually transmitted infections all have strong influence with culture (Airhihenbuwa, Clemente, Wingood, & Lowe, 1992; Chanakira, Alicia, Goyder & Freeman, 2014; Crawford, 1994; Ebisi, 2012; Izugbara, 2004; Kreuter, *et al.,* 2005; Kreuter & McClure, 2004; Michal-Johnson & Bowen, 1992; Schoepf, 1991; Wamoyi, Wight & Remes, 2015).

Consequently, opinions have been canvassed on the inevitability of integrating communication knowledge with cultural imperatives as a crucial step towards stemming the tide of ravaging sexually transmitted infections as one of the prerequisite required in the health communication field in the twenty-first century (Obregon, 2000). There is a strong rationale therefore to find ways of making health communication to become culturally sensitive to the culture of the people, particularly in a country like Nigeria where the scourge is existing as a "silent" serious public health enemy.

The clarion call by scholars such as Airhihenbuwa *et al.* (2009) and Dutta (2008) to restructure global health efforts to imbibe the cultural traits of target population in their communication intervention led to what we know today as the notion of being culturally sensitive in health communication. Cultural sensitivity is theorized and practiced across

communication contexts and health scenarios in today's increasingly multicultural society (Dutta & Basu, 2011). Issues on cultural sensitivity have been widely researched and explored from different disciplines such as public health, communication, education, psychology, nursing, and medicine. Resnicow, Soler, Braithwaite, Ahluwalia and Butler (2000) noted that cultural sensitivity has several labels- cultural consistency, cultural tailoring, cultural legitimacy, cultural appropriateness, multiculturalism, cultural relevance, ethnical sensitivity, cultural diversity, cultural pluralism, cultural competence and cultural targeting. They explained cultural sensitivity in health communication as the extent to which the characteristics of the cultural group such as values, norms, experiences, behavioural patterns including their historical connections, environmental standards and social influences of health communication campaigns are fused into the health promotion campaign.

Similarly, Dutta (2007) agrees that the cultural sensitivity approach should strive to design health promotion messages that are attractive to their audiences on the basis of cultural values and beliefs. He clarifies further that an intervention can only be successful when it responds adequately to the variables that have been identified by health communication experts as important to the effectiveness of the message. Therefore, a culturally sensitive approach seeks to tailor its message to suit the most important feature in a culture of a target group that would lead to the development of a successful health messages (Alden, Friend, Schapira & Stiggelbout, 2014; Dutta, 2008; Gould et al., 2014; Ulery & Amason, 2001; Sue & Sue, 1999).

In some health communication projects, Ulery and Amason (2001) found that cultural sensitivity is operationalized by coming up with scales to measure it and connecting it with outcome factors. They found that cultural sensitivity has a positive correlation with satisfactory doctor-patient communication outcomes. Similarly, Bresnahan, Lee, Smith, Shearman, and Yoo (2007) developed a culturally sensitive spirituality scale to predict why research partakers from Korea, Japan, and the United States were keen or unwilling to donate their organs. In addition to developing scales to theorize cultural sensitivity in health communication, Dutta (2007) notes that cultural sensitivity in health communication campaign is the application of harmonized health and communication theories to actualize a commendable effect of health promotion among its target audiences. Such harmonized theory recognizes the elements of culture and its ultimate role in interpreting communication codes and its laudable influence for behavioural health changes campaigns.

Researchers have discovered that culture is one of the factors responsible for the upsurge of HIV/AIDS infections in Africa (Airhihenbuwa & Webster, 2004). Cultural elements such as beliefs and values influence the regard that Africans have for sexual activities, determines sexual activeness and the nature and choice of sexual partners. For instance, Shisana and Simbayi (2002) explored the South Africans behaviours and attitude towards protected sex and their findings indicate an explicit influence of culture. Another similar study was conducted to determine the sexual orientations and reactions towards the construction of HIV/AIDS in Senegal revealed a convincing connection with their cultural beliefs and values (Niang *et al.*, 2003). However, the infection of

HIV is not limited to sexual intercourse since medical sciences have proven that it can be contracted out of sexual engagement such as the use of some unsterilized medical apparatus (Gisselquist, Potterat, Body &Vachon, 2003). The prevention of both sexually and non-sexual infection of STIs can be culturally conceptualised by incorporating some cultural sensitive elements into preventive campaigns which will discourage people from involving in risky sexual behaviour. This would presumably result into a change of behaviour that will result in the prevention of STIs. Consistently, some sexually related behaviour is informed by some cultural norms, for instance there are some cultures that impose the belief of vagina dryness to enhance penis friction (Gyiman, Tenkorang, Takyi, Adjei & Fosu, 2010; Sambisa, Curtis & Stokes, 2010; Yang, Xia, Li, Latkin & Celentano, 2010).

Parker and Aggleton (2003) studied the role played by culture in the stigmatization against AIDS infected patients. The study revealed that stigmatization of AIDS patients can only be understood within a cultural context. A three year longitudinal research under the UNAIDS projects to invent new HIV/AIDS preventive methods in Africa, Asia, Latin America and the Caribbean culture was included among the major tools for preventions, help and treatment of AIDs in Africa (Airhihenbuwa, Makinwa & Obregon, 2000). Invariably, culture and other socio-economic features must be an emphasized and centralized in the design and conceptualisation STIs prevention and control in Africa.

Furthermore, Airhihenbuwa (1995) reiterated that the meanings that are attributed to individuals are not merely a function of one's choice of identity but rather it is enshrined

in their past experiences. Thus, identity is a process of constructing the self in relation to one's context. And this context influences and is influenced by one's perceptions (knowledge, attitudes, values, and beliefs that have an impact on how one is able and willing to change behaviour), enablers (social and cultural systems that may enhance or act as barriers to health behaviour change), or nurturers (behaviours and beliefs in family and community that influence individual-level behaviour change) (Dutta & Bassu, 2011). Tied to identity and relationships, according to Airhihenbuwa (1995) are positive, existential, or unsafe health behaviours that should be either fortified or discouraged through communications that empower cultural participants to enact healthful behaviours without being displaced from the context of their cultural values.

The cultural sensitivity concept was divided into two dimensions namely: surface and deep structure (Kreuter & McClure, 2004). The surface structure is recognised as the process of making frantic efforts in ensuring that intervention resources and messages match the target population's social and behavioural features. More so, it involves the systematic use of the characteristic and features of the people like language, brand names, people's environment and locality familiar to and preferred by the target population. It also involves the use of channel of communication that can best reach the audience and settings such as religious institutions or schools that are appropriate for the disseminating of health messages and programs (Ahmad & Harrison, 2010). The bottom line is that the dimension of cultural sensitivity denotes the degree to which the intervention is appropriately tailored towards the experience, culture and behavioural pattern of a target group. Sensitivity to deep structure put into consideration the extent to

which members of an audience comprehend the health risks in their environment and the obstacles that they need to overcome in order to reduce or manage the risk (Romer *et al.,* 1999). Deep structure also emphasizes how cultural, environmental, psychological, historical and social factors can possibly affect health behaviour. This dimension encompasses an in-depth understanding of how the target audience views the course, cause and treatment of illness as well as how they observe the underlying factors of specific health behaviour (Glanz & Rimer *et al.,* 2002). Religion, family, society, economy, and government are also environmental variables that are considered in the dimension.

In the view of Dutta (2007), cultural sensitivity approach is initiated by accentuating an agenda for the health communication program. Afterwards, cultural variables of importance are then defined following which the cultural variables are measured in constructive research. Finally, the answers to health communication that correspond to the cultural variables identified in the constructive research are thereby strategically developed. The program is then executed based on criteria produced by the experts which later forms the pathway to a strategically designed health communication campaign.

In order to achieve an effective cultural sensitivity programs, various scholars have advocated that interventionists have to put into due consideration both explicit or surface cultural manifestation as well as the implicit or deep manifestations of culture (Resnicow *et al.,* 2000; Resnicow *et al.,* 1999; Wilson & Miller, 2003). There are

several distinguished strategies to achieve the aims of cultural sensitivity (Kreuter & McClure, 2004; Wilson & Miller, 2003). The first of the strategy is the presentation strategy which encompasses the evidential, peripheral and linguistic strategies. This strategy make use of native language and cultural sensitive scripts and context with the intention of enhancing the information receptivity and accessibility; the second is the socio-cultural strategies which strive to enhance the salience of the message by juxtaposing the intervention within the framework of the experiences, values, norms and beliefs of the people. Another way of achieving cultural sensitivity is the use of constituent-involving strategy. It refers to the active involvement of members of a cultural setting in the design and implementation of a program (Bertens, Schaalma, Bartholomew & Borne, 2008).

2.4 Awareness, Knowledge and Prevention of STIs

Discussion on cultural sensitivity in health communication relates to messages being culturally attuned towards changing the behaviour of people within a particular cultural environment. With particular reference to STIs, the problem seemingly is that knowledge in this area is still very sparse which adversely affects young people being exposed to ambiguous information about STIs (Oladepo & Fayemi, 2011). This ambiguity has heightened the inability of the necessary information not being easily understood by them. One natural precipitate is the cultural inappropriateness of the STIs messages often relayed as the messages tend to fail to take into account the specific needs of the culture in which the youth are existing, thus creating a divergence in their existential reality (Temin *et al.,* 1999). The outcome of this cultural inappropriate

campaign has been catastrophic leading to the pandemic that STIs are assuming among the younger generation (Airhihenbuwa & Webster, 2004). A UNAIDS (2006) report, for example, shows that 25 years after the discovery of HIV/AIDS, majority of people that are highly susceptible to the infection were still unaware of the prevention methods because many of the countries have not taken or adopted the proper procedures that can make awareness work. For instance, studies in Asian and Western countries show that while young people have high knowledge of HIV/AIDS correspondingly their knowledge of other STIs is low (Awang, Wong, Jani & Lowi, 2013; MacPhail & Campbell, 2001; McManus & Dhar, 2008; Oncel, Kulakac, Akan, Erausar & Dedeoglu, 2012; Sandfort & Pleasant, 2009; Suominen, Karanja-Pernu, Kylma, Houtsonen & Valumaki, 2011; Trani *et al.*, 2005).

On the other hand, in Italy, Trani *et al.* (2005) pointed out that though majority of young people have sufficient knowledge of the consequences of unprotected sex, however they still indulge in risky sexual behaviour. This finding corroborates with Suominen, Karanja-Pernu, Kylma, Houtsonen and Valumaki (2011) study among Finland students which shows that majority of the country's young people are careless about their involvement in risky sexual behaviour despite their high knowledge of protective measures.

Although these findings depict the existence of protective measures against the STIs, nevertheless, a study conducted in Turkey by Oncel, Kulakac, Akan, Erausar and Dedeoglu (2012) shows that young people have little knowledge concerning STIs

protective measures. Hence, the results are mixed as far as awareness of preventive measures on STIs is concerned in Asian and Western countries. These findings are almost consistent with outcomes of studies in African countries. For example, Taggoe (2009) discovers that knowledge about other types of STIs besides HIV/AIDS is low among Ghanaian women relative to men. This almost paints identical picture of the situation in Nigeria where Temin *et al.* (1999), Obiechina *et al*. (2001); Ayankogbe *et al*. (2003) discover that young people in Nigeria though have high knowledge of HIV/AIDS; however their knowledge of other STIs is very low.

These results conform with the findings of Makwe, Anorlu and Odeyemi (2012) and Mbakwem-Aniebo, Ezekoye and Okoko (2012) who revealed that young people in Nigeria generally have inadequate knowledge of HIV/AIDS. There are however some variants to these positions. Consistent with this pattern are the examples of the studies of Arowojolu *et al.* (2002), Nigeria Demographic & Health Surveys (2003), Onoh, *et al.* (2004), and Otoide *et al.* (2001) whose findings maintain that the same low level as far as protective behaviour is concerned among Nigerian young people. This is the primary reason adduced for the upsurge in harmful sexual practices in the county (Brabin *et al.*, 1995; Okonofua *et al.,* 1999; Otoide *et al.,* 2001). Another important discovery is that several young individuals who engage in risky sexual behaviour do not perceive themselves as engaging in risky sexual behaviour. This denial fuelled by wrong perception is dangerous because the consequences of their action were not immediately known (Thompson & Tashokkori, 1992).

The studies above show that compared to the high awareness of HIV/AIDS, knowledge about STIs is still low among Nigerian youths. Indeed, a recent discovery shows that there is high prevalence of risky sexual behaviour among young people in Nigeria within the age range of 10-24 years, a population group that is expected to explode to an all-time high 57 million exposed persons by year 2025 (May, 2012). Certainly, this finding indicates the time bomb that risky sexual behaviour has become for Nigeria.

What grievous forebodings are these disastrous omens painting about the sexuality of the younger population? The studies apparently show that mixed results concerning knowledge, awareness and prevention measures of STIs on the part of this vital capital asset of nations. In one breath, several studies show that they have abundant knowledge of measures to safeguard themselves from STIs. On the other hand, we see them still actively indulging in risky sexual behaviour (Arowojolu *et al.,* 2002; Erinoso, Isiugo-Abanire, Joseph & Dike, 2012; Fawole, Ogunkan & Adegoke, 2011; Odunsanya & Bankole, 2006; Olashela *et al.,* 2004; Olasode, 2007; Peltzer & Oladimeji, 2004; Smith, 2003; Tagoe, 2009). Unfortunately, studies investigating why awareness and knowledge of STIs of young people have not significantly influenced their perception on risky sexual behaviour have been limited. As a result, a higher number of discussions on knowledge, awareness and prevention pertaining to STIs and risky sexual behaviour measures among young people have largely been inconclusive. The implication is obvious that more studies are needed to investigate the level of awareness and knowledge of STIs among the young people, especially in Nigeria, where the exponential growth of the population of vulnerable youth has become frightening.

The current study therefore tends to examine the extent of the awareness and knowledge of youths on STIs. With this knowledge, it will be possible to gain insight into their perception on their predisposition to indulging in risky sexual behaviour. In tandem with this, this study will also examine the extent to which the misconceptions of STIs messages have affected their (the youth) perception of the risky sexual behaviour. Doing this will provide more illumination on how to arrive at a logical conclusion on the appropriateness of the information gap in communication campaign that is still making young people to be involved in risky sexual behaviour.

2.5 Cultural Elements in STIs Communication

Since the early 1990s, the use of cultural elements in health communication has been an indispensable frame through which STIs prevention and communication has been projected (Parker, 2001). Wyatt (1991) suggests that culturally responsive STIs educational material should strive to identify important aspects of a specific culture appropriate for a cultural group. He advocates that the materials should measure up to the cultural standards of the environment and must encompass accurate information regarding their cultural images, language with a depiction of the values, religion, norms, customs, activities that people appreciate and use if it is to accomplish the health goal. The utilisation of these cultural elements in the creation and structuring of prevention messages make it possible for them to overcome barriers of communicating with people at the grassroots level. Wyatt (1991) refers to this method as building cultural competency because it involves the critical scrutiny of norms and values that prohibit risky sexual behaviours while providing an alternative way of life.

Scott and Mercer (1994) explained that extending it to the community level advocates that effective STIs prevention programmes do not only need sufficient time, fund and expertise, but that the preventive programmes also require an awareness of the cultural and social factors that might affect the judgement, interpretation, spread and prevention of STIs. In essence, the intention of cultural scripts must be to influence the knowledge and attitudes known to impact sexual risk behaviour in the community. Normatively, STIs prevention through the creation of programmes achieves more if embedded in cultural elements of the recipients, is driven by lessons learned through philosophical as this leads to culturally informed programmes that are better than those that are culturally irrelevant (Parker, 2001).

There are risky effects of cultural inappropriateness in STIs prevention as evident in the experience of the design made for European Americans but then implemented in ethnic minority communities which have shown the importance of cultural attributes in the creation of effective STIs interventions (Airhihenbuwa *et al.,* 1992). Helman (1996) emphasised that the pattern of sexual behaviour practiced in certain cultures or societies may have an influence on the transmission of STIs. All these indicate the direct correlation between culture and STIs. Reddy, Meyer-Weitz, Van den Norne and Kok (1999) argues further that socio-cultural conditions of a community exercise a lot of impact on the sexual behaviour of the people, which in turn are related to the transmission of STIs.

Another element of culture is religion. Studies from Western countries by McCree, Wingood, DiClemente, Davies and Harrington (2003), Holt, Lewellyn and Rathweg (2005) Rew and Wong (2006) and Muturi (2008) show that religion and spirituality have positive influence on sexual behaviour. It also affects attitudes towards safe sex as well. For instance, McCree, Wingood, DiClemente, Davies and Harrington (2003), pointed out that religious conscious participants were found to have used condoms in the past six months of their study, delay sexual debut, and quite often are attuned to regular condom usage. Likewise, Muturi (2008) findings reveal that religion serve a prominent role in the Jamaican culture as it helps curtail the sporadic spread of STIs. Similar studies conducted by Lengwe (2010) and Mulwo (2010) revealed that religion is a concept that makes young people to restrain themselves from indulging in risky sexual behaviour.

However, studies conducted by HEAIDS (2010); Forest, Austin, Valdes, Frentes and Wilson, (1993); Noden, Gomes & Ferreira (2010); Rahamefy *et al.* (2008); Štulhofer, Šoh, Jelaska, Baćak, & Landripet (2011) revealed that religion and spirituality has no or minimal effect on sexual behaviour and safe sex. While, Forest, Austin, Valdes, Frentes and Wilson (1993) assert that religion did not seem to play any major role in male's attitude towards risky sexual behaviour. In similar vein, Rahamefy *et al.* (2008) maintain that religion does not have an association with the use of condom. Likewise, Noden, Gomes and Ferreira (2010) highlighted their discovery that religiosity had minimal effects on sexual activity for the females. While Štulhofer, Šoh, Jelaska, Baćak & Landripet (2011) asserted that religiosity does not seem to substantially reduce STI and HIV related risk-taking.

The divergence in the findings from these Western studies mirrors a parallel with the experience in African countries. Gilbert (2008) who beamed the searchlight on the young people in Senegal reported that even those who were religious conscious still did not delay their sexual debut. Kagimu et al. (2011) compared Muslim and Christian faithful in Uganda and it was reported that the two religions did not fortify STIs prevention intervention within the local communities. Likewise, Kagimu *et al.* (2012) maintain that religious precepts like trustworthiness and honesty and the hyper-pigmented spot on the fore head obtained as a result of regular Muslim prayers did not connote that those who wear Muslim cap were most likely to abstain from sex.

The general feeling however pertaining to the young people in Africa is the inexactness of the value of religion as influence on the sexual drive of African young adults. Takyi (2003) observed that the virtual absence of significant impact of religion and spirituality on the knowledge about the level of STIs. On the other hand, Akwara, Madise and Hinde (2003) pointed out that religion has a negative influence on young people's perception as regards risky sexual behaviour. Therefore, from both the sides of Western and African countries, there is a mutually reinforcing evidence of mixed result concerning the influence of religiosity and spirituality on young people's risky sexual behaviour.

Another cultural variable to be underscored is the family values. Family values influence the predisposition, or otherwise, to risky sexual behaviour. Villarruel's (1998) work

among young Latino adolescents made the fact obvious that family values positively influence risky sexual behaviour. Likewise is the enlightening work of Buhi and Goodson (2007), too. In their review of 69-study listed factors, inducing young people to involve in risky sexual behaviour in the USA, they found out that thirteen of the empirical studies discovered parental values as having significant influence on the risky sexual behaviour of young people. From the studies, the overwhelming evidence showed a direct proportional result between a child's early sexual debut and reduction in parental monitoring. There is also direct correlation with their acquisition of sexually transmitted infection (Bettinger *et al.,* 2004; Broman, 2007; Diclemente *et al.,* 2001; Li, Stanton & Fegnelman, 2000; Longmore *et al.,* 2001; Miller, Forehand & Kotchick., 1999; Romer *et al.,* 1999). Issue of increased sex frequency (Benda 2002; Miller, Forehand & Kotchick, 1999) coupled with higher sexual risk (Huebner & Howell, 2003; Li et al., 2000; Unger, Molina & Teran, 2000) were all reported as resulting from early sexual activity, particularly among boys (Smith, 1997).

Biddlecom and colleagues (2009) cross-cultural study of the influence of parents on the risky sexual behaviour of adolescent in four African countries – Malawi, Ghana, Uganda, and Burkina Faso – revealed that males that were not properly guided by their parents resulted in many of them engaging in premarital sex. Extrapolating the Ghanaian experience, the startling discovery was that young people with "loose parental monitoring" were found to have four to seven times more likelihood of indulging in premarital sex than those with strict parental monitoring

In another study on African American young people aged between 14 and 19 years old, a direct opposite of permissiveness in parents was discovered. Strict parental supervision is said to have resulted in a low incidence of gonorrhoea and chlamydia (Bettinger *et al.,* 2004). Broman (2007) also reported that young people who have closer relationship with their parents were most likely to delay their sexual debut till after marriage. Nevertheless, a few American-based studies contradicted the proposition and rather would have it believed that a very weak relationship between parental care is not significant enough to induce risky sexual behaviour in young people (Aronowitz, Rennells & Tood, 2005; Backer *et al.,* 1999; Baumer & South 2001; Benda & Corwyn 1996; Browning, Leventhal & Brooks-Gunn, 2004; Capaldi, Crosby & Stoolmiller 1996; French & Dishion 2003; Miller, Forehand & Kotchick., 2000; Perkins *et al.,* 1998; Whitebeck *et al.,* 1999).

Generally, Africa remains a substantive environment of permissive and indulgent cultural norms and practices encouraging the preponderance of sexually risky behaviours. On one side is the African men's concept and attitude to marriage that promotes risky sexual behaviour (Ezuma, 2003). Another is the decadent morality that tolerates marital unfaithfulness aided by a culture that promotes double standard of morality between men and women. Men hold the power to decide sexual health issues; it is never a balanced game with women having a voice on sexual matters as compared to other parts of the world. Turshen (1991) (cited in Ezuma, 2003) noted that cultural norms support married men having multiple sexual partners, keeping concubines, a travesty of morality which only encourage male promiscuity. A contrary opinion by

Gausset (2001) however argues that the cultural practices of Africans do not automatically promote risky sexual behaviour. In his opinion, belief like this is based on a long history of Western prejudice against sexuality in Africa, which tends to focus on side of the prism, issues that have been found exotic like polygamy, adultery, wife-exchange, circumcision, dry sex, levirate, sexual pollution, sexual cleansing, indeed, the varieties of the so-called African "uncivilized" beliefs and taboos.

Gausset (2001) argues further that it would be counter-productive to view the elimination of some African cultural practices as a way of eliminating STIs because it is incompatible with safe sex behaviour. As far as he is concerned, their eradication would not necessarily ensure the protection of people; rather to fight them might lead to alienating those whose cooperation is necessary if the spread of AIDS is to be checked. Gausset (2001) concluded that in order for STIs campaign to be meaningful and practical, HIV/AIDS or STIs message campaigns should not focus on fighting against the local African culture but rather should search for ways of making the behaviour and practices safer. Only campaigns which are culturally acceptable to the people stand a chance of being successful.

Nigeria that is a chip from the African cultural block presents no radically differing scenario. Marriage is generally referred to as a sacred institution yet men's unfaithfulness flourishes by the day. Women are culturally constrained to remain silent, suffer their husband sexual exploits, due to the intense societal pressure that sees a woman with a broken marriage as a failure and disgrace to her family (Ebisi, 2012). As

far as the Nigerian culture goes, it is a privilege to the woman if a man restricts himself to a single sexual partner. Ebisi (2012) explained that any attempt at re-defining the masculine superiority responsibility must strive to deconstruct some of these existing perceptions that are disposing men to risky sexual behaviour. Smith (2010) asserted that from experience, several campaigns tend to give women the impression that by remaining faithful, they will be safe from STIs. Yet, the reverse has remained the case due to the infidelity of men (Mills & Anarfi, 2002). A corroborating data show that married women do in fact pay the price for the infidelity of their husbands as they have been known to be vulnerable to contracting STIs through them (Nigeria Federal Ministry of Health, 2004; Smith, 2007). In other words, Nigerian men cannot be absolved as constituting transmission of STIs to their wives.

The cultural irony must not be lost sight of, however, that despite the male promiscuity, Nigerian culture places premium on virginity of the females. Chastity is still an admirable value expected of a socially upright young woman (Ebire & Ola, 2014). Rarely is there any part of Nigeria where it is not a pride – not just that of the individual girl but that of the family and community – for a young girl to have preserved herself until marriage (Oyefara, 2013).

In contradistinction, however, is the opprobrious cultural practice of "wife inheritance" whereby a widow is passed on to a member of her dead husband's family. Ebisi (2012) reported this practice, often perpetrated without the woman's consent, is one of the main leading causes of the prevalence of STIs in Anambra state of Nigeria. Incidentally, this

practice has is corollary in Kenya, too, where among the Luo and Luhya tribe of Western Kenya it is fashionable for widows to be forced into sexual intercourse with her brother in-law as part of the burial rites cleansing exercise (Ocholla-Ayayo & Schwarz, 1991). This abuse of women is even surpassed by another horrendous cultural practice: wife sharing which also fuel STIs in Kenya. Polygamy is another cultural issue which allows the male folks to have more than one wife. It is a practice that exposes women to multiple sexual relationships and as Reddy *et al.* (1999) argued that this cultural practice fraught with the danger of spurring a high tendency of risky sexual behaviour which can metamorphose into STIs. Thus, in Nigeria as in Kenya, the examples of cultural beliefs and practices that favour multiple sexual relationships have their serious complications because they can eventually exacerbate the STIs infections.

In most cultures in Nigeria, open discussion of sex is almost a taboo. Hardly can a Nigerian culture been encountered where open and free discussion of sexual matters, especially between parents and children, or between partners, is promoted (Izugbara, 2001; Onyeonoro et al., 2011). The prevailing norm and culture is keeping mute about sex, to be circumspect when sex is the topic of discussion, and show reticence in matters connected with sexual relations because sex is deeply rooted in the socio-cultural beliefs where the boundary is strictly defined in terms of discussions that constitutes decent and immoral exchange (Izugbara, 2001). Similarly in Ghana, cultural norms do not allow the female folks to speak openly and publicly about sex and sexual issues the way their male counterparts do (Tagoe & Aggor, 2009). The general perception is that only promiscuous ladies talk about the topic. The inhibitions predispose young females more

to risky sexual behaviour.

For example, instead of referring to sexual organs of the body and sexual emotions, in Nigeria, the resort is to make use of several ambiguous and indirect expressions to depict body parts, make reference to sex, sexual desires, relate subjects like menstruation and masturbation, that spontaneously provoke cultural disquietude on the point of slightest hint. This driving underground of sexual topics silence has worked particularly to the disadvantage of women because they could not be sure of which question to ask before putting their partners on edge, or raising the suspicion antennae of their prospects. This climate of enforced silence and denial just like the religious and cultural taboos constraining open discussion about sexual practices and preferences tend to work in concert in the wrong direction of driving up the graph of STIs (Izugbara, 2001). Many of the young, middle-aged, and even the old – who ought to know about the effective methods of protection least have those ideas how much more to be informed and aware (Rankin *et al.,* 2005).

Where are the youths located amidst the conflicting African cultural milieu? The first answer comes from a study that have revealed that young people do not automatically adhere to the cultural norms and taboos that restrain them against involvement in risky sexual behaviour (McGrath *et al.,* 1993). It was established that, in one account, their involvement in risky sexual behaviour, had to do with financial reasons and the need for greater sexual satisfaction. In many countries of Africa, the discovery was made that the risky sexual behaviour of young people was fuelled more by core values and social

norms that appeared to be more endogenous to the young people (Blum & Mmari, 2005; Feldman, O'Hara, Baboo, Chitalu & Lu, 1997; Muturi, 2005).

According to Akwara, Madise and Hinde (2003), who examined the relationship between perception of the risk of HIV infection and risky sexual behaviour in Kenya, it was found that more male than female were involved in risky sexual behaviour. Prevalence among the male was the case of multiple sexual partners as compared to the casual partners' inclination of the female. Contrarily, ethnicity and religion did not have a positive impact on young people's perception of risky sexual behaviour. The two elements showed a negative influence. However, it was found out that prevailing socio-cultural environment did have a huge effect on the group's perceptions because of internalization of generational norms, sexual beliefs and practices. The study resolved that in order to achieve a successful and effective intervention programmes, there is a need for program developers to take the cultural diversity of a targeted people into due consideration because a single programme cannot serve the interest of all communities. Nonetheless, diversity still exists in the youth culture across boundaries.

However, a number of discordant cultural practices appear to be cross-boundary and cross-region with their adverse effects. One is the superiority accorded to men virtually in all cultures. Whether in the Western or Africa countries, the element tends to be common though with different degrees of cause-and-effect relationship. Established was that the concentration of power in men to decide sexual health issues tend to be fostering low-level knowledge of sexual matters. It is also precipitating low-level skill utilization

in the prevention of STIs among Africa women. Other women in other parts of the world are not excluded too. These cultural defects have been documented as a leading contributory factor to the sporadic increase in STIs (Ebisi, 2012; Izugbara, 2008; Momoh, Moses & Ugiomoh, 2013).

In Anambra State of Nigeria, for instance, Turshen (1991) (citied in Ezuma, 2003) demonstrated the authenticity of the averments in the Nigerian community. The serial negative cultural practices – the paternalistic nature of the culture where married men indulged in multiple sex, keep concubines, the sort of double standard in morality – all encourage male promiscuity facilitating an upsurge of STIs in the area. Recognition has to be taken that the marital unfaithfulness tolerated by some cultures hardly accord with reduction of STIs.

Obioha (2008) made the same discomforting discovery in a study which investigated cultural impact on the HIV/AIDS pandemic in Taraba State of Nigeria. Several risky behaviours were discovered to have been fuelled by the prevalent culture in the area. Such areas of negative culture include permissive sex, unscreened blood transfusion, lack of commitment to marriage institution by many, polygamy, and quack medical practice. The argument is that the culture of the people constitutes a non-negligible variable in the conceptualisation and design of a preventive campaign program aimed at achieving a considerable impact on the audience. Despite the popular consensus that cultural elements are important phenomenon, there is a need for more extensive study on how these elements can be used to influence the targeted audience.

2.6 Cultural Sensitivity in Message Design

A well-tailored, properly conceived, and appropriately disseminated message is the heart of STIs prevention and education irrespective of the cultures. It is the way to put the epidemic under control through effective communication. Consequently, ways of conceptualising and disseminating appropriate messages to people from different cultures stand as an important aspect of STIs preventive communication. In the light of this, a great demand is placed on health communication professionals to develop culture-based messages that segment their audience based on their identified cultural characteristics (Kreuter & McClure, 2004; Kreuter, Skinner & Steger-May, 2004). Media message reception with the example of African Americans shows that people react positively to mass media communications that strategically address their particular interest (Grier & Briumbaugh, 1999; Grier & Deshpande, 2001). Segmenting the population is an important preliminary step because of its tendency to improve accessibility to, reception of, and the salience, concerning the communication being presented (Kandula, Khurana, Makoul, Glass, & Baker, 2012). Hence, information has to be designed in such a way that it will not only be sensitive to the culture of the target informants but also be appropriate for them.

How can culturally sensitive communication in the health sector be approached? Several scholars have keenly approached this subject. The result has been a variety of several ways of incorporating cultural constructs into the contents and context of social message production promoting health (Sabogal, Otero-Sabogal, Pasick, Jenkins & Perez-Stable,

1996). With reference to specific subject of risky sexual behavioural-change media messages, similar attempts have been made to study mechanisms of evolving strategically designed campaign that can address the critical beliefs propelling risky health-related behaviour. This assertion calls for a need to empirically identify those underlying cultural elements essentially inducing the audience's attitude to health promotion messages. Though some beliefs may be apparent, but the mediatory power of other not too apparent beliefs cannot be left to intuition or guess-work, hence it must be carefully researched (Swanepoel, 2005). Communication targeting health promotion therefore has to be research-and-culture based.

The imperative is that a culturally appropriate message that combines both peripheral and evidential strategy, nuanced in linguistic, constituent-involving, and socio-cultural context stand the greatest chance of delivering the effectiveness required (Kreuter, Lukwago, Bucholtz, Clark & Sanders, 2003). Kreuter and colleagues stressed that the approach need not be unidirectional; that health communication practitioners do not necessarily have to limit themselves to the utilisation of one strategy when planning an intervention program. Taking note of the intervening peripheral variables means that intended message should be designed in such a way that it is culturally appealing to a specific group of people in the population. This approach indicates the use of images, fonts, colours, including pictures that can strike the public visibly and register decisive impact on them. The evidential factors, the second layer of the factors that can affect the results envisaged, encompass the use of evidence as a means of persuading people to embrace a healthy way of life. As for the linguistic interference, it is to utilise the

predominant native language of the target population. The constituent-involving equation involves the utilisation of the experience of members of the target group in the conceptualisation of the message (Hamilton, Agarwal, Song, Moore & Best, 2012).

Lastly, is the socio-cultural imperative, which demands that social and cultural characteristics of the target group be factored into the health-related campaigns. Resnicow *et al.* (2000) insists that these factors should be taken into cognisance because they present what is called the "deep structure" defining cultural sensitivity. The recognition of, and infusion of the 'deep structure' in the conceptualisation and design of health promotion communication enhances the understanding of evolved messages, helping the purpose the messages are meant to serve among a target population to be achieved.

Empirical studies have shown that an inseparable association exists between a culturally tailored and developmentally oriented communication targeting behaviour change. It gives the mass media a catalytic role. Studies on media as tools of intervention in young people's world suggest that media messages have the tendency of promoting safer and responsible sexual behaviour (DeVroome *et al.,* 1990; Hauser & Michaud, 1994). Other studies also suggested that mass media are well suited to serve the goal, especially as regards providing accurate information on STIs to young people because they are often uncomfortable to discuss sexual matters with their parents (Creatsas, 1997).

From the perspectives of Western countries, studies have shown that the integration of

socio-cultural attributes of people into message design did result in the effectiveness of the message campaign (Ahmad, Cameron & Steward, 2005; Bender & Clark, 2011; de Nooijer, Lechner & De Vries, 2002; Hamilton, Agarwal, Song, Moore & Best, 2012; Kline, 2007; Koo, Kwok, White, D'Abrew & Roydhouse, 2012; Purnell *et al.*, 2010; Sznitman *et al.*, 2011; Wrigh, Naylor, Wester, Baver & Sutcliff, 1997). Another study conducted by Wrigh, Naylor, Wester, Baver and Sutcliff (1997) found that the utilisation of community traditional values, norms and mores that emphasized the cultural value of breastfeeding in the message design influenced their health behaviour positively in favour of breastfeeding thereby leading to a rapid success in changing their breast feeding behaviour.

Correspondingly, Nooijer, Lechner and Vries (2002) evaluation of two projects designed to encourage voluntary testing for cancer, demonstrate that culturally tailored message contrary to one with mere general information has a higher propensity of recording success. The tailored information had made use of socio-cultural symbolic elements featuring culture, interest, and characteristics of the target group as compared to the general information that merely relied on general expression. The result of this study emphasized the futility of putting hope on "one-cap-fits-all" message production to resolve conflicting behavioural issues in the contemporary world.

From the opposite direction have also been documented cases of what could go wrong when communication neglect the cultural perspective of recipient of the message. The PEN-3 model of cultural sensitivity explained that cultural sensitivity is a prerequisite in

any contemplated health promotion media campaign (Airhihenbuwa, 1995). The model reiterated that for health promotion to be effective, it must be culturally appropriate to the targeted audience. However, if this is not taken into due consideration it will keep sustaining the several dysfunctional "double-barrel expressions" being witnessed in contemporary information packaging (Airhihenbuwa, 1995). This was the case with Hamilton, Agarwal, Song, Moore, and Best (2012) study which discovered the lack of effectiveness in the health communication that sought to reach out to elderly Black Americans who were cancer survivors. The failure of the communication to incorporate socio-cultural strategy was found to have undermined the relevance of the behaviour change communication was intended to have amongst the target population. The same shortcoming was recorded in Bender and Clark's (2011) study that investigated the absence of culturally tailored health promotion on obesity among the racial minority group in the United States of America (USA). Owing to the poor result of the ineffectiveness of the campaign, it became obvious that adoption of socio-cultural strategy can no longer be divorced from giving effectiveness to health communication.

Furthermore, surface cultural manifestations involving such elements like language, contexts, clothing and traditions, along with other deep manifestations of culture such as norms, values, roles and beliefs must be given due consideration (Sznitman *et al.*, 2011). The inevitable conclusion emanating from wide-ranging studies is that only culturally tailored media interventions making use of peripheral and socio-cultural factors have the higher possibility of encouraging young people to adopt safe sexual behaviour.

Attention also has to be paid to the use of constituent involving strategy. Constituent involving strategy is significant if effectiveness is to be achieved in attitudinal and behavioural change concerning health issues. When constituents are involved in message design, the possibility of the message reaching a wider range of the population is high. It is economical and faster compared to any other method (De Anda 2002; Ross and Williams, 2002). Van Der Veen, Van Empelen and Richardus (2012) allude further that dissemination of information through existing social networks have the positive effect of reinforcing and making changes among peers a norm regarding safer sexual behaviour. The experience of these authors show that interventions delivered through unfamiliar health professionals have low utility rate and often turn out to be unsuccessful. Kulukulualani, Braun and Tsark (2008), in turn, taught similar lessons to those of Ross and Williams (2002) and De Anda (2002) from their work with Hawaiians on producing educative brochure about cancer, the lesson was taught of the value of cultural sensitivity, as participants preferred messages designed with the picture of Hawaiians who were healthy and active. Only few of the respondents did not agree with the majority. Contrary to the picture of a physician, the people preferred that of a healthy and active Hawaiian instead, because of the image of the physician conjured phobia in the memory of the people. Therefore, the conclusion was made that involving the constituent as strategy serve the good end of making messages appealing to the target audience because it enhances reception. Furthermore, incorporating some of the other "deep structure variables" like socio-economic background of constituents enriches the potential of the message reception.

One other unavoidable prerequisites determining the effectiveness of health communication messages is "evidential" proof. Implementing cultural sensitive message design demands convincing facts and figures. Royak *et al.* (2004) and Thompson *et al.* (2008) emphasised this point of accurate, objective and relevant data being *sine qua non* when presenting information seeking to improve the perceived importance and understanding about a disease. Royak *et al.* (2004) in the experiment with Black American on colorectal cancer discovered that the usage of statistical information enhanced the understanding of the participants about the subject while at the same time encouraging measures to reduce the incidence of developing breast and colorectal cancer. Thompson *et al.* (2008) added depth to the subject by discovering the strong link between the use of ethnic specific data (evidential strategy) and the level of acceptance and comprehension of messages. Not only did the data encourage the respondents to take positive action, it had the added benefit of giving hope to the people.

The reviewed literature highlighted that different strategies have been used from conception in the design and dissemination of health messages. From the reviewed literature, the studies used different strategies to realize the goal of inclusion of appropriate cultural sensitivity. Also, only few studies investigated message strategies on STIs (Anda, 2002; Ross & Willaims, 2002; Van Der Veen, Van Empelen & Richardus, 2012; and Snitman *et al*.,2011). While majority of the studies tend to focus on cancer (Kandula, Khurana, Makoul, Glass & Baker, 2012; Kline, 2007; Kulukulualan, Braun & Tsark, 2008; Koo, Kwok, White, D'Abrew & Roydlous, 2012; Lu *et al.*, 2012; Nooijer, Lechner & Vries, 2002; Purnell, Katz, Andersen & Bennet,

2010; Royak *et al*., 2004; Tanjasiri *et al*., 2007; Thompson *et al.*, 2008; Wang *et al.*, 2008).

Owing to the paucity of studies on STIs, experience was shared with other health-related studies. Apparently, additional studies are required in this area of STIs research and the current study serves as a contributing stream from the Nigerian perspective. Although the few previous studies on message strategies for STIs have shown that socio-cultural strategy and constituent involving strategies are mainly used, the current study attempts to examine the best among these strategies towards the effective realization of the objective which motivated this study. This is particularly important in the quest to get STIs preventive information across to the targeted youths through the vehicle of mass communication.

2.7 Cultural Sensitivity of Communication Channels

The basic communication theory teaches the importance of channel in the flow of communication. Channel is the heart of communication as the human heart is to living organism. Incidentally, the means of communicating health messages has grown significantly with the rapid explosion in the means of communicating as witnessed in the 21st century. Today, there is a wide range of available communication channels which range from the internet, mobile phones and other varieties of media in the information and communication highway. This has led to a complication of health issues as people now demand for more and quality information on health matters (Liu & Chen, 2010). However, cultural differences continue to be an interface regarding the way different global populations access information and communicate on health matters. Cultural

differences, to a reasonable extent, determine the type of media channels that specific set of people are exposed to on health messages. This is true especially in respect of sensitive issues like sexual behaviour of which STIs form a major part. Consequently, it is paramount to evaluate and redefine the various approaches of communicating not only culturally relevant messages, but also the usage made of particular channels by a specific audience view to ascertain the culturally appropriateness of the chosen media. No doubt, campaign planning need a huge understanding of the target audience (Airhihenbuwa & Obregon, 2000), in order to ensure that only appropriate channel suitable to the audience is utilized. For instance, a handful of health communication and health promotion programmes that are carried out in Africa have tended to undervalue oral communication, which may be inconsistent with the cultural milieu of the people though may accord with the academic exalted preference of written and visual modes of communication. Ugboaja, an African communication scholar adjudged that oral media has a great relevance in rural Africa (Soola, 1991).

Empirical studies have shown that the affinity between the culture of the people and the type of channels used in reaching them cannot be discountenanced. This is particularly valid for health information because the channel used to disseminate a health campaign matters. Coincidentally, there are varieties of communication channels to choose from which vary from video, parental communication, mass media, television, community level approach and inter-personal communication. For instance, video is found to be an influential medium of communication in health matters when the issues involved perhaps the youth. Studies from Western countries (Lauby *et al.*, 2002) confirm that

video possesses the latent possibility of influencing attitude, knowledge and behaviour of young people, especially the poorly educated ones. In another vein, Mathew *et al.* (2002) from South Africa revealed that exposure of young people to a video based health education promotion led to improvement in the confidence level of the individuals in notifying their partners of a sexual infection.

Continuing the specific attention to STIs, parental form of communication is discovered to have some potency in conveying information to the young ones. Stanton, Li and Galbraith (2001) and Caron *et al.* (1993) encounter this positive value of parental communication in an experiment where parents were encouraged to effectively communicate with youngsters on sexuality issues that might lead to STIs. The authors found out that between the parents and their children, trust and confidence was engendered as the latter looked up to the former as an important source of sexual education and information.

Television is also another means of disseminating culturally sensitive messages. In western countries such as United States of America, television has been massively used to disseminate STIs messages to young people with report of encouraging result of behavioural change. Through television, for instance, a high percentage of condom use was said to have been recorded with accompanying improved individual motivation for continued use (Zimmerman, *et al.,* 2007). A similar positive result on HIV/AIDS awareness was reported in India through television education and entertainment programmes (Sood, Shefner-Rogers & Sengupta, 2007).

The utilisation of the combination of several channels of communication has been recognised as a valuable means for passing across persuasive health-promoting messages to numerous audiences. This is against the backdrop of the mass media messages potential to change attitude and practices, especially of young people, as evidence in Western countries, where individuals with steady partners, have been reported to be motivated towards adoption of safer sex (Bertrand & Anhang, 2006; Kennedy, Mizuno, Seals, Myllyluoma & Weeks-Norton, 2000; Mullen, Ramirez & Strouse, 2002; Pedlow & Carey, 2003; Robin, Dittu & Whitaker, 2004). This is proven to have worked best particularly combined with inter-personal form of communication (Sznitman *et al.,* 2011).

Fortunately, if there is an area of shared similarity between Africa and the West, it is in the influence of the media on the sexually active members of their populations. Researches from the two sides of the cultural divide are accord that the minds of the young people can be opened to media health messages. McCombie, Hornik & Anarfi (2002) and Agha (2003) for instance, revealed that the mass media campaign on HIV prevention had a tremendous influence in reducing the engagement of young people in sexual activities. Other studies like that of Rumisha *et al.* (2006); Poolman, Kamali and Whitworth (2006) and Marum, Morgan, Hightower, Ngare and Taegtmeyer (2008) conducted in other part of Africa showed a similar trend. However, the advertised success of the mass media notwithstanding, a drawback has been the lack of penetration of the rural areas disadvantaged (Silva & Meek, 2003). Consequentially, they argued

that there is a need to close the gap among those who are educationally and economically disadvantaged (Silva & Meek, 2003). While Peltzer *et al*. (2012) put the issue in its right perspective that the success of STIs campaigns would need to move from mere awareness creation to attempting to inculcate safer sexual behaviour practices. Instructive is Nigeria's experience with the "VISION" campaign whose objective is the promotion of safe sex (Keating, Meekers & Adewuyi, 2006). The campaign which ran in four states in the country was partially successful. Though the project exposed the necessity of condom in promoting safe sex, which was the best it could achieve. It failed to turn the habit into a cultivated personal safe sex habit (Keating, Meekers & Adewuyi, 2006). A campaign that is effective with good result goes beyond accomplishing episodic change in behaviour; it should have a long-lasting effect.

Surprisingly, some results from the use of interpersonal communication in promoting health issues threw up better results of the channel being amenable to long-lasting effect in the dissemination of STIs messages to young people. For instance, in the United States of America (USA), an HIV preventive campaign was conducted with the use of a small counselling group. The programme that was school based resulted in a resounding success (Centre for Disease Control and Prevention, 2001). Ultimately, confidence is being buoyed regarding that interpersonal communication might be a better prospect than traditional media in changing STIs related behaviour (Albarracin *et al.,* 2005). This view has proponents in researches such as Noar, (2006) who advocated that inter-personal channels such as small group counselling as being better suited to achieve

audience participation in activities geared at skill training, modelling and role play that media messages could not achieve.

Again, in both cultural contexts of the Western world and African countries, there is no disparity on this notion about inter-personal communication. For instance, in Uganda, Low-Beer and Stineburner (2013) reported that the success in the reduction of prevalence of STIs had a lot to do with the utilisation of personal channels of communication. Between the period of 1989 and 1995, a heavy dose of the means of disseminating information about HIV/AIDS to both genders in urban and rural areas relied on inter-personal communication channels. Similarly, Adeokun *et al.* (2005) reported that the impact of HIV/AIDS prevention campaign in Nigeria derived its success from integration of the inter-personal communication channels to the HIV/AIDS campaign. Expectations were only met but the result was startling – there was better impact of the messages disseminated.

The obverse side of inter-personal communication is the community level platform in dissemination of health message. Much of the exploration of this subject was the work of Kennedy, Mizuno, Hoffman Baume and Strand (2000) and Sznitman *et al*. (2010) which reported a positive correlation. One of their findings indicated that preventive STIs campaign using the community platform approach resulted in improvement in the level of awareness of STIs among young people. It encouraged the cultivation of positive STIs preventive behaviour like condom use, change of adolescents' view of customary practices inducing STIs. On the other hand, fears was expressed that

community-focused treatment of STIs treatment while being useful for counselling might actually not help to reduce the risky sexual behaviour. Particularly to STIs' positive young people, community platform might just be a fleeting, momentary, "shot-in-the arm" approach (Snitzman *et al.,* 2011). The reason for the scepticism has to do with the observed fact that young people with modified sexual behaviour after exposure to STIs communication more often than not revert to their old behaviour after six months. Therefore, Sznitman and colleagues prefer the combination of mass media with community-based campaigns to achieve steady reduction in risky sexual behaviours.

Candidly, it is apparent that most of the studies in this segment of the study have largely used traditional mass media such as television, radio, video and interpersonal form of communication such as family level intervention, community engagement, and parent-ward communication (Betrand & Anhang, 2006; Caron et al., 1993; Galraith, 2001; Kennedy, Mizuno, Seals, Mathew et al., 2002; Mullen, Ramirez & Strouse, 2002; Myllyluoma & Weeks-Norton, 2000; Pedlow & Carey, 2003; Robin, Ditu & Whitaker, 2004; Sood, Shefner-Rogers & Sengupta, 2007; Zimmerman et al., 2007). Equally, the media utilised tend to be based on the cultural appropriateness of the channels. The findings, undoubtedly, clearly indicate the paramount imperative of health media practitioners selecting their channels of communication with an eye on the impact the chosen media will have on the target audience. Prudence must be weighed with economics if media are to have desirable impact. A good example is the lesson that should be learned from a study by Rumisha (2006). The study shows that using newspapers and radio as means of passing across information might be as productive as

envisaged. In the study, it was discovered that the two channels led to a waste exposure. The exposure expected could not be achieved because cost affordability had created accessibility problem to the respondents. Another study by Sznitman *et al*. (2011) showed the possibility of un-anticipated result during the life-cycle of a campaign. The media campaign, which centred on HIV/AIDS, began on a promising outlook with a positive development only at the end to record a disastrously negative result after the campaign. These developments warn of care in selecting and using a medium of communication for social change.

One shortcoming that cannot fail to be noticed is the neglect of the appraisal of the contributions and roles of the new and social media in the health communication campaign. The new and social media have become inseparable companions and sources of getting information on health issues with the possibility of potentially improving health outcomes (Guse, Levine, Martins, Lira, Gaarde, Westmorland, & Gilliam, 2012; Hanson, West, Neiger, Thackeray, Barnes & McIntyre, 2011; Levine, 2011). Through them the world has become indeed a global village. More than that, they have also redefined the world, life, existence and identity of – people, nations and societies. The world, today, is at the finger-tip of a button. This is true today of the youths as the generation has become sold to and addicted with the Information and Communications Technologies whose breath-taking development has opened far greater possibilities for the youths in today's world (Guse et al., 2012; Hanson, West, Neiger, Thackeray, Barnes & McIntyre, 2011; Levine, 2011). In this wise, horizons to explore wider new possibilities, to become limitless, are now opened to every human endeavour. The

choice is that of the investigator not any longer of limited possibility, particularly in relation to media, which have become vast and burgeoning. Indeed, any subject concerning the youth cannot neglect these media as they get most of their information from the new and social media networks.

Also, majority of the campaigns reviewed showed a bias toward HIV/AIDS and not STIs in general. It is in the nature of the area of the research interest that has been preponderant over time. Therefore, this study departs from its predecessors by veering into less considered new and social media networks in the interaction with STIs' campaign.

2.8 Health Communication Model and Theory

This section explores the health model and theory that have been deployed towards the eradication of STIs around the world. Notably, behaviour based theories and models have featured prominently in the quest at evolving strategies at combating HIV/AIDS and other STIs where the medical efforts have been either to contain them or to find a lasting cure. With respect to STIs in particular, the preponderance of the research efforts have been to devise ways of evolving a reduction mechanism through changing the risky sexual behaviour of the people. As has been explained, the most common route to STIs transmission in Africa has been through culturally permissive heterosexual behaviour, which can be prevented with proper behaviour modification (DiClemente & Peterson, 1994). Though behavioural scientists spearheaded the fight against STIs, the effectiveness of their efforts has been undermined by the fact that most of the

approaches they adopted have tended to be Western biased and oriented (Airhihenbuwa, 1995, 2007; Dutta, 2007, 2008). The context of their enquiry derived its background from the Western cultures. This has left Africa in the periphery of such intellectual endeavour. As a result, Africa has tended to benefit little from the welter of intellectual pursuits that have been devoted to understanding the methodology of fighting against the sex related scourges. Africans live in communities and employ the communal way of living exerting vast implications for the search of appropriate models that would suit her cultural context.

At present, models emanating from the West that have enjoyed primacy lacked the sensitivity to the prevailing cultural, environmental and social factors that condition the individual African behaviour (UNAID, 1999). Cochran and Mays (1993) did in fact advocate the discarding of the current models because they failed to respect the peculiarity of African ideology of communism, which centred on interdependence, unity and cooperation, as compared to Western values whose orientation rests on individuality, independence and competition. This cultural divergence opened the door to the cynicism about whether the current communication approaches could potently promote healthy habits and disease prevention communication as it concerns particularly STIs prevention in Africa (Airhihenbuwa, Makinwa & Obregon, 2000; Airhihenbuwa & Obregon, 2000; Foster, Phillips, Belgrave, Randolf & Braithwaite, 1993). As the past made manifest, several of the past interventions, designed to improve conditions, have failed to register acceptance in most communities as the target local population viewed them as an imposition from external agents. They therefore turned their backs on them

because the projects have not been community-oriented (Airhihenbuwa & Obregon, 2000; Bayer, 1994; Campbell, 2003; Foster *et al.*, 1993). Hence, this study proposes to learn from the errors of the past. It therefore believes that there is a need for a paradigm shift. To echo Campbell (2003), the interest of this study is 'a paradigm drift' constructed on STIs health intervention idea that involves the community stakeholders in the design of culturally appropriate media approach that can stimulate and sustain behaviour change.

However, a short digression by asking the question: What has happened to the body of theories evolved to explain behaviour change? Kalichman and Hospers (1997) provide a precise answer to the question. Aptly, they stated that many of the theories on behaviour change have been inadequate in addressing the issues of sexuality, sexual relations and sexual contexts within which STIs transmission takes place. As a result, it is important to investigate the past with a view of knowing the extent of their inadequacy both regionally and contextually (Airhihenbuwa *et al.*, 1998; Airhihenbuwa & Obregon, 2000). Both the tone and direction of the attempt here are therefore set by Kalichman and Hospers. It involves looking at the models and theories where cultural sensitivity has been the prime agent of directing scholarly and intellectual thought in the study and design of health intervention such as intended to be achieved here. Hence, this section explores the Theory of Reasoned Action (*TRA)* that has explicated beliefs, attitude and values as deterministic variables in behaviour change. First, the individualistic theory will lay the foundation in the exploration of the subject-matter before it moves on to focus on its ground-work of establishing the concept of paradigm shift within the

context of culturally-based model considered important to designing health promotions and interventions in STIs prevention for a country such as Nigeria. In the end, practical application of this health model to help the youths of Nigeria through new STIs intervention programmes will round up the section.

2.8.1 The Theory of Reasoned Action (TRA)

The basic assumption of the Theory of Reasoned Action (TRA) is that the individual exercises power of control over decisions. Developed by Martin Fishbein and Ajzen in 1975, it is predicated on psychological approach to understanding of human behaviour. The TRA has been particularly useful in the development of communication projects with goals meeting information, education and /or communication needs (Fishbein, 2000).

Central to the TRA's theory is the conception of human behaviour as rational; that behaviours are matters of volition, which means that people do have the capacity to control their actions. The theory avers that situated within a particular context and at whatever given period, people have the capacity for rational contemplation before deciding whether to follow or adopt a given behaviour (Ajzen & Fishbein, 1980). As far as the theory is concerned, the belief and attitude of an individual correlates with his/her intentions and behaviour (NIH, 2005). Although the TRA is built on a similar conceptual framework with the Health Belief Model, the difference is that the TRA adds a further element that relates behaviour to intention and intention as the determinant of health behaviour. Specifically, the theory alludes to the fact that personal intentions determine

an individual's motivation to follow or execute a particular action or behaviour. If someone is positively disposed towards an issue, for example, the likelihood of such a person following through that action or behaviour is high. The opposite will be the result in situation of negative interest or desire.

Subjective norm is another concept that the TRA has addressed. It is an idea saying that the way and manner a socio-cultural context (subjective norm) is perceived can have a major impact on behaviour and the control deriving from such behaviour. Subjective norm makes apparent the influence that social capital – that is, cultural values – can exert in changing individual's behaviour. It is believed, for instance, that there is low probability that people will adopt a different behaviour if the resources to achieve the change in attitude are beyond their means though they may hold strong attitude towards the behaviour. For such a resource-handicapped person, it is even immaterial that quite a significant others approve of the behaviour (Montano & Kasprzyk, 2008). In sum, by the theory, a person's intention is a function of attitude (the underlying personal behaviour) and the 'subjective norms' (that is, the social influence). The variables of the theory and the meanings attached to them by Ajzen and Fishbein, 1980 are:

(a.) Behaviour: Behaviour is a combination of four components: action, target, context and time (e.g steps taken to implement a sexual risk reduction strategy (action) by using condoms with casual sex partner (target) in brothels (context) every time (time)).

(b.) Intention: Intent (the adjective of intention) measures the likelihood or possibility that a desired behaviour will actually occur. Intent is measured by using the same yardsticks to define behaviour: action, context and time.

(c.) Attitude: A person's displayed positive or negative feelings toward a defined behaviour.

(d.) Behavioural beliefs: Behavioural beliefs are a combination of a person's beliefs regarding the outcome of a defined behaviour and the person's evaluation of potential outcomes. These beliefs differ from population to population depending on their inherent norms.

(e.) Norms: Normative beliefs combine a person's beliefs in relation to other people's views on a given behaviour with an indication of the person's willingness to conform to those views. Normative beliefs play a central role in TRA because of its focus on an individual's perception of other people regarding how such people – especially if they are influential – expect the person to behave. Among the key people in the influential group are peers, family members, parents, religious leaders and other groups in the society. Normative beliefs also vary from one people to the other.

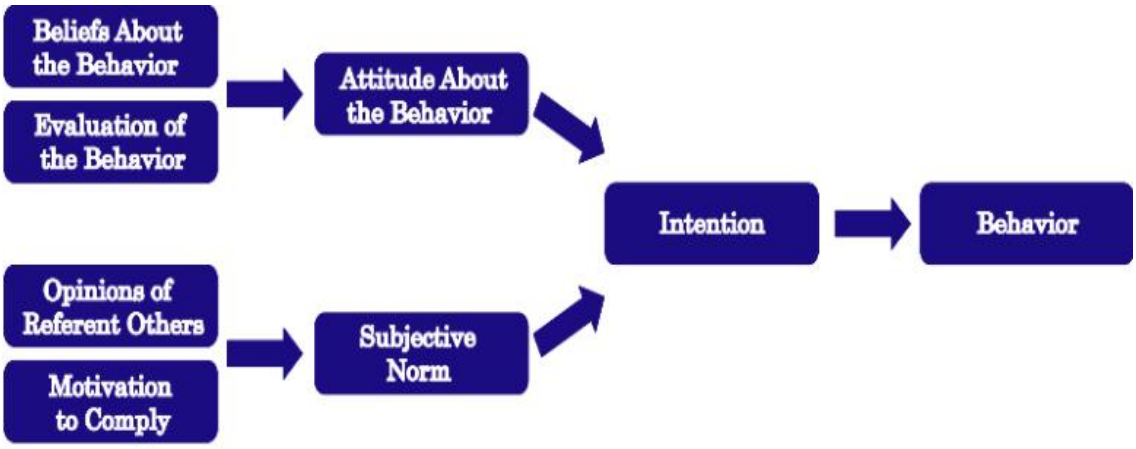

Figure 2.1. Fishbein-Aizen's Theory of Reasoned Action

The TRA model uses a linear process. It hinges on the fact that a person's actual behaviour is affected ultimately by modifications from the individual's behavioural and normative beliefs (i.e. cognitive structures). It stems from the strong view that a person's intention remains the best indicator that the desired behaviour will occur. This is in view of the cognitive structures (i.e. the behavioural and normative beliefs) that shape an individual's attitude, and in line with the subjective norms that provide the living environment for the attitude. Consequently, as attitudes and norms shape a person's intention to perform behaviour, their influence on a person's intention still vary. The theory posits that every action is grounded toward achieving a particular objective within a given context and time. Every incidence of behaviour, the theory upholds, is uniquely determined, while each behaviour requires a peculiar intervention strategy in which the various beliefs that determine the action is taken into due consideration (Fishbein & Yzer, 2003). One of the greatest contributions of TRA is that it institutionalized the interpretation, identification and measurement of both individual and community behaviours apart from establishing a vital relationship between those

behaviours in their interaction with traditions and cultural values and beliefs (Montana & Kaspryzk, 2002).

The behavioural intent which is an attribute of Theory of Planned Behavior (TPB) is not is not an important feature for this study. The concept was proposed by Icek Ajzen to improve on the predictive power of the theory of reasoned action by including perceived behavioural control (Ajzen & Fishbein, 1991). The perceived behavioral controls are influenced by the attitude about the likelihood that the behavior will have the expected outcome and the subjective evaluation of the risks and benefits of that outcome. It is one of the most predictive persuasion theories. It has been applied to studies of the relations among beliefs, attitudes, behavioral intentions and behaviors in various fields such as advertising, public relations, advertising campaigns and healthcare. However, the various attributes of TRA are adequate for this study because it addreses the attitude of individuals and the subjective norms that determine their final behaviour.

However, the TRA has been criticised for its over-optimistic individual-bias. The opponents say it is not appropriate for African context that thrives on communal co-existence. Montana and Kaspryk (2002) argue that the theory lacked environmental and demographical feeling that primarily influences the behaviour of young people. Rather, it is mainly concerned with individual motivational factors, giving the impression that they are the only determinants of behaviour. Even though these two factors are essential, as Fishbein and Yzer (2003) indicated, they (the two factors) should be taken as a strong

determinant of behaviour change of individuals, but certainly, not the only exclusive factors. In other words, the theory has been silent on other determining factors.

Another important omission, which Cochran and Mays (1993) draw attention to, is the assumption by the theory that individuals have the capacity to use their freedom of decision to make a rationale decision. Presumed by TRA is that every individual has the capacity and required skill to translate needs directly into a behavioural occurrence. Unfortunately, this is a contradiction in fact and practice. A typical example is that of several people like women, youths, commercial sex workers that are highly susceptible to STIs yet find themselves in environment and situations beyond their control. The consequence is that their behaviours are highly unpredictable given factors such as financial resources, housing, education and mobility that could have helped reduce their vulnerability but whose absence only manage to deepen it. In such a situation, intention may not readily lead to a desired behaviour.

Even worse is the observation of Michal-Johnson and Bowen (1992) that TRA may not be entirely suitable for STIs related behaviours, which often are deeply influenced by sentiments e.g. the condom usage. According to Singhal and Rogers (2003), situations or sexual encounters may disallow rational intention to adhere to condom usage. They argue, therefore, that an individual-based intervention and its corollary of using the individual as the unit of analysis might not work well for STIs. This is because STIs are deeply influenced by societal conditions and situations in which people find themselves. Susser and Stein (2000) not only share this viewpoint but counselled that each society

should be studied and evaluated in terms of their peculiarities and local situations. This will afford the discovery of the preventive measures to be used and which will meet the unique needs of that community. The individual may count but the community cannot be over-ruled too.

The central framework of the TRA has however shown that individual behaviour can metamorphose through the cognition process. The theory offers a solid framework in understanding the health behaviour change. While the work acknowledges the possibility of personal belief influencing behaviour change, respect is also paid to other significant factors such as the prevailing cultural values of the society (Airhihenbuwa, 1995). It is believed that the TRA, within the limits of its scope, did provide a better understanding and framework to guide the study of a community group of people who may have different philosophies and cultural orientation. It is as a result of this, that the TRA has loaned itself as a sound and solid theoretical foundation to this study to appreciate how messages affect health behaviour.

2.8.2 Cultural Frameworks

It simply cannot be over-emphasised that culture and health communication's nexus are inseparable for tangible results. It is a functional dynamics, as several scholars in the field of health communication have come to realise. Indeed, to African, Asian, Latin American and Caribbean countries; exploring health communication as an intervention, without integration of the cultural dynamics, remote is the possibility of the result leading to favourable behavioural change. Consequently, the cultural framework serves

the purpose of developing a culturally sensitive campaign. The model's advantage lies in eliminating many of the other problems associated with other approaches used for STIs' interventions. Many of these less effective models being too individual-centred in conformity with Western nature originating them were deficient as instruments of resolving the communal nature of the extant culture of nearly all of the African societies (McKee, Bertrand & Becker-Benton, 2004). By nature, Africans live communally with their approach to life and living shaping the principle of collective existence. It is the same approach they extend to problem solving which takes on collective nature with communities serving as the grounds for the decision.

2.8.3 The Paradigm Shift

A major development therefrom has been the paradigm shift culminating in reduced dominance of behavioural theories and models to the gradual evolution of cultural approaches in the field of health communication. Some of the reasons accounting for the change are:

Firstly, as Umeh (1997) stated, behavioural variables often fail to give adequate information on the impact of economic, cultural, and social factors that are pervasive and frequently intercede in risky sexual behaviours. Thus, reason demands that when studying young people, it is important to appreciate and diagnose their risk and threat to STIs reduction with a youth-centred approach. Understanding the socio-cultural influences that shape sexual relationships among young people – Nigeria, inclusive – is critical to the development and implementation of a "tailored" and effective programme.

Secondly, psychological theory such as the "Theory of Reasoned Action," which was used in the past equally failed because they did not put some socio-cultural contextual issues like class and ethnicity and others into consideration (McKee, Bertrand & Becker-Benton, 2004; Michal-Johnson & Bowen, 1992). Underlying this theory is the assumption that individuals make decisions out of their own volition, and, by extension, each individual does take rational decision when it comes to health prevention (Singhal & Rogers, 2003). This has been proved to largely be a fallacy, an unfounded pre-supposition.

Contentious as well, is the significance attached to language by the theories. Airhihenbuwa (1995) explains that the language of a community is its culture and largely defines the people. He advocates for oral tradition in health communication intervention in cultures where oral communication is the primary basis of communication. Airhihenbuwa's idea is a radical departure from the individualistic theories and models that overlook the use of local language and media of the recipients of the information being purveyed. With enlightening insight of Panford, Nyaney, Amoah and Aidoo (2001), that communication may not be effective when modern communication strategies are used in regions where majority of the people are illiterate, it becomes understandable why many health campaigns fail in Africa. Many have always made the wrong assumptions that once information is packaged, the various mass media would deliver them to the people. Of course, while the mass media can bring about awareness but the proven fact is that awareness may not necessarily lead to

behaviour change. Also, though the mass media may use various mass media channels but that too does not translate to the media accomplishing the set-mission because at a point the employed media may not be culturally appropriate. For example, a village (called Samburu) in Kenya with low literacy was exposed to an English-based billboard on HIV/AIDS (Wanyoike, 2011). Obviously, the billboard resulted into a waste of resources as majority of the inhabitants could not understand the message though they were aware of the information about HIV/AIDS. Hence, it is clear that awareness about a disease is not tantamount to behaviour change; therefore, a media channel that is not culturally appropriate serves less as an effective tool to effect behaviour change. To come up with relevant interventions, it is necessary to study and understand the community, which is the chief means of coming up with appropriate and community tailored communication that will have a profound and effective impact on the people (Airhihenbuwa, 1995). Majorly, health promotion campaigns that are culturally appropriate are more effective than a general health campaign and as stressed by Kreuter and McClure (2004) and people easily associate with sources that are trustworthy, credible and familiar to them. Probability of success becomes higher when people can relate with such sources in terms of age, gender, race, socio-economic status, marital status, employment and other demographic variables than those unknown or strange to them.

2.8.4 The PEN-3 Model

The PEN-3 model was developed by Collins Airhihenbuwa, a strong proponent of the cultural approach, which is in contradistinction to the behavioural models that have been

in use for some time. Airhihenbuwa, (1995) argues that the PEN-3 model is more suitable for health education on STIs because it provides answers to cultural sensitivity in the target communities. The model was primarily developed to investigate the place of cultural factors such as language and associated behaviours influencing the health of the people. Significantly, it has worked its way up to become the centrepiece of structuring people's interactions with health within the socio-cultural context (Airhihenbuwa *et al.,* 2009). As illustrated below, the PEN-3 Model has the following components:

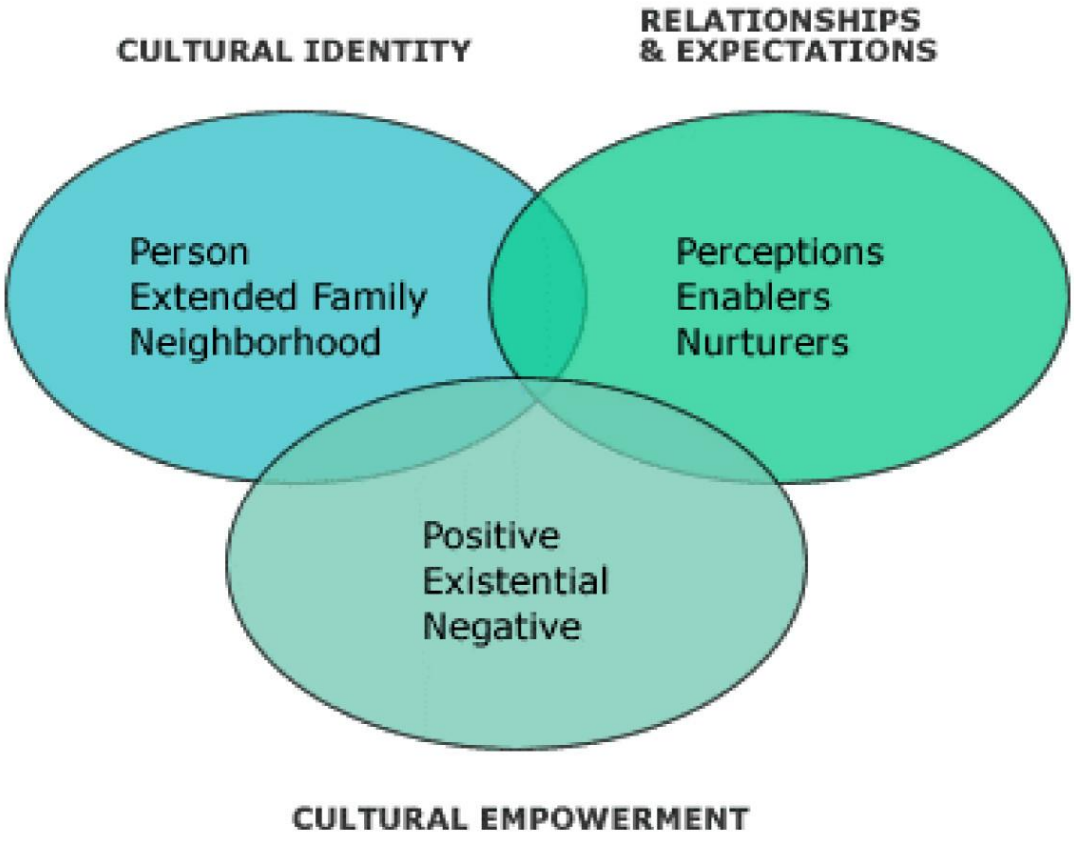

Figure 2.2. The PEN-3 Model (Airhihenbuwa 1989)

The aforementioned model proffers the recognition and understanding of the perception as well as the attitude of the community in addressing and resolving their health

challenges. It is directly opposite to the norm of policy makers-based tradition of decision making process. The model has three interrelated dimensions: (a) Cultural Identity (CI), (b) Relationship and Expectation (RE), and, (c) Cultural Empowerment (CE) (Airhihenbuwa, 2007). These three elements are discussed below:

A. Cultural Identity

From time immemorial, scholars have always had an intense argument over the issue of identity being a cultural marker. Since demographic variables often tend to be taken as identity markers in measuring individual differences toward explaining or predicting a problem, identity has always been taken as a useful parameter in measuring problems and deviance. The tendency to use identity as a causative factor in explaining problems is the reason for the existing debate, especially in the context of race and ethnicity as identity markers among the US minorities. For example, Dubois (1969) reiterated that identity markers would present a huge problem in the 20th century as to its viability in evaluating whether race and ethnicity or culture should serve as the more important marker. Airhihenbuwa & Webster (2004) have however argued that the main issue that ought to be addressed should be whether race and culture constitute the main plank of identity or multiple identities that is experienced by people from different cultural background. For people from Africa, the reality may be more on the side of multiple identities. Take the case of a South African who is from the Zulu ethnic background. He/she may be forced to embrace the lived experiences of speaking the English language, having an oppressed background, or being a poor person, all bespeaking multiple identities. McKoy (2001) argued further that the discourse on race will be a

critical point in different parts of the world. However, identity markers would mean that whatever one's knowledge or belief about forms of identity, what is key is that identity is an important intervention point of entry in health communication campaigns. These three components of cultural identity cannot be neglected:

(i) P – Person: Health campaign must necessarily focus on an individual who may be the recipient mostly affected by health decisions. For example, for some STIs' campaigns, the intervention point of entry may be the secondary source. Preventive communication through promotion of condom use may, for instance, focus on training wives and ladies despite the fact that the problem comes from the husbands or boyfriends refusal to use condoms. A husband or boyfriend's refusal however may be conditioned by what he perceives to be his role (positive or negative) against the psychological expectation to demonstrate the attribute of being a 'good husband or boyfriend (Airhihenbuwa & Webster, 2004).

(ii) E – Extended family: Health communication has to take into cognizance the role of kin and family members in decisions that may affect an individual in the family. A good example is the role of mother-in-law. She may be the source of certain behaviours that need to be changed given her influence on the wife and her son, particularly in matters relating to sexual negotiation in Africa (Airhihenbuwa & Webster, 2004). Thus, certain interventions would need to take kinship and familial relationships within the context of the family into consideration.

(iii) N – Neighbourhood: This refers to the community's means of receiving communication in their community. It could also relate to the economic status and power structure within the community. These two factors affect STIs information meant to be culturally appropriate. Again, from another South African experience, an attempt to communicate HIV/AIDS prevention billboard in white communities that used the faces of blacks/Africans only succeeded in provoking antipathy among the white population (Airhihenbuwa & Webster, 2004). They took the racial undertone with scepticism of the HIV/AIDS message with the consequence that they were lured into a false sense of security. Naturally, the billboards failed woefully to achieve its objective of effecting a behavioural change among the whites. The images misrepresented reality and rather than evoke identification provokes alienation. A gap was subsequently created between the relationship and expectation through the inappropriate communication channels used.

B. Relationship and Expectation

The approach of the individual-based models of behaviour therefore shows the flaws that can arise despite their focus on perceptions, resources, and the influence of family and friends in health-related decision-making. This domain of PEN-3 model focuses on these same characteristics of behaviour, but from the point of view of how cultures define the roles of persons and their expectations in family and community relationships (Airhihenbuwa & Webster, 2004). PEN-3 model attaches importance to culture as defining the roles of persons and their expectations in family and community relationships. In this way, personal actions are construed as functioning within broader

social cultural contexts. Construction and interpretation of behaviour is based on the interaction between perception and behaviour, resources and institutional forces, and, the influence of family, kinship and friends as nurturers of behaviour (Airhihenbuwa & Webster, 2004). Fundamental to this cross-correlation of relationship and expectation are the followings that require a bit explanation:

(i) P – Perceptions: This refers to knowledge, beliefs and values underpinning decision making on the part of either individuals or groups (Airhihenbuwa & Webster, 2004). They also come as complementary emotions and rational cues surrounding behavioural actions. A good example of this is the belief that STIs can be contracted through the usage of dirty toilet or that HIV/AIDS is a disease that is meant for Europeans – these are largely matters of perceptions.

(ii) E – Enablers: Enablers are facilitating agencies. They include resources and institutional support, including socio-economic status and wealth that measure the existence of resources and the power (individual, corporate and governmental) to services and their accompaniments available (Airhihenbuwa & Webster, 2004). All these factors either encourage or deter efforts at altering behaviour. A good example can be the unavailability of Antiretroviral (ARV) drugs for HIV/AID patients, unavailability of funds to support a healthy life style or the ease or difficulty of access to condoms for young people that desire to indulge in safe sex practices.

(iii) N – Nurturers: This is the part played by friends and family in supporting or discouraging changes in the health behaviour of an individual (Airhihenbuwa & Webster, 2004). The supportive and/or discouraging influences of families and friends can come in various ways. They may be by way of tradition and custom, family and community mores, religion and spirituality issues, peer pressure, marriage and social relations norms (Airhihenbuwa & Webster, 2004). An example from this category could be the culture of collectively caring for the sick at home, and, the patriarchal custom of forcing a widow to marry her brother-in-law.

C. Cultural Empowerment

All these functional elements have given the PEN-3 model its critical importance. Its relevancy in actualizing a culturally sensitive health programme in a developing country like Nigeria is obvious (Airhihenbuwa & Webster, 2004). This is because it demonstrates both the positive and negative characteristics of culture. Culture is a powerful instrument of empowerment; a fact borne out of the fact that culture represents a continuum of the way of life in time and space. It is true that there is good and bad culture, therefore, the goal of cultural empowerment is to ensure that an intervention is developed with the idea of not only mitigating the bad culture, but also promoting the unique aspects of culture that are common currency among a people (Airhihenbuwa & Webster, 2004). As a result, this model insists that regardless of the entry point of the intervention, a culture's positive areas must be identified as the first priority; otherwise, the intervention itself could become part of a problem (Airhihenbuwa, 1999).

Incidentally, too, the concept of cultural empowerment stands on three main planks whose shorthand and full meaning means:

(i) P – Positive Behaviour: What this means is that positive health behaviour resulting in positive consequences should be encouraged (Airhihenbuwa & Webster, 2004).

(ii) E – Existential Behaviour: This relates to values and beliefs that are practiced but pose no threat to health. Cautioning against naively blaming these values for failed interventions, Airhihenbuwa & Webster (2004), argue about what is called the *language elasticity*. A language may have various codes and meanings in relation to other languages. The implication is that language that has flexible principles should not be judged by the rules of a language whose principles are rigid. It is common that even the same language, the example of which Yoruba in Nigeria can be made, has different dialects, and even within a dialect, some words of the same spelling may equally have different meanings, when the intonation differs. Therefore, campaign planners need to be mindful of the difference in intonations that alter the meanings of words (Airhihenbuwa & Webster, 2004).

(iii) N – Negative Behaviour: As far as negative behaviour is concerned, it refers to values and behaviours that contribute to health problems (Airhihenbuwa & Webster, 2004). They are the challenges confronting campaign planners, which they should make effort to change among the people.

When all is said and done, the significant points that PEN-3 model has drawn out are:

i. That health communication expert should strive to focus on both the positive and negative behaviours of people in their health campaigns. Quite often many campaigns pay undue attention to negative behaviour without regard to the positive behaviour which ought to have been the take-off point towards changing behaviour (Airhihenbuwa, 1989).

ii. Singhal and Rogers (2003) reiterated that culture should not be seen as an explanation for the failure of a health intervention programme but rather it should be viewed in terms of its being an asset and whose qualities may be helpful in planning STIs prevention, care, and support projects.

iii. Thirdly, community members have to be involved in health communication campaign. According to Airhihenbuwa (1989), the process requires that: one, to evaluate the needs and wants of both individual members and the community at large in the design of health education. Two, is to follow up with a structure or lay out of a potentially effective health communication programme. Three, is to execute the strategy laid out for the health education programme. And, four, to assess the effectiveness of the programme with collaboration at every phase with members of the community.

iv. It is important to put into consideration from the beginning to the end the cultural diversity of the people. This would mean making the plan to be sensitive to what is

acceptable and relevant in the community; avoiding what may be repugnant, offensive, or unsuitable, no matter how trivial or inconsequential they may look or sound.

One of the greatest and unique attributes of employing community participation strategy is that it creates a higher level on the health system. However, it is only when there is full involvement of individuals, families, and communities for whom a programme is tailored for that this can be achieved. A programme is even much more successful when the local populace are allowed to be part of the team. Their participation will not only afford genuine problem identification but can lead to designing cost-effective solutions. It means that making intervention programmes culturally appropriate, and deliberately promoting the sense of belonging or ownership of the projects by the community members, are essential two critical success factors that cannot be ignored. The PEN-3 model adequately gives expressions to these requirements. These factors, amongst others, that have made it of significant value in STIs intervention because PEN-3 has redefined the methodical approach from behavioural model to the cultural idea (Airhihenbuwa, 1989; Singnal & Rogers, 2003).

2.9 Chapter Summary

This chapter has enabled a detailed glimpse into the efforts of the past in connection with the most of the STIs communication campaigns. The preponderance of the behaviour change theories as the prominent intellectual approach in resolving the STIs upsurge, and the shortcomings of the efforts were also highlighted. From the emergent picture, it was evident that many of the brilliant approaches of the past had had limited

application in helping many of the countries of the sub-Saharan African out of the quagmire (Ford *et al.,* 2003). Both the theories and models have proven inadequate because they ignore cultural and contextual realities conditioning African's sexual interaction. Work of scholars arguing that Africa need a new approach was also admitted in their differing perspectives and depth. Clear from the articulated points of view was that health communication on STIs would need a new grounding on socio-cultural approach because it is on this that knowledge, perception and attitude that influence and condition people's response to behaviour change communication depends. The population would have to be addressed culturally to be convinced to forgo the risky sexual practices. Cochran and Mays (1993) states the minds of the new advocates that the current behavioural theories would require serious amendment because they are not compatible with the African socio-cultural worldview, where societies' values rest on communalism, unity and teamwork as opposed to Western values of individualism, competition and independence.

This section has made it apparent that there is a need for a paradigm shift. STIs communication intervention and delivery method needs a new approach. Factors such as religion and culture must become part of the new baggage. The two can determine the success or failure of STIs interventions. They were baggage left behind by the earlier theories and models; treated as it were, as unnecessary factors (Amaro, 1995). Yet, we have seen the outcome of that costly error, which has been the detriment of reducing the fatality of sexually transmitted diseases, particularly among the young and the vulnerable. Correcting this error means putting culturally based approach on the

ascendancy of new intellectual and empirical efforts, and testing the validity of its effectiveness in containing the ever-growing spectre of the STIs. This work's methodological approach is therefore influenced by the desire to seek objective answer to the question of, as to what extent ideas like the PEN-3 model, canvassing cultural sensitivity, can lead to making sex a less risky adventure among the youths through STIs' preventive communication. Nigeria provides the testing ground that enables the questions to be answered.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter beams the searchlight on the methodology adopted to find answers to the questions at the heart of the study. Here, the underlying research paradigm, the framework that shapes the philosophical assumption, coupled with the influence on research design were all explored. According to Cresswell (2012), the nature of the research problem, the aims that the research seeks to satisfy, along with the paradigm it postulates, are among the factors that define the choice of research methods. Hence, this study utilised the qualitative data approach. The main instrument employed in the data collection was in-depth face-to-face interviews. Other information presented in the chapter also includes how the study was carried out as well as how the intended audience were identified, selected, sampled, and the procedures for conducting the in-depth interviews.

3.2 Research Design

This study is an exploratory one which considered the use of qualitative approach as suitable towards achieving its aims. Qualitative method was used because it is highly effective and the best approach in the field of health communication for investigating STIs preventive programmes in particular because it allows for the provision of community-based insights into sensitive cultural issues such as sexuality in their relation to STIs (Hansen, 2006; Myrick, 1998; Morgan & Krueger 1993; Morrison 1998; Morgan 2004).

Also, qualitative research design gives the researcher the opportunity to gather a comprehensive data on the experiences of young informants on cultural sensitive issues that relates to sexuality and STIs which resulted in a deeper and clearer understanding of the phenomenon under study (Morgan, 2004; Morgan & Krueger, 1993; Morrison, 1998; Myrick, 1998; Sandelowski, 2000).

From its inherent advantage of allowing interpretation of social phenomena, the perspective of the individual who experienced the phenomenon can be understood. This is healthy for investigation of that nature because social phenomenon is grounded on an individual's ideas, feelings and motives (Babbie, 2001; Denzin & Lincoln, 2003; Fraenkel & Wallen, 2000). "Interpretivism" which is a concept about how "people being studied make sense of, and [relate] their world or experiences" is thus appropriate in this study on cultural sensitivity centring on STIs preventive communication campaign in Nigeria. Also, "*Verstehen",* which refers to the creation of meaning from the perspective of the participants in a social environment, added vitality to the research design as being purposeful (Baker, 1999).

With interpretive approach, primary data are formed by the interpretations, perceptions, meanings and understandings of respondents' verbal communication (Mason, 2006). Developed by philosophers in the last century largely as a reaction to the application of positivism to the social sciences (Smith, 1997), "interpretivism" is anchored on social construction of 'reality'. It argues further that such social reality construction does not necessarily have to be objective. Shotter (1993) and colleague in identifying the key

element of social constructivism explained that it is a means for people to extract meaning from their environment especially through sharing their experiences with others using the media that they understand, that is, language. “Interpretivism” insists that people create meanings in distinctive ways based on context and personal frames of reference as they engage the environment that they are interpreting (Crotty, 1998). With “interpretivism”, the reality is that social construction emerges from the perspective or eyes of human beings (Higgs, 2001). “Interpretivism” is therefore appropriate in studying and understanding the cultural perspectives of STIs young people – positive and negative – on the existing communication campaigns in Nigeria. It offers insight into how the culture of the target population can lead to improving the observed inadequacy of the current communication. “Interpretivism” can open an avenue to derive better knowledge regarding the framework within which youths expressed their thoughts, feelings, and actions as STIs in Nigeria (Marshall & Rossman, 1995; Rudertam & Newton, 2001).

One argument of the proponents of “interpretivism” is that it does not have to lead to generalizations from its enquiry (Sandelowski, Docherty & Emdem, 1997). Nevertheless, while the motive of this study is not to generalise, it intends to amply provide a good comprehension of the cultural perspectives of young people with infections concerning existing STIs interventions in Nigeria. This understanding of the cultural perspectives on STIs communication is important in designing more effective communication strategies for young people in Nigeria. Given the end to which this research effort is directed, the interpretive paradigm is the most suitable instrument for

this research because of its potentials of generating better and novel understanding of the multidimensional problematic issues surrounding STIs that the research is investigating.

It is important that the reality of the situation is understood. People rather than objective factors determine this 'reality', as already indicated earlier. Further complements come by way of participants-researcher interactions that aid the findings of this type of research (Cresswell, 2012). While the fear of subjectivity may be valid in the sense that humans are incapable of total objectivity, the fact remains that as much as possible efforts were made to contain to the barest minimum such errors. Likewise, the research is value-bound, given the nature of the questions asked, the researcher's own values were prevented from interfering with the study, and the ways and manner that the findings generated and interpreted were insulated from extraneous influences (Ajjawi & Higgs, 2007).

3.3 Research Preparation Processes

The first stage of the study involved the dual process of development and testing of the interview protocol. Interview questions relating to meeting the aims of the research followed. Subsequent to this was the drafting of the research proposal, a prerequisite to conduct a research in the designated government hospitals in Nigeria, constituted the second stage. The hospitals were the medium through which the researcher reached the young people that were STIs positive. Thereafter, contact was established with hospital management boards of six hospitals across four states of Nigeria in the South-West (Lagos, Ogun, Oyo) and North-Central Nigeria (Kwara) which were selected for the study. Afterwards, the research proposals were sent to the institutions. All the hospitals

had Ethics Approval Committees established by their Management Boards with the primary responsibility of ensuring that researchers explain the objectives of their researches to the hospitals coupled with how such studies would benefit the health institutions as well as Nigeria. It was also the responsibility of the Ethics Committee to ensure that research applicants complied with the ethical standards of the hospital. However, while the researcher had the approval of four hospitals based in Lagos and Ogun state respectively, one of the health facilities – the University of Ilorin Teaching Hospital, Ilorin – declined to grant the required permission. It was understood that the rejection was at the instance of the hospital's review panel. Another hospital – the University of Ibadan Teaching Hospital, Ibadan – did not respond to the researcher's request. Overall in the South-West, the researcher was able to interview STIs positive informants in four major health institutions made up of the Federal Medical Centre, Idi-Aba, Ogun State, Sagamu Community Health Centre, Sagamu, Ogun-State, Olabisi Onabanjo Teaching Hospital, Sagamu, Ogun State and General Hospital., Igando, Lagos State. Similarly, the research exploited the opportunity of interviewing some STIs positive patients in Lagos who were members of a Non-Governmental Organisation called the Network of People Living HIV/AIDS (NPLHA). The president of the NGO gave the researcher the time, date and venue when the NGO group holds its weekly meeting. On arrival at the venue (a health centre in Lagos State.) of the weekly meeting on a Saturday, the president introduced the researcher to members of the NGO. She encouraged them to cooperate with the researcher by making themselves available for the interview. Therefore, the members of the group that participated in the interview session were those that voluntarily decided to partake in it. The researcher explained the

rationale for the study to each informant before the interview commenced, they were also assured of confidentiality on the information that they disclose.

For the STIs negative individuals, two institutions – Moshood Abiola Polytechnic, Abeokuta, Ogun State (in South West) and University of Ilorin, Ilorin, Kwara State (North Central) – provided avenues for interacting with some of their students. The rational for choosing students in the two institutions was because they represented a cross section of the youths in Nigerian society.The ethical approvals for the research were provided by the appropriate authorities in the academic institutions. As a preliminary step, the students were appraised about the research during a general lecture at the two institutions by their lecturers. The process involved interested students being asked to put down their names with their class governors. The researcher was mindful of the ethnic background of each interviewee. Therefore, the gathering of the data followed a conscious effort to recruit participants with differing ethnic backgrounds in Nigeria.

The next stage involved a pilot study testing the sampling procedure. Sampling and testing of the data collection instruments were done on the first day of the researcher's field visit to Moshood Abiola Polytechnic, Abeokuta, and the Lagos State Hospital, Igando, Lagos respectively. The pilot study involved five informants from each group of both STIs positive and negative young people. Through the pilot study, questions that appeared ambiguous or repetitive were successfully identified. This resulted into the revision of the interview protocol that culminated in either deleting or reframing some questions. For instance, question such as "tell me about how you get to know about

STIs" was changed to "tell me the medium through which you were exposed to STIs message". The changes were made in order to simplify the ambiguous questions that were previously developed. In addition, follow-up questions to bridge the information gap were developed. The reason for revising and adjusting the interview protocol was to safeguard the validity and reliability of the results of the study. Another way that validity and reliability was ensured was by ensuring that reactive measurement effect did not distort the information or confound the findings of the study (Webb, Campbell, Schwartz & Sechrest, 1996). As a way of double-checking against any other unanticipated variable, member checking method was employed to further strengthen the reliability and validity test. With the revision of the interview protocol, more informants were now recruited for the field exercise through the help of nurses on duty in the hospitals and lecturers in the selected institutions.

3.4 In-Depth Interview

Interviews can be described as a dyadic encounter between a researcher and a participant which enables the researcher to investigate and gather the narratives of lived experiences of people on a particular issue (Cresswell, 2012; Denzin & Lincoln, 2005; Lindolf & Taylor, 2011). The researcher asks open-ended questions that brings about concrete examples, stories, accounts, and explanations in order to gain insight into informants' knowledge, perspectives and worldviews on the issue being addressed (Cresswell, 2012, Seidman, 2012). Most health based researches use in-depth interview to gather information on the meanings of some behaviours and interactions by recreating opinions of events and experiences in relation to the health care delivery (DiCicco-Bloom &

Crabtree, 2006). Furthermore, Boyce and Neale (2006) describe an in-depth interviewing technique as a qualitative research method that makes it possible to conduct intensive one-on-one interview with a small number of respondents with a view of knowing or obtaining their views on a specific idea, program, or situation.

In the case of this study, unstructured in-depth interview was used to collect the data from the STIs positive and negative informants. The technique afforded the researcher the opportunity of obtaining quality, rich and in-depth knowledge and sharing of experience of their risky sexual behaviour (Conway, 2012). The appropriateness of in-depth interview as a means of collecting data is because it made it possible for fewer inhibitions because sexual issues are considered sensitive, personal and sacred. Therefore, some individuals may not be comfortable talking openly about it in a group. This makes a one-on-one interview the best means of ferretting useful information from young people. Hansen (2006) says it is the most appropriate strategy for data collection in health related issues. He reiterated further that the format gives researchers an opportunity to have adequate understanding of the health problems of individuals which questionnaire will not be able to achieve.

Therefore, by asking the right questions, the required and appropriate answers needed by the study was brought into fore. Hence, the reliance on in-depth interview enabled the researcher to hold deep conversations with the STIs positive and negative young people in the exploration of the topic on STIs, themes and issues related to the study. It also helped to enhance the understanding of the informants' perceptions and views, both in

detail and in-depth, as far as the subject of interest was concerned (Mason, 2006; Rubin & Rubin, 2011).

Furthermore, the rationale for the interview was to avail the researcher on the opportunity of getting a clearer picture on how to incorporate appropriate cultural values and norms into the dissemination of STIs preventive campaigns in Nigeria through culturally appropriate messages and communication channels. Informants were questioned to bring out their perception and understanding of how culture can be used to effectively disseminate STIs message to young people in the six geographical zones of Nigeria. The researcher interviewed 89 young people who fit into the catgory of young people that the reaserch was based on. The researcher interviewed informants as large as 89 inorder to get the essence of the story on cultural sensitivity in STIs preventive communication campaign. After the transcription of the 89 interviews, the researcher chose the most appropriate interviews that adequately answered the research questions that the study set to achieve. Therefore, the study derived its strength from the perceptions and views of 22 STIs' positive young people who shared their perspectives on how a culturally sensitive preventive communication campaign can be effectively conceptualised. The study also incorporated the viewpoints of STIs negative young people which further provided insight from opposing different perspective. Nineteen (19) of such STIs negative young people across the six geo-political zones in Nigeria contributed their views. Thus, in all, 41 young people were interviewed for the research.

The in-depth interviews brought about rich information on how culture can be used in the conceptualization of a culture based STIs preventive communication campaign for young people in Nigeria. During the interview session, it was observed that most of the STIs positive interviewees were not comfortable to be interviewed nor were they ready to give in-depth researchable response. This development, most certainly, arose because of a number of reasons. First, is the sensitivity of the topic. Secondly, is the stigmatization of their status in the society. Thirdly, is the low educational background of some of them. Since the research needs individuals with experience of, or still experiencing STIs as at the time of the study, the researcher made strenuous efforts to overcome the reluctance by empathising with them. The researcher also made use of confidence building mechanism the substance of which was high-level assurance that the exercise was merely an academic exercise. Also, the researcher assured them that the study will be highly confidential which made them to willingly cooperate in the provision of reasonable information which satisfies the objectives of the research.

"Confidentiality", indeed, was an operative word in the conduct of this study. At all levels of its work, the research took cognizance of the importance of confidentiality. From the interview sessions to the period of under-taking the write-up, the rule was strictly applied. There is nothing paranoia about this because as Merriam (2014) maintained the anonymity of informants must be highly respected with indeed, the researcher resorting to making use of pseudonyms to protect the identity of the interviewees. Once there is a non-disclosure agreement or pact between the interviewee and the interviewer before the commencement of each interview, the onus is on the

researcher to respect the oath. Owing to the burden of the pledge made to the informants, henceforth, in referring to informants the use of anonymous identifications was applied. Informants who are STIs positive are identified with alphabet A used as a prefix and numbers; thereby running from "A1 – A22", while informants who are STIs negative are identified with alphabet B and numbers which made the identification to range from B1 to B19.

Another feature of the interview is that all through the process, every new interview had to be compared with the previous one for confirming or disconfirming evidence. Preceding interviews too were re-analysed to sift out new concepts that might have emerged in the later interviews. To ensure accuracy, the researcher took the personal responsibility of transcribing all the 41 interviews. The researcher listened meticulously to the recordings before typing out the information that the interviewees provided on the recorder. At the end of the transcription, the researcher made use of all the 41 interviews; from them were rich information valuable to helping the study achieve its objectives.

The concluding stage in this process was the codification and categorization of the generated themes using NVIVO 10 qualitative software. Three main themes with 14 sub-themes and 44 sub-sub themes were identified. Culture which became the first theme meticulously answered research question 1. It produced four (4) sub-themes and eleven (11) sub-sub themes. Message was the second theme and it sufficiently answered research question 2. Expectedly, it has the largest sub-themes. This arose because the

backbone of the study was the conceptualization of culturally appropriate STIs message campaign. It has seven (7) sub-themes and 24 sub-sub themes. The third theme was media and it answered research question 3. This generated three (3) sub-themes and nine (9) sub-sub themes.

The data will be presented one theme at a time. In the analysis of this study, interpretation may go beyond simple description. It may require interpretation to draw out the significance of a data and explain its relevance within the configuration of the study or particular themes (Patton, 1990). As much as possible, the section provides a rich description and interpretation of the discovery from the field exercise. But first, there is a need to look at the profile of the interviewees.

3.4.1 Sample Design

The study group for this study was selected from three states in Nigeria: Lagos, Ogun and Kwara States. The reason for the selection was as a result of NACA's 2012 report which indicated that there was an increase in STIs in the three-year period covering 2008 to 2010 in three regions which are North-Central, South-East and South-West. While the increase in the North-Central was given at the rate of 2.1%, that of the South-East was put at 1.4% with the South-West recording the lowest rate of 0.9% respectively. Lagos and Ogun, the states in focus are from the South-West, while Kwara state occupied the North Central zone.

Lagos State is the most cosmopolitan state in Nigeria and it is situated within the South-West geo-political zone. It is the commercial capital of Nigeria and is predominantly dominated by the Yoruba ethnic group. Highly metropolitan and densely populated state, it is a commercial, administrative and industrial centre in the country. As a result, it attracts different people from different parts of Nigeria. Naturally, such a highly urbanised place is a natural abode for the thriving of risky sexual behaviours. Also, with its high youth population, Lagos is a natural habitat for risky sexual behaviours; hence a study of this nature is well directed in exploring how culture affects the sexual behaviour of young people which results into STIs. Ogun state was chosen because of its close proximity to Lagos State and it is also in the South-Western part of Nigeria.

On the other hand, Kwara State of Nigeria is located in the North-Central part of Nigeria; however, it is not as urbanised as Lagos. The unique geographical positioning of the state in Nigeria earned it the appellate of "gateway" between the Northern and Southern parts of the country. The state consists of a large number of indigenous tribes and sub-cultural groups like Fulani, Nupe, Baruba and Yoruba. From the ethnic diversity, the state is a hotbed of socio-cultural differences, whether in terms of culture, religion, or social belief. The state is selected purposely because of its composition of different ethnic groups, which will enrich the data needed for this study.

In order to fulfil the objective of this study, the sampling design was based on purposive sampling method. The utility of the technique was based on its ability to bring out rich and comprehensive data (Patton, 2002). Given the desire to achieve a holistic culturally

sensitive perspective on STIs communication in Nigeria, individuals within the ages of 15-26 years, who fell into the two broad categories of STIs positive and negative groups, were selected. The study was specifically youth-focused because the young population represented the most sexually active groups in the country (Nwokoji & Ajuwon, 2004; Onwuliri & Jolayemi, 2006; Obidoa, M'Lan & Schensol, 2012).

Furthermore, this study aligned with the laid down procedure governing audience research, which prescribed that several measures must be strictly taken into consideration to ensure that those purposively selected are actually STIs positive and negative individuals that represent diverse geo-political zones, socio-economic, ethnic, educational and employment backgrounds in Nigeria (Bryman, 2012; Coolocan, 1994).

The sample size for the study constituted 22 STIs positive and 19 STIs negative informants. The size of the population poses no worry to the quality of result that was obtained from the efforts. According to Guest, Bunce and Johnson (2006), the number of informants is immaterial as long as the researcher reaches the saturation point in the investigation. The golden rule therefore in this type of research is the persistent endeavour to attain saturation which is key in conducting qualitative research. The researcher, bearing this in mind, was persistent in probing the informants until convinced that a level of saturation point had been reached. The saturation level for this research was achieved when the researcher observed that as the data gathering exercise went on, more data did not lead to additional new information (Cresswell, 2012). As

more interviews were conducted with the various informants, the same kind of information keep on re-occuring, that was when the researcher knew that a saturation point has been achieved.

3.4.2 Data Collection

This study used one on one in-depth interview to get quality information from each informant. The interview questions were designed as open-ended questions. As has been repeatedly said in this study, the in-depth interview is a popular method that has been used extensively in health-related research (Rice & Ezzy, 1999; Shavers *et al.*, 2012). The process enabled the informants to ventilate their ideas, share their experiences by using the mode of expression they know how to use best (Seidman, 2012). Informants had the opportunity to express themselves either in the local dialect or in English language as consistent with the methodology of conducting open ended in-depth interviews. They had the opportunity to express freely their opinions on the cultural sensitive issues playing around STIs preventive campaign in Nigeria. The interviews were immediately transcribed while those conducted in the local language were later translated into English for ease of analysis.

In order to achieve the essence of the story, researchers need to hold at least three (3) in-depth interviews with each informant (Seidman, 2012). The study followed this process by engaging each informant for a minimum of two different times while for some, they had three sessions. The task of the first interview was to get the demographic information of the informants, to understand as much as possible the cultural influence

on STIs prevalence as well as get familiar with the informants. The second interview concentrated on concrete details of the informants' present lived experiences on the topic being investigated. The third interview was necessitated for some informants in order to correct some ambiguities that were experienced in the previous two interviews. What determined the duration of the encounters was the ease at which the "story" was obtained from each informant against the backdrop of ascertaining that "saturation" had been achieved from the interviews. The interview session's duration with each informant was for a minimum of 30 minutes and a maximum of 80 minutes. Flexibility was maintained throughout the period of the interview by paying attention to the enthusiasm of the informant in terms of willingness and openness to share information that adds value to the objective of the study. Every interview conducted utilized the open-ended questions that was designed in the interview protocol as well as follow-up questions which probed the informant on his/her perceptions and the variables impinging on the issues of cultural sensitivity of STIs preventive communication campaign.

A token amount of 2000 Naira (RM 45) was paid to each informant to cover his/her transportation cost. The interviews were strictly guided by the theoretical frameworks and other conceptualisations that had been discussed earlier in the previous chapter. Unbroken all through the period of the interviews was the taking of copious notes and electronic recordings during the interview sessions by the researcher. This became very helpful in the effective transcription of the materials gathered after the sessions. The interview transcripts were analysed using thematic analysis.

3.5 Data Analysis

Analysis in qualitative research derives from interplay of an investigator's investigation and the data successfully generated from the field exercise. In order to aid the data management, Nvivo 10 qualitative software analysis was used. The process of data analysis began with by importing the recording of each participant into the software. The recordings were listened to and transcribed verbatim. The transcription of each informant was read and re-read in order for the transcriptions to be accurate. This stage enabled the researcher to get a better understanding of the data. Each time the data was read, it gave the researcher a richer understanding of the information at hand as well as guiding the pattern in which the coding emerged.

In terms of coding scheme, the researcher followed three coding stages which are open, axial and selective coding (Corbin & Strauss, 1990). In open coding, Corbin and Strauss (1990) suggested that fracturing data helps the researcher to reduce bias. Based on this suggestion, the researcher divided the data into segments and they were later scrutinised for commonalities that might reflect categories or themes. The sorting of the transcriptions were placed under different arrangements and themes, which demanded altering and re-altering of both the arrangements and the themes until the attainment of a satisfactory result (Yin, 2011). The thematic analysis of the data produced three main themes which were identified as culture, message and media. Once the data have been thematized, then they were examined for properties that characterise each theme. The researcher was careful during the categorisation stage by examining and identifying the meaning of the data by asking questions; making comparisons; and looking for similarities and differences between the comments. This stage comprises of

reassembling data so that identical data fell under similar theme while dissimilar data were grouped under their separate relevant theme. This enabled the evolvement of a hierarchy within the different groupings.

The next stage is the axial coding in which the researcher gradually re-examined the initial themes that have been coded in the previous stage of open coding. Axial coding is therefore a process of reassembling or disaggregating data in a way that draws attention to the relationships between and within categories. Through such re-examination, few preliminary codes were eliminated because they seemed to express more of personal characteristics than those of interaction based on cultural sensitivity in STIs preventive communication campaign. The researcher then interpreted how the themes that have been retained are connected. Interconnections of the themes were examined by looking at informants' experiences, the conditions that gave rise to the experience, and the contexts or situations in which the experience occurred. Through this process, the researcher was able to systematically seek for a full variation of the phenomena under study.

The researcher later moved to the final stage which is referred to as the selective coding. Selective coding refers to the final stage of data analysis to be completed after core concepts emerging from the coded data main themes and sub-themes have been identified through open and/or axial coding. At this stage, the researcher identified discrete concepts and themes in the data and they were further defined, developed, and refined to produce sub-sub theme. The product of this stage gives a deeper and broader

story on the issue under investigation. This stage helps to answer research questions that are related to it.

3.6 Ethical Considerations

A study of this nature operates within many ethical boundaries. The study was very strict in ensuring that ethical boundaries were not crossed. Sex and sexual issues are very sensitive subjects; matters that are often considered to be very private ones. Hence, the research had recourse to establish strong ethical rules and standards. Some of the guidelines involved that all the participants had to be duly informed verbally and in writing regarding the objective of the study (Miller & Crabtree, 2004). Also, it was made plain that their participation was voluntary (Babbie, 2010). Equally, informants were given the opportunity to opt out of the interview session before or during the interview's duration. Prior to the engagement of the informants, each informant was provided with a research information sheet, which explained the nature of the research and other details along with a consent form, which was duly signed by them (Miller & Crabtree, 2004). Every participant was reassured that the data resulting from the in-depth interview will be treated with high confidentiality. To this end, written and verbal assurances were made towards ensuring the protection of the anonymity and confidentiality of individuals (Babbie, 2010). In several ways – confidentiality of data, anonymity and confidentiality of sources, accuracy, objectivity and fairness in reporting and publication of findings – maintaining ethical conduct was put into due consideration during and after the period of the research. The overall ground ethical rule was that all raw information including videos, audios and transcripts had to be stored and preserved securely for an appropriate period of time.

3.7 Chapter Summary

This research made use of the qualitative methodology approach because it is the best approach for research in the domain of health communication in general and STIs prevention programmes in particular. Unstructured one-on-one in-depth interview was used for data collection on STIs positive and negative informants. In order to gather a holistic cultural sensitive perspective of STIs communication in Nigeria, informants who are STIs positive patients as well as those who are negative individuals within the ages of 15-26 years were selected in Lagos, Kwara and Ogun states in Nigeria. The STIs positive young people that were informants for this study are those receiving treatments in STIs treatment units of 4 designated government hospitals in Lagos and Ogun states. Few other STIs positive informants were also selected from an HIV based NGO in Lagos. The sample for the STIs negative young people were purposively sampled among young people in tertiary institutions in Ogun and Kwara states. All unstructured in-depth interviews were conducted in either the local dialect of the informants or in English language. The interviews were immediately transcribed and those that were conducted in the local language were later translated into English after each interview to ease the analysing process. The interview transcripts were analysed using thematic analysis. Subcategories were developed based on the information elicited via the interview. Nvivo 10.0 software was used for the analyses of the data.

CHAPTER FOUR

DATA ANALYSIS AND INTERPRETATIONS OF FINDINGS

4.1 Introduction

The aim of this chapter is to present, discuss and analyse the data collected. Through the analysis, answers will be found to all the research questions. The data that emerged used the interpretive thematic approach to undertake their analysis. The approach effectively and appropriately offers a trail of evidence on how the data gathered uncover relevant issues that were impinging on cultural sensitivity in connection with STIs preventive communication campaigns in Nigeria. By using the informants' actual words and lived experiences, the reliability content of the discussion and analysis is submitted for scrutiny. Chapter Four also affords an opportunity to grapple with the richness of the data collected in relation with the research's questions against the background of the theoretical framework that underpins the study. Through the explanations that followed, the significance of what the study uncovered was drawn out.

4.2 Profile of In-depth Interviewees

Forty-one interviewees formed the total sample for the in-depth interviews. Twenty-two (22) were STIs positive while nineteen (19) were negative. Of the forty-one informants, five (5) had received primary education; eight (8) with secondary school education, while twenty-two (22) were products of tertiary education. Only one (1) was without any formal education. In terms of gender, twenty-two (22) females while males constituted nineteen (19). The general profile is as shown below:

Figure 4.1
Informants Background Information

NO	Informants	Age	Gender	Locality	Education Qualification	STIs Status	Occupation
1.	Informant A1	25	Male	South-West	Secondary School Certificate	Positive	Employee
2.	Informant A2	25	Male	South-East	First Degree	Positive	Employee
3.	Informant A3	25	Female	South-West	Certificate in Education	Positive	Self-Employed
4	Informant A4	23	Female	South-West	Primary school	Positive	Self-Employed
5	Informant A5	23	Female	South-East	National Diploma	Positive	Student
6	Informant A6	25	Female	South-West	Certificate in Education	Positive	Employee
7	InformantA7	25	Female	North-West	Certificate in Education	Positive	Employee
8	Informant A8	25	Female	South-West	Certificate in Education	Positive	Employee
9	Informant A9	25	Female	South-West	Secondary School Certificate	Positive	Self-Employed
10	Informant A10	25	Male	South-East	Primary School	Positive	Self-Employed
11	Informant A11	19	Female	South-West	Secondary School Certificate	Positive	Self-Employed
12	Informant A12	25	Female	South-West	Primary School	Positive	Self-Employed
13	Informant A13	19	Female	South-East	Secondary School Certificate	Positive	Employee
14	Informant A14	25	Female	South-West	Secondary School Certificate	Positive	Self-Employed
15	Informant A15	25	Female	South-West	Not Educated	Positive	Self-Employed
16	Informant A16	25	Female	South-West	National Diploma	Positive	Employee
17	Informant A17	25	Female	South-South	National Diploma	Positive	Self-Employed
18	Informant A18	23	Female	North-Central	Certificate in Education	Positive	Self-Employed
19	Informant A19	25	Female	South-West	Secondary School Certificate	Positive	Employee
20	Informant A20	25	Female	South-West	Secondary School Certificate	Positive	Employee

Table 4.1 continued

21	Informant A21	24	Male	South-East	National Diploma	Positive	Student
22	Informant A22	22	Male	South-West	Secondary School Certificate	Positive	Student
23	Informant B1	19	Male	North-Central	National Diploma	Negative	Student
24	Informant B2	25	Male	North-Central	First Degree	Negative	Student
25	Informant B3	25	Male	South-West	National Diploma	Negative	Student
26	Informant B4	25	Male	South-West	First Degree	Negative	Student
27	Informant B5	25	Male	North-West	First Degree	Negative	Student
28	Informant B6	23	Male	North-Central	National Diploma	Negative	Student
29	Informant B7	25	Male	North-East	First Degree	Negative	Student
30	Informant B8	25	Female	South-East	First Degree	Negative	Student
31	Informant B9	25	Male	North-Central	National Diploma	Negative	Student
32	Informant B10	23	Female	South-South	First Degree	Negative	Student
33	Informant B11	23	Male	North-East	First Degree	Negative	Student
34	Informant B12	24	Male	North-East	National Diploma	Negative	Student
35	Informant B13	23	Female	South-East	First Degree	Negative	Student
36	Informant B14	25	Male	North-East	National Diploma	Negative	Student
37	Informant B15	23	Male	South-West	National Diploma	Negative	Student
38	Informant B16	23	Male	South-East	National Diploma	Negative	Student
39	Informant B17	23	Female	South-West	National Diploma	Negative	Student
40	Informant B18	21	Male	South-East	National Diploma	Negative	Student
41	Informant B19	24	Male	South-West	National Diploma	Negative	Student

Table 4.1 above shows the background of the 41 informants. On the age distribution list, the informants fall into two distinct groups. Only three (3) informants fell within the age bracket of 16-20 years. Thirty-eight (38) of the informants were within the age bracket of 21-25 years. This shows that the bulk of the informants were in their early and mid-

twenties. The reason for the large informants within the age bracket of 21-25 years was because those within that age bracket were the ones mostly available during the period of the research.

The above table shows that there are more females than males. A total number of 21 females were interviewed compared to the males numbering 20. This slightly edging out males by females is explained by the fact that there were more female STIs positive patients than STIs positive male patients.

The above table also shows the pattern of distribution of the locality of the interviewees. The 41 informants represented the six geo-political zones in Nigeria. Nineteen (19) of the informants were from the South-West, Nigeria; South-East had nine (9); five (5) came from North-Central; while the North-East, North-West and South-South had in the following order four (4), two (2) and two (2) informants respectively. The South-West had a higher level of representation compared to other regions because the in-depth interviews were mostly conducted in states occupying that region.

The above table also shows that the educational qualifications of the informants. From the table, majority (29) of the interviewees have tertiary education, eight (8) secondary school education, and four (3) had primary education. Only one of the interviewees had no formal education. Informants with tertiary education took the lion share because of the influence of informants drawn from two tertiary institutions that were used in this study.

Table 4.1 above shows informants according to their status. Of the 41 informants, 22 were STIs positive, the largest number of the interviewees. Close to that are the 19 STIs negative young people. The study was slightly tilted towards STIs positive young people because focus of this research work has to do with the STIs.

In terms of the occupational distribution of the informants, Table 4.1 above shows that ten (10) of the interviewees are self-employed while nine (9) are employees. Twenty-two (22) of the interviewees are students of tertiary institutions. The reason why students take the majority share among the informants was because the STIs negative interviewees originated from two tertiary institutions used in the study. This swell the figure compared to the smaller figure of volunteers from the STIs treatment clinics.

4.3 Theme One: Cultural Elements in STIs Preventive Communication

Culture relates to the way of life of a group of people. It encompasses their knowledge, beliefs, arts, morals, law, and other identities acquired by man as a member of a society. Hence, it portrays a group of people in their completeness about how they live. Nigeria has a rich cultural heritage. The country has over 400 ethnic groups (Chinenye & Ogbera, 2013). Nigeria's diverse cultural beliefs and values show distinct peculiarities among her different ethnic groups. Most of these practices have endured for centuries. The people's cultures not only affect their health but also manifest in all their lives affairs including their well-being and existence.

Different aspects of the Nigerian culture affect the health of her people in diversified ways. Some help positively others negatively while others encourage the maintenance of adverse effect of some diseases. Some cultural doctrines perpetuate health challenges such as STIs. Nevertheless, not all Nigerian cultural practices and beliefs particularly relating to sexual behaviour and practices are bad. Especially concerning the country's young people, some of these age-long customary practices have endured and become instrumental to creating modern day challenges concerning the health of the Nigerian people. Therefore, it is important that those areas or aspects of culture that are known to be remarkably causing direct or indirect impact on the implementation of a health campaign on STIs be investigated with a view of containing diseases arising from that obviously are detrimental to her young population. The following four sub-themes have emerged as issues of cultural importance in the Nigerian-STIs nexus which also help answer research question 1:

i. Religion
ii. Values and Taboos
iii. Practice
iv. Civilisation

Figure 4.1 below shows dynamics of the functional relationship between the theme – culture and the four sub-themes – religion, values and taboos, practice and civilization – as generated by the study.

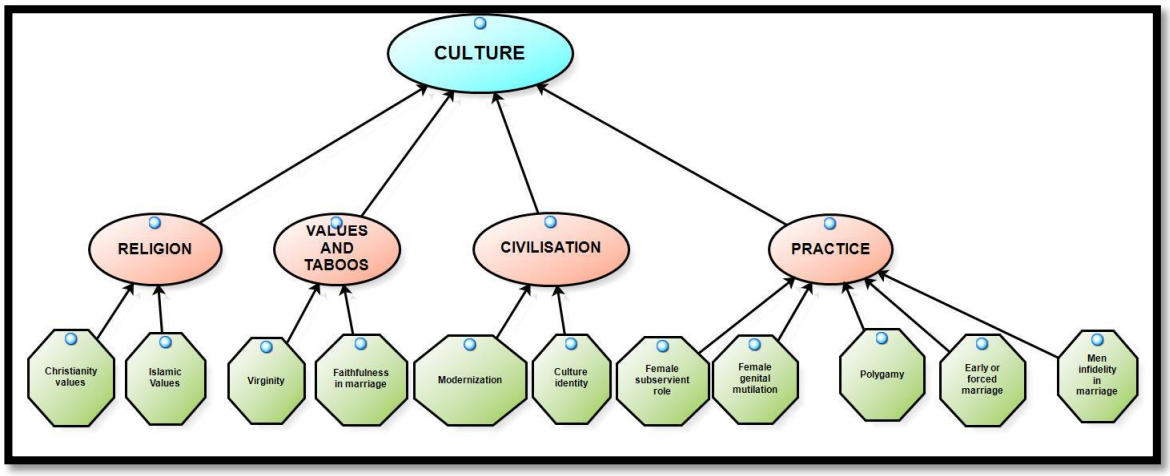

Figure 4.2. Main theme and sub-themes of cultural element in STIs preventive communication campaign

4.3.1 Religion

Religion is a reality in human cultural experience. It has a pervasive influence on the existence of human beings. Religion as an element of culture describes the way man relates with the supernatural world or the Divine Being. This relationship finds expression in beliefs, worships, creeds and symbols. Nigeria is a religious pluralistic society; all the three religions – Islam, Christianity and traditional worship – have active presence. Pockets of other faiths like Hinduism, Bahai, Judaism, Reformed Ogboni Fraternity, and Grail message are also in existence (Kitause & Achunike, 2013). These other types of religions are basically practiced by foreigners or negligible number of Nigerian citizens.

Adherents of the major religions are found in every city, town and village of the country. The Islamic religion is dominant in the northern part while Christianity is more prevalent in the South-Eastern and South-South regions. For the people of the South-West, they share the two religions of Islam and Christianity with an almost equal passion. Though the traditional religion is not prevalent in the country, however a few people still believe and practice the religion. From all indications, religion remains a potent tool of culture interfacing with STIs preventive communication. Its potency lies in its ability to prevent young people from involving in risky sexual behaviour. It can thus lead to the reduction of the prevalence of STIs. The injunctions from the Holy books can be adapted to communicate encouraging messages to young people to lead righteous life. Figure 4.4 shows the two major religions that exist in Nigeria which are Islamic religion and Christianity as cultural variables under the theme religion.

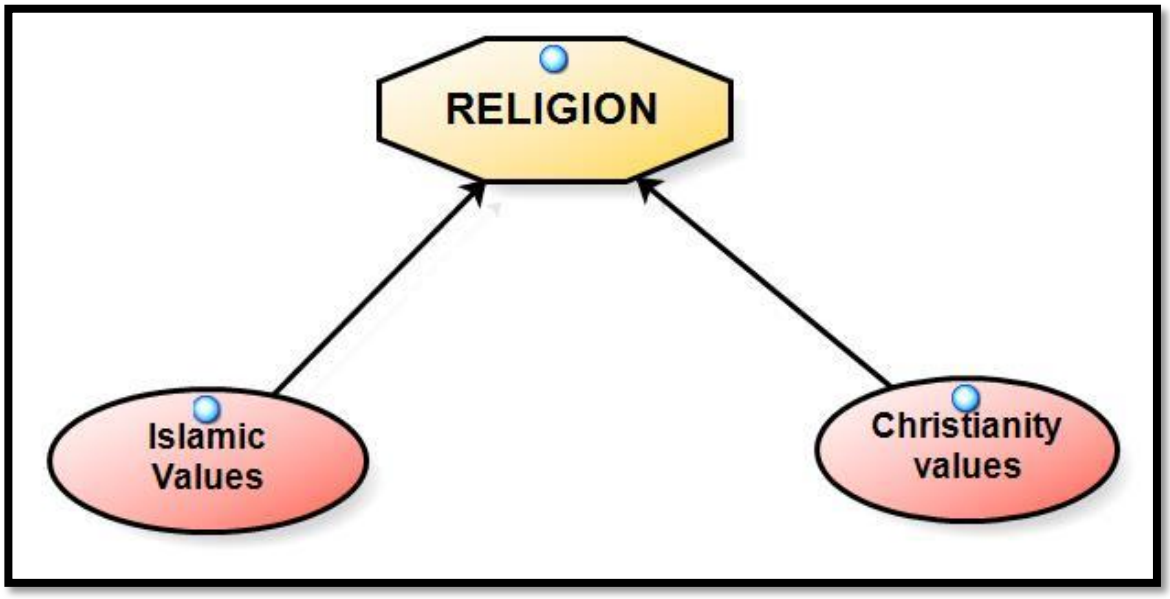

Figure 4.3. Religion in STIs preventive communication campaign

Informants were forthcoming on the potency of religion and how it can be used to prevent STIs. Evidence shows that religiously inclined youth in the sampled population avoid engaging in sex because their religious beliefs frown at pre-material sex and/or sex outside marriage. This study found that some young people's commitment to religion protects them from engaging in sexual risk behaviour. Most of the informants agree that religion is one aspect of culture that can be used to prevent young people from involving in risky sexual behaviour or pre-marital sex.

Informants with strong religious faith mentioned lessons on virtue of temperance assist them in curtailing their sexual desires thus reducing their chances of exposure to risky sexual behaviour. Furthermore, the spiritual tenets of praying and fasting are mechanisms of control of thirst for "things of the flesh" like sexual pleasures. This shows that religious principles have the capacity to inculcate self-discipline in the young, thus acting as break in the protection against immoral and risky sexual behaviour. Lengwe (2010) and Ahmad and Harrison (2007) corroborate that religion is a good concept that makes young people to cultivate self-discipline; and as Mulwo (2010) also asserts, with religion young people can be motivated to develop self-mastery when it comes to sexual matters. How an informant perceives religion is captured eloquently in the view of an informant who says:

> I think religion is the best cultural element to deter one from risky sexual behaviour because in some churches, the pastors will say that if we can hear and practice, then it will be well with us. Not that I do not sometimes feel like having sex, but anytime the feelings come up I just pick up my bible and go to church. (Informant B18)

Another informant equally gave religion a pass mark because:

> Religion is the most important aspect of culture and it will have a tremendous impact in convincing people to change their attitude on sexual issues. Imams and pastors used to talk to us on moral things and it always make some impact on people. (Informant B6)

The above comments show that religion can be instrumental as a powerful stimulus conditioning the young in refraining from premarital sex. There is however a contrary opinion. Some see the act of religiosity as not being enough shields to dissuade young people from treading the path of risky sexual behaviour. An informant was emphatic on this:

> I think what is important is protection because… religious aspect is not helping… even someone who is recognized as a minister in the church and an Imam in the mosque are practicing extra or premarital affair behind and you don't know… not that they don't know of STI or they are not being told at home or in church but …. (Informant B4)

Informant B4 further stressed the limitations of religion:

> Christianity and Islamic religions both condemned adultery and fornications. It is good if this attribute of religion is used in advert…. However, it now boils down to personal conviction of every individual. Some may ignore it while it may have positive effect on others. (Informant B4)

The above statement shows that the moral precepts preached by religion may not be impactful enough. The findings of this study corroborate the discovery of HEAIDS (2010) which found that cognitive traits act protectively against involvement in sexual activities. Ironically, consensus cannot be built on this point as Lengwe (2010) suggests

cognitive trait not to be significantly related to sexual behaviour. Indeed, for females, as Eleazar (2009) found, self-esteem seems to be a vital protective shield as he found out among the female undergraduate students.

What is not in dispute, whether Islam or Christianity, is that the Holy books are explicit in their injunctions concerning sex. The Christian doctrine, for examples, expressly forbids single people to be involved in premarital sexual pleasures. Informant B13 expressed that''…the bible says it is bad and it is in the Ten Commandments that one should not do such because it is a sin''. Informant A21 who is also a Christian supports the informant by adding that ''…you know the bible teaches that sex before marriage is adultery and adultery is a sin.'' The Muslims too hold one to this belief that sex before marriage is unwholesome. Some Hausa informants who are Muslims explained that the lives of the Hausas revolve around the Holy Quran and thus some aspects of their culture relating to sex is derived from this holy order:

> The Quran frowns at sex before marriage… Hausas believe that the Quran is actually the right way (Informant B5)

> For someone like me while growing up, we had Islamic teachings that deter us from having relationship with the opposite sex. So, I believe religion can deter us from having risky sexual behaviour which can curb STI (Informant B1).

> I will first chose religion because there is punishment for anybody who is not married to involve his/ herself in sexual activities. I will just advise him/her to withdraw because for instance I am a Muslim, Islam does not encourage extra marital affair. And it is not good for someone who is married to involve in

> extra marital affairs. One of the verses in Quran says one should not commit adultery (Informant A22).

It is incontrovertible that religions through their doctrines exert strong influence on the lives of young people. In a country like Nigeria where religious sentiments is high – religion practically determines the life of the individual from the cradle to the grave: what a person eats, wears, schools that are attended, including occupation that is followed, the choice of spouse, to list a few – all these are nurtured by religion. How true this assertion is can be verified from the perceptions of the informants in the study.

> If we use religion, one we will be getting attention of 70% audience … about STI. We can also use [the] Islam [aspect] to talk to the Islamic people and the traditional to the traditional people. If we meet their priest (sic), they have where they worship, like I know of the Ogboni people here in Abeokuta, we can use their priest to talk to them. (Informant B3)

> …in Hausa society, religion will be utmost effective. People can ignore other elements of culture but religion cannot be overlooked. Experience has shown that Imams have a soothing effect on people in troubled areas; religious people are viewed as man (sic) of God and whatever comes out of their mouth are the noble words of God. Even the politicians are afraid of them. So they can be a very important link in the dissemination of STI campaign. (Informant B12)

> Religion is embedded in beliefs, when you talk of belief, you talk of religion. The traditional belief says that wherever we are, God or the gods are watching us. The religious leaders are good instruments for passing across STIs messages to young people. Young people will be easily influenced by information from the religious leaders. (Informant B9)

These responses show that young people have a strong conviction that religious institutions can be used to change the orientation of the young people in relation to risky sexual behaviour that might eventually lead to STIs contraction. Religious institutions are recognised as enablers for reforming young people in the society. Furthermore, a glimpse into the Holy Quran reveals how some verses condemn adultery and fornication in all its ramifications. For instance, Quran 17, verse 32 says ‘‘Do not go near adultery. Surely, it is a shameful deed and evil, opening roads (to other evils)’’. Quran 7 Verse 33 expounded further on the issue by stating categorically that "Verily, my Lord has prohibited the shameful deeds, be it open or secret, sins and trespasses against the truth and reason.’’ The Noble book of God as in Quran 24 verse 26 admonished that ‘‘Women impure are for men impure, and men impure are for women impure and men of purity are for men of purity, and men of purity are for women of purity.’’ The punishment for adultery in Islam is severe:

> ‘‘the woman and the man guilty of fornication , flog each of them with a hundred stripes: Let no compassion move you in their case, in matter prescribed by Allah, if ye believe in Allah and the Last day: and let a party of the Believers witness their punishment’’(Quran 24 verse 2).

Islamic religion, however, is not the only religion that condemns fornication and adultery. Practically all religions do, including many of the world cultures do because adultery and fornication are destructive of martial relationship. It can destroy the family; break careers and leave by-products of severe emotional problems. Adultery and fornication are unlawful, and many societies have prescribed standards of legal, customary, traditional and religious sanctions imposed upon their perpetrators. The Holy

Bible, for instance, says that '…whoso committeth adultery with a woman lacketh understanding: he that doeth it destroyeth his own soul' (Proverb 6:32). And Corinthians 6: 18 exhorted that: ''Flee fornication. Every sin that a man doeth is without the body; but he that committeth fornication sinneth against his own body''

In summary, it was indicated that religion protects against risky sexual behaviour, particularly the young people who have strong faith. It can also be seen that STIs negative informant responded effectively on the issue of religion compared to their counter part who are STIs positive. Majority of the STIs positive informants expressed the view of religion being a potent element of culture that can be utilised to prevent young people from involving in risky sexual behaviour. However, contrary opinions also exist insisting that religion is not enough, that individual chastity and self-control need to be cultivated as additional planks.

4.3.2 Values and Taboos

Values and taboos are an integral part of the Nigerian traditional culture. Before the advent of the modern age, they were inseparable in communal life and very potent in regulating social relations. Values are culturally bound, therefore, a value or certain values adored by a community might be frowned upon or deemed unworthy by another. Some existing values in Nigeria are however still held in high esteem. Furthermore, taboos are another major component of the Nigerian culture. Taboos are means through which the society registers its displeasure on certain kinds of behaviour believed to be harmful to its members, either out of supernatural belief, or because such behaviour

contravenes a moral code. As Osei (2006) posits, "taboos represent the main source of guiding principles regulating and directing the behaviour of individuals." They can have a wide range application, from the prohibition of eating, touching, dressing or making expressions in a particular way, or performing an act that may be tantamount to offending the gods, the repercussion of which is to bring harm not only to the individual offender but the entire community. Every society in Nigeria has taboos that in a sort of way hold it together; some dealt with the issues of health and safety; some on traditional institutions; some on the general well-being and security of the citizens. Most authorities agree that these taboos tend to create a sort of social order in communal existence (Adebileje, 2012). Incontrovertibly, taboos and values are elements of culture with currency in the Nigerian life. They are veritable instruments that can be used to enhance STIs' preventive communication campaigns in Nigeria. Taboos can be applied to portraying those aspects of the Nigerian culture that discourage risky sexual behaviour while in contrast values can be exploited to show those areas of the Nigerian culture gratifying or encouraging virtuous life style. The reason as portrayed in Figure 4.3 is that there are some virtues – notable examples of which are virginity and faithfulness in marriage – present in the Nigerian values and taboos that can be used positively for this purpose.

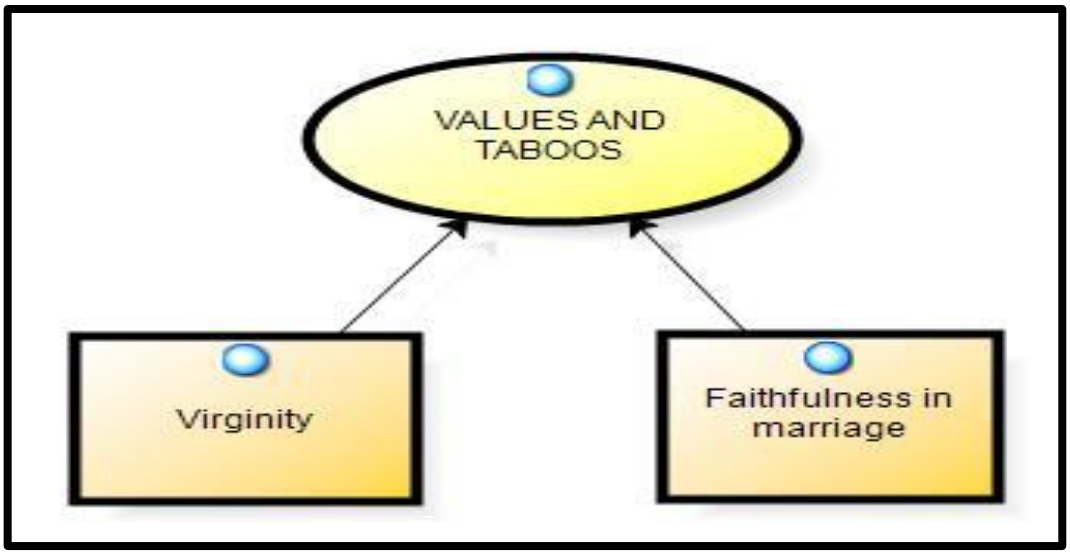

Figure 4.4. Values and Taboos in STIs preventive communication

What is the perception of the Nigerian youths regarding values and taboos and in their interconnectedness with the focus of this study? Firstly, young people see values and taboos as cultural manifestations that have powerful influence on socially acceptable behaviour in the society. They are seen as defining how to behave in a given situation. In this wise, they have the potential to restrict the transmission of sexually transmitted infections. Secondly, as social rules setting the boundary for agreed-upon behaviour, through them society can regulate the conduct of members, sifting the good from the bad, the moral from immoral, that become yardsticks of measuring the values of an individual in the society.

4.3.2.1 Virginity

In most cultures in Nigeria, great value is attached to virginity. Ladies who preserve themselves until their weddings are regarded as pride not only to themselves but to their

families as well. Maintaining virginity means delaying sexual experience and by inference a strong avenue to curtailing STIs. The in-depth interviews revealed that virginity is a high on the scale of cultural attributes that can be used in STIs preventive campaign. Liberalism of the modern age, notwithstanding, there was a near unanimity, because a good majority of the young people agreed that virginity is an African value that ought to enjoy protection. In their views:

> As a lady, your virginity is your value. It is a dignity and when you get married as a virgin, you will be placed at high value and your husband will always respect you. But when you are married and you are not a virgin, he will be thinking what kind of life you lived before you got married to him and then you start seeing that mistrust starts paving way. (Informant A21)

> There was this tradition practiced then, I don't know of now. The woman/lady has a virtue to protect… as a lady you have to keep yourself as a virgin till you get married. It can actually work for the ladies; this type of culture if celebrated can actually work… you know when you get into consummation with your husband on the wedding night and you know… with the white handkerchief stained by the blood of the consummation to attest you are virtuous, and[that] you have kept yourself. (Informant B4)

> According to my culture, like I told you earlier, if your husband marries (sic) you a virgin, you will have more value … he will value and respect you knowing that the lady is not a wayward child [person]; you know some men will be like, after all, I did not marry a virgin, [suspicious that] you may have been living some kind of life… some will even say they pitied you and washed you up to manage you! (Informant B13)

The above perceptions illustrate the extent that the culture regards virginity as a cultural value. It bears no equivocation that it can be used to reduce the STIs that is rampant in

the Nigerian society. By the complementing data presented in this study, the evidence shows that young people still treasure and value virginity despite not being a virgin themselves. The Yoruba people of Nigeria, indeed, attaches premium to virginity of girls until marriage. In that part of the country, a girl that was a virgin on her wedding day in the olden days would apart from being celebrated would be presented with exorbitant gifts by her in-laws (Ebire & Ola, 2014). To most of the informants, however, they condemned the imitation of Western culture that made the young females susceptible to loss of moral virtues like chastity.

This study also investigated whether the value placed on virginity has an impact on the family honour. The opinions of the majority of the informants expressed that it was the reason why many of them strive to preserve their womanhood, especially to avoid out-of-wedlock pregnancy, which is usually a source of shame to the family, particularly to mothers. The views of the informants corroborated this fact:

> In Idoma land, there is a popular belief that a man and a woman must not involve in sexual activities before marriage. They see such sexual escapades as a taboo. Anyone caught doing this will be publicly disgraced and excommunicated for a while. (Informant B9)

> I cannot categorically say that we do not have elements that restrict people from involving themselves in risky sexual behaviour but the shame is the most potent one. If it is a woman and she was impregnated at an early age, she will stay at home and no one will ask for her hand in marriage. (Informant B11)

> The possibility of illicit relationship between girls and boys is really restricted even when both sexes meet at a function in town. Everybody is scared of the family reputation so they hardly and scarcely involve themselves in risky sexual behaviour. People try to avoid everything that will spoil the family image. (Informant B12)

Even in the Hausa culture where the tradition encourages child-marriage, early sex is still not a permissible behaviour. In a categorical statement, an informant explained:

> For a lady to get pregnant or have sex before marriage is illegal and prohibited by the Hausa culture. I can call that a great sin. It will affect the whole family of the lady in question. I had seen scenario before it happened far from my area and as I told you earlier it was a big disgrace to the lady and the family. The lady will be banished from the area and she will go far away to start her life all over. The man can go ahead and marry the woman if he wants to but the stigma will still be there. (Informant B13)

Across cultures in Nigeria therefore, virginity is tantamount to not only bringing dignity and prestige to the family of the bride but it is also seen as a mark of honour that dedicates the bride as having lived an honourable life. Since girls are aware that the family's reputation is also closely attached with their virginity, hence many tend to take precautions to guard their virginity closely. However, some informants who are from the northern part of Nigeria explained that even if a girl were to break this social custom, she would do so away from her neighbourhood where her parents and folks reside. Informant B10 explained that: "…generally, in Kebbi (a state in the Northern part of Nigeria), illegal sex is not encouraged but people do it underground because of the shame attached to it'' In addition, another informant enlightened further:

> Literally, when you look at it at the surface it is like all men and women in Kano (a state in the Northern part of Nigeria) don't have sex before marriage but the truth is one(sic) can go far off and do whatever they want to do…. (Informant B14)
>
> It is because most Hausa men could not have easy access to sex with the lady (sic) they are dating and this makes them to secretly patronize prostitutes for a fee paying sex. (Informant B5)

There is an understanding as expressed by a number of Informants (B4, B8 and B11) that when ladies uphold their virginity, it reduces exposure to risky sexual behaviour which in turn leads to reduction in the prevalence of STIs. Informant B8 was of the categorical view that the virginity aspect of the Nigerian culture has helped to curb sexual exuberance of some young people. Pointedly, the informant (that is, B8) said ''Culture has really helped to reduce the sexual behaviour of people to a reasonable extent in the sense that young people are encouraged to hold on to their dignity by maintaining their virginity.'' This was also the view of Oyefara (2013) who stated that virginity is a Nigerian heritage that can promote the prevention of STIs transmission in Nigeria.

According to one of the informants, B4, within the context of Nigeria, the recommendation is for traditional rulers and parents to subject young people to virginity test, presumably before marriage. Expectedly, the gender activists strongly opposed the suggestion which is seen as insulting, barbaric, demeaning and a violation of the integrity of young girls (Adeokun *et al.,* 2006). With such an opposition and coupled with exposure to the happenings in other parts of the world, it is impossible that the bar

raised on virginity as a social and customary prerogative for girls can be sustained as an all-time high value in the contemporary Nigeria.

4.3.2.2 Faithfulness in Marriage

Another sub-theme of this study is the faithfulness of women in marriage. Marriage goes beyond copulation; it is an exchange of strong feelings and intimacy between two consenting partners. Love is involved; sex is involved; care is well involved; welfare is involved; procreation is involved; and above all, it is supposed to be a life-long union. In Nigeria, there are two major types of marriages: monogamy, a marriage of one man to one woman; and, polygamy, a marriage of one man to two or more wives. Marriage institution represents a sacred union where man and woman have the liberty to enjoy the intimacy of sexual pleasure without any restriction or inhibition. Majority of the informants explained that a lady has to be ready for marriage before taking the leap because marriage is a life time contract.

As to the place of the wife in the home, they insisted that the woman owns the home because she is the pivot of the marriage. Informants unanimously agreed that adultery is permissible for men but married women should not engage in the vice because it forebodes consequences. On infidelity in relationships, the young people explained that cultural norms precluded married women than the single ladies. Furthermore, married women had the cultural imposition to still be faithful to their husband even when husbands were neither faithful nor alive to his marital responsibilities. The onus is more on women going by these informants' feelings:

> It is also not right for a woman to shake the hands of another man except with the permission of the husband. There is an oath that is always taken during the marriage rites that prevents married women from having close contact with another man apart from the husband. A woman that goes contrary with these [oaths] injunctions will die unceremoniously. This is a cultural belief that is used to create fear in people; invariably this also curbs the risky sexual behaviour, which might lead to STIs. Some of these norms (virginity and hands shaking) are still practised in some parts of Idoma land. (Informant B9)

> The culture frowns at a lady having a multiple sexual partner … for a lady [with a] multiple sexual partner is known as a dog or a whore; it doesn't speak well of her and her family, she will not be able to talk to people in the community… people will not listen to such a lady that has a multiple sexual partner… she may not even find a person to settle down with considering her past records. (Informant A5)

One interesting question surrounds the observation that the cultural norms tend to be most stringent concerning the married woman than single ladies, or even the married men. The answers provided are that generally marriage has a stringent code in the culture because:

> It seems they [culture and tradition] belief that it is better to enjoy yourself while it lasts as an unmarried individual but once you are married you must be ready to settle down and comply with what the tradition expects of you. (Informnt B16)

Informant A5 shares the view of informant B16 on this point:

> Let me say the culture has helped to curb STIs especially for the (sic) married women because once you are married, "them no born you well" (woe betides anyone caught violating the canon!). Because you will lose

> your husband, your integrity, your dignity and everything that speaks of self-respect to you because once you are labelled as one … like my uncle's wife that the thing happened to (Informant A5).

As could be inferred from the evidence of the last informant, in some parts of Nigeria, grave consequences would be experienced by not only the married woman caught with infidelity but her family as well. In areas of those sub-cultures, unfaithfulness is also deemed to expose the husbands of such women to grave risks.

> To the best of my knowledge, for the married woman, once you are married it is a taboo to have extra marital affair… in fact, if a man woos you on the road, you have to spit the saliva away… it is a taboo; it is an abomination because the consequences is not even for the woman. It is the husband that is at risk because it can lead to his death... (Informant A5)

> A married woman that is involved in extra-marital relationship will be exposed even if she does not tell anybody about it. This is because there will be some sickness that will manifest on the husband and this will be a pointer to the fact that the wife is involved in extramarital affairs. When a married woman gets involved in extra marital affair, when the husband meets her, it will appear on the man's body. He will be swelling up and if you touch him, his skin will be soggy, at that point you will know that the wife is or was involved extra marital affair. And immediately, the woman must be sent out. If care is not taken, the man may die. It is beyond our reasoning why it affects only the man, but that is how it has been from inception (Informant B15).

Informant B15 further revealed how a married woman's infidelity can be exposed once the husband's suspicion is aroused. In that culture, a special broom is normally kept in the house, and when a wife is involved in extra-marital affairs, the moment she uses the

broom to sweep, she will start confessing about her infidelity acts. Other informants explained further on the consequences that befell a woman who is involved in extra-marital affairs. He said:

> If she… gets pregnant, she won't be able to give birth to the baby unless she confesses. If she cooks for the husband, the husband may die. If this does not happen, the children she had before, will die. If she was pregnant for the husband and goes out, she will not put to birth until she confesses (Informant A10).

> Like in my mother's place, they believe that once a woman is married, even if her husband is far away she is prohibited from having sex outside as long as she is already married or else she will be having ill health (oha quan so). There might be the need to do some sacrifices to cleanse her from the curse she has acquired. (Informant B16)

Evidently, cultural norms governing the matrimony vary from one ethnic community to another. But all the cultures have severe sanctions that may befall a woman who is sexually loose. It is also obvious that young people hold the cultural norms regulating matrimonial conduct in high esteem. They regard them as some of the avenues through which sexually transmitted infections can be prevented, particularly among married women. When asked if a similar severity of sanctions discouraging unfaithfulness applies to husbands like their wives, the positions were clear that there was cultural bias in favour of men:

> It is better for a married woman to stick to her husband instead of going out for extra marital pleasures because she might contract STI in the process. Even if the husband has extra marital affairs, the wife should continue to pray that he does not infect her with STIs (Informant A5).

> The culture favours the male than the female. In Igbo land they believe that males are more superior to the females and there are so many things that males get away with that women cannot and must not even think of doing. It is a man world anyway (Informant B16).

It is clear from the comments above that fidelity among married woman is held in high esteem while it is normal within the cultural practice for men to get away with many of the constraints put on the path of women. This finding shows that there is gender inequality, a wide gulf between the rights of female and male in the Nigerian society. The socio-cultural practices reinforce the patriarchal system of Nigeria. Women are placed at a relative disadvantage (Ebisi, 2012). Thus, a woman cannot question her husband about his sexual activities; on the other hand, the woman is also expected to tolerate and live with her husband's infidelity (Awusabo-Asare, Anarfi, & Agyeman, 1993; Ebisi, 2012). The effect of this act makes married women to be susceptible to STIs. As it is also the custom, men are supposed to be the head of the home, the undisputed authority, sexual relations, is therefore, constructed in the image of masculinity, which portrays whatever the male does, is both normal and proper (Izugbara, 2004).

In summary, it is clear from the above discussion that, first, virginity remains a cherished value of the Nigerian culture to which the young people are still bound irrespective of the dictates of the modern civilisation. Virginity can therefore be a theme and underlying variable that could be used in STIs preventive communication targeting young people. The voices of STI negative informants were more visible on the issue of

virginity compared to their counterparts who were STIs positive. Secondly, it has been confirmed that marriage is equally of a cultural essence among Nigerians. Young people in this study hold the cultural norms guiding the matrimonial homes in high esteem. They regard it as an avenue through which sexually transmitted infections can be prevented. It can be seen that both the STIs positive and negative voices were heard on the issue of faithfulness in marriage.

4.3.3 Cultural Practices for STIs Communication

Every culture has practices that define its ways of life and which it strives to protect. This is with a view to preserving the community's existence and to ensure that its traditional values, beliefs, norms and mores are transmitted to its future generations. Cultural practices denote peculiar ways that a group of people carry out their multifaceted activities. Through their practices, communities guide individuals on what to do at a particular time, how to go about achieving the task, and in what manner the social relations should be conducted. Cultural practices do not exist in a vacuum; rather they are part of the culture, grew from it, and are defined by them. Culture prescribes how practices derived from it are to be followed: what to do; what not to do; when to conduct the activities; and who to direct or conduct the activities. Cultural practices are part and parcel of the people. In Nigeria, some specific traditional practices promote social cohesion and unity while others have negative influence on the physical and psychological health and integrity of individuals. From the thematic analysis using application in Nvivo software, practices as men's infidelity in marriage, female

subservient role, polygamy, early or forced marriage and circumcision are constitute key areas of interest in this chapter.

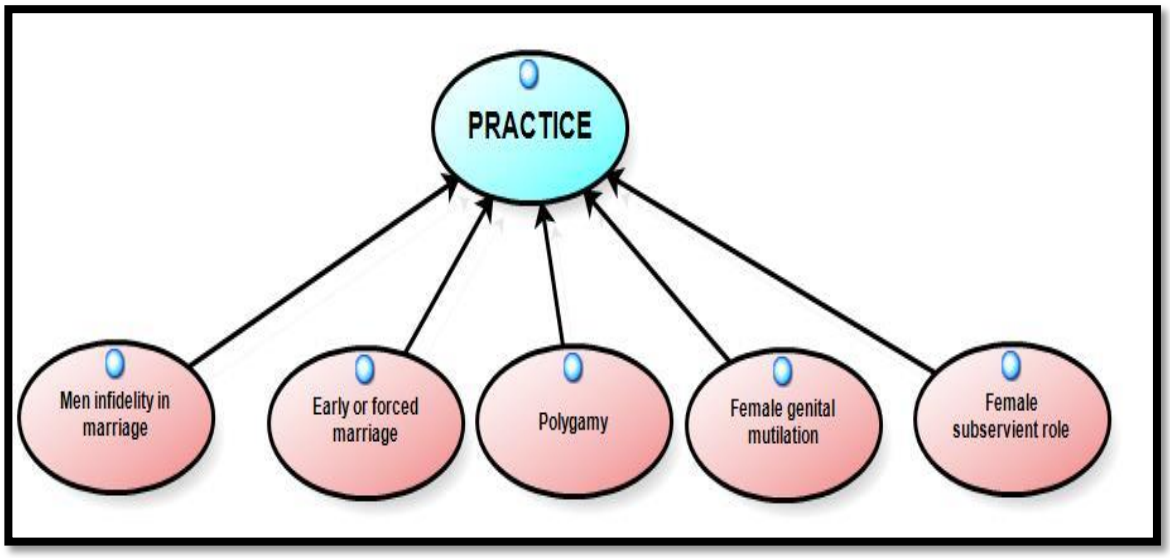

Figure 4.5. Cultural practices in STIs preventive communication campaign

From the onset, it has to be said that informants identified that cultural practices have shaped the orientation of people for several centuries even before the advent of the colonial masters. The informants recognised that there are both positive and negative cultural practices. The positive ones include those that have positive impact on the transmission of STIs while the negative practices are those correspondingly bound to have negative impact on their transmission.

4.3.3.1 Men's Infidelity in Marriage

The researcher sought information on the fidelity of men in their marital homes. Infidelity of men has an important role to play in the prevalence of STIs in the Nigerian society. Regrettably, the cultures in Nigeria do not address this serious marital subject.

Rather, the brunt of the culture is against the womenfolk. As a result, several married men engage in risky sexual behaviour that increases the prevalence of STIs. A major point however is that since infidelity is a cultural practice in Nigeria, it is important to have a good knowledge of the subject and its influence on the prevalence of STIs.

From the interviews conducted, it did emerge that this practice is culturally acceptable irrespective of whether religion forbids the having of "mistresses" or "concubines" outside the matrimonial home. As explained, for instance, by Informant B8, ''The culture do not really see anything bad if a man should have extra marital affairs but it is the ladies that the culture frowns at if she involves herself in extra marital affairs or fornication.'' Another interviewee in support of the above statement observed that:

> For the men, they have a free hand, they can do whatever they want to do, it is only if a man loves his wife or has the fear of God [that there will be restraints or caution]. It is better for a married woman to stick to her husband instead of going out for extra marital pleasures because she might contract STIs in the process. Even if the husband has extra marital affairs, the wife should continue to pray that he does not infect her with STIs (Informant A5).

Interestingly, informant A10 (male), is one out of the mainstream of self-opinionated Nigerians on the supremacy of the male. The informant was of the view that "a man should have respect for his wife by putting her into consideration." From this point of view, it is clear that it is an accepted norm in Nigeria for men to have extra-marital relationships, but it is important that when the men take concubines, he should rather not drag his wife into it. Practising polygamy is also within their boundary. Both, however,

put women at risk of STIs. Inequality between the genders in Nigeria also deepens the vulnerability of the females (Momoh, Moses & Ugiomoh, 2013). They become critical issues to take along in finding sustainable solutions to checking STIs in Nigeria.

4.3.3.2 Forced or Early Marriage

Forced or early marriage is another correlate with cultural ambiguity in its relation with STIs. The reason is that it can bring positive or negative effects depending on the circumstances surrounding the marriage. Proponents of early marriage observed that it negated STIs prevalence because it curbed the promiscuity tendencies of a young girl. They argued that once a girl is married she wouldn't be able to involve in risky sexual behaviour. On the other hand, early or forced marriage has implications, which may also lead to the occurrence of STIs. For instance, in some parts of Nigeria, girls do not have the right to choose who to marry. Betrothal decisions are single-handedly taken by the fathers. Not infrequently, girls have been betrothed to an elderly man at an early age with ostensible believe that it will lead to less promiscuity in them. There have been equally many incidents of girls running away from such marital homes when they cannot cope with the challenges of marital daily living. Some of them also resorted to commercial sex work leading to the spread of STIs. Informant B7 narrated the cultural milieu under which this happen especially in the Hausa land:

> They usually arrange marriages without the girl's consent. An average Hausa girl do not have a say on who she wants to marry. In fact, sometimes some ladies are used as (sic) trade by barter but in a more advanced way by their parents. The rich men go to the father (sic) to seek the hands of their daughters in marriage. They don't have the opportunity to go out and see

> any man. This aspect of culture is actually checkmating risky sexual behaviour… (Informant B7)

Similarly, informant B16 also expounded further on the practice of forced marriage in the Igbo part of the country.

> In parts of Abia State, once the husband of a woman dies, the brothers of the late husband do not allow the woman to take the husband's properties rather they acquire all the properties and send the woman back to her father's house. And sometimes, the next brother of the late husband acquires the late brother's wife as his wife even though he is married. This still happens till today in some places in my town. (Informant B16)

The views above show that the fact that girls are given out to matured men in marriage without their approval is no abhorrent cultural behaviour. The same too is wife-inheritance, which is the taking over of the wife of a deceased brother or relative by other siblings or family members. This is rampant among the Igbo people because widows are still seen as the property of their dead husbands' family. In the case of the Hausa land, it was identified that early marriage is a cultural practice that is still persisting with a fond attachment. This is mostly for monetary gains by the parents of the would-be child-bride. Informants from the region through the underneath direct quotations narrate the severity of the situation:

> … young people are encouraged to get married early so that they will not involve themselves in risky sexual behaviour. The perception they have is that if young people do not marry early, they will flirt and this will result into STIs. (Informant B9)

> Another iota (sic) of culture used to curb risky sexual behaviour is to push little girls to get married. The Hausa philosophy is that a girl of 16 years is

> matured physically to get married and to give birth. In order to prevent the girl from misbehaving and also to protect the family name, Hausa culture prefer that the girl should be married off to a man that desires her hand in marriage. (Informant B12)
>
> You know age is just a number, you can see an 11 year old that is matured enough to get married or 13-14 years… you can marry her so long as she is semi educated. (Informant B14).

A number of research findings indeed loaned corroborative support to the views of the informants. Erulkar and Bello (2007) found out that majority of early marriages rarely consider the wish of the girls. It was also discovered that in most of the cases, the age differential between the husband and the proposed wife was not less than 18 years. Mmari, Oseni and Fatusi (2010) in turn, observed that, it is common for the young girls to become second, third or fourth wife respectively. While Aderinto (2000) and Fisho-Orideji (2001) further corroborated that no embarrassment is suffered for a teenage girl to be given out in marriage to a man who is between the ages of 50 and 60. The criteria are for the would-be husband to be any of these: friend of his potential wife, a benefactor, or a spiritual cum traditional leaders.

Other views regarding the use of marriage to curb sexual recklessness of young people was expressed by an informant from the South-West, Nigeria, thus:

> In my culture when a lady flirts, people talk to her to change and the parents of the girl can also reprimand her. But when a lady is of the marriageable age, the parents will only ask her if she has met the family of the boy. At this stage the parents especially the mother counsels the lady in an

> appropriate way and they will encourage her to get married. (Informant A18)

Within the cultural configuration of forced or early marriage operating in Nigeria, differences can be sifted between the national ethnic sub-cultures. Among the Hausa ethnic group, the belief is that once a lady reaches puberty and/or is semi-educated, she is considered ripe enough for wedding. Contrarily, there is delayed wedding for a girl in the South-West until the young girl is deemed matured enough unless she is observed to be loose and is flirting around when the pressure is brought for a quick wedding. The belief in the north is that the earlier a lady gets married, the better her risk of avoidance of risky sexual behaviour. It is also evident that perspective of supporting early marriage in the Northern part of the country hardly takes into consideration the biological, emotional and psychological state of the girl (Alabi, Bahah & Alabi, 2014). There is however a similarity in the belief between the North and South-West Nigeria about early marriage generally being instrumental to containing risky sexual behaviour among the young females. But there are marked differences in the values attached to the perception of at what point in a lady's life is she physically and emotionally mature for the life-long contractual obligation. Outside this, it is unequivocal that early marriage remains an active cultural practice relevant to checking the risky sexual behaviour among the young people. Studies conducted in Nigeria and other parts of the world, indeed, bear testimony that in several cultures, early marriage has had the in-built propensity of acting as check for young women to indulge in risky sexual behaviour (Aderinto, 2000; Fisho-Orideji, 2001; Schitz-Robinson, 2006).

4.3.3.3 Polygamy

Polygamy is a cultural practice with cross-cutting influence or impact on STIs. Polygamy is a man marrying more than one wife. In the Yoruba and Igbo culture of the past, a man takes a second wife, for instance, if the first wife fails to give birth to a male child; a heir who can take over his property and continue with the family name. Another reason, especially in the period of subsistence living, when agriculture is the mainstay of the economy, more wives means increased labour force to till the farm and market the produce through which the family earns its livelihood and boosts its prosperity or wealth. Furthermore, polygamy throve in those days because more wives meant more children especially girls who could bring substantial addition to the family wealth through the bride price. For sure, these reasons are no longer tenable in the modern Nigeria. But, polygamy are still of attraction to some Nigerians, obviously for other reasons outside the ones mentioned above.

Polygamy has implications for the prevalence of STIs. The reason is simple: the contraction of any of the STIs can mean a contagion for the rest of the members in the polygamy. The crucial question however is: how do the informants see polygamy both as a cultural practice and as a cross-cutting factor in the STIs prevention? Their responses are diverse. As examples, Informants B5 and B12 are of the views that polygamy only encourages men to boost their egos and demonstrate the influence of men in the society. It is also a way for a man to demonstrate his wealth, power and status. Sometimes it is thought that polygamous men attract higher respect in the society. Coincidentally, all the informants in this study admitted that it is natural for an African

man to be a polygamist! There are those who however, pointed out that the cultural permission is not a blanket exercise. Informants in this category point out that there are prerequisites that a polygamist is expected to put into consideration before taking the step. Central is that, "Though, a man can still marry more than one wife if he so wishes … he must get the consent of his first wife" (Informant B2). Contrary to the Quran that some use to justify their resort to polygamy, an informant insists that the correction is that:

> … I personally belief that people just manipulate the Quran to suit their selfish purpose. The Quran says you can marry one, two, three or four, but if you are afraid you will not be just and fair among them just take one. People use this as an excuse forgetting the condition of justice, which is very difficult to achieve. (Informant B12)

Furthermore, there was the claim that polygamy notwithstanding; it still did not prevent a man from having extra-marital affairs:

> It is sad to note that the culture of the Hausas is not effectively curbing the risky sexual behaviour of the people. I have a cousin that has three wives yet he was still involved in risky sexual behaviour outside of his matrimonial home. My cousin is late now and he died of HIV/AIDS. Before he died, he was sick for a very long time and he was taken to different hospitals for treatment but unfortunately for him he died. We later discovered that he died of HIV when his daughter that was given birth to after his death was diagnosed of having HIV/AIDS. When my cousin was sick, people thought it was a diabolic or spiritual attack from someone that envied him because of his wealth. The wives are still looking healthy and we cannot tell if they are already HIV positive. (Informant B5)

This finding suggests that polygamy is no hindrance to indulging in risky sexual behaviour, which can lead to contraction of any of the STIs. Therefore, polygamy as a cultural practice can aid the prevalence and spread of STIs in Nigeria. What is being advertised beyond proof, is that "self-restraint" remains one of the panaceas to risk-bearing sexual behaviour. The question is beyond sentiments because not a few studies in Nigeria have shown that though polygamy is accepted as a cultural norm in Nigeria, yet it is one of the major reasons for the prevalence of sexually transmitted diseases (Azuonwu, Obire, Putheti, & Ekene, 2010; Iyayi, Igbinomwanhia, Bardi, & Iyayi, 2011; Owuamanam & Bankole, 2013).

4.3.3.4 Female Genital Mutilation

There are two sides to circumcision because it involves males and females. In most of the Nigerian cultures like that of the rest of Africa, males usually undergo circumcision. The contentious issue however is about the female circumcision which is also refered to as female genital mutilation. Female genital mutilation () is regarded as one of the harmful traditional practices because it involves the cutting of a female's clitoral prepuces and tip of the clitoris for the reason of protecting chastity and reducing her sexual enjoyment. The rationale for this traditional act was anchored on the premise that the reduction or "killing" of the sexual pleasure will reduce the risky sexual behaviour of young ladies. Other reasons adduced to justify the harmful traditional practice include the preservation of the custom and tradition surrounding female sexual purity; sustaining of family honour; protection of virginity; prevention of promiscuity and to increase the sexual pleasure a woman gives to her husband. Female circumcision is also believed to

enhance female's fertility, and give a sense of belonging as a fulfilled member of the ethnic group to which the woman belonged (Mandara, 2004). Among the Yoruba tribe of Ekiti State and Atakumasa in Osun State, female circumcision is performed with the notion that it eases delivery during labour as the removal of the clitoris prevents the head of a foetus from coming in contact with it and thus save the unborn child from infant mortality (Oguntuyi, 1979). Female circumcision remains an undying traditional practice in many parts of Nigeria.

According to some of the informants, circumcision is still performed by "old" traditional attendants who use unsterilized knives and razors that have the high potential of exposing their patients to STIs particularly HIV/AIDS. The two categories of STIs' positive and negative young people are of the opinions that:

> Culture affects the increase in the spread of the disease in so many aspects. For instance tribal marks and circumcision that are done with the same sharp objects have serious health implications on people. HIV can be contracted through this means (Informant A1).

> Circumcision is performed on matured ladies who were not circumcised when they were still a baby. The razor blade used for circumcision may be used for three or four girls and this can also cause HIV infection (Informant B5).

What is the feeling of the informants in respect of the circumcision of the female whose intention is to reduce her sexual libido compared to that of her male counterpart that is intended to have the opposite effect of increasing his own sexual libido? As far as many were concerned, subjecting women to such a barbaric practice was bad. Emphatic was the response by an informant:

> They also do circumcision for a woman that was not circumcised when she was a baby prior to her wedding day. They do the circumcision based on the belief that it will prevent a lady from being promiscuous. Circumcision is bad, it does not stop one from being promiscuous. Anyone who wants to do what he or she wants to do will still do it. Some villages have stopped it but some are still doing it. It should be stopped. (Informant A17)

The alarming picture painted by Informant B4 does not reduce the crudity surrounding the exercise:

> I know of the general Yoruba tradition of female genital mutilation; well… I don't know if it is still being practiced, the ladies when they come of age, the older ones are taken into a room to conduct female circumcision on them. At some point, they use the same blade to cut all the ladies genitals without sterilization. The reason they do this mutilation is to prevent them from being promiscuous. These days the male mutilation or circumcision is still on; but the female mutilation or circumcision… as in there is a fight to end it. But if it is still being done, then it is done secretly and such is not professional. There are times when the entire clitoris is deeply cut and the lady gets no pleasure from sex; so the belief is if she has no pleasure she will not practice sex. (Informant B4)

It is clear from the above sentiments that the informants believe that circumcision, especially, that of girls, is a bad, retrogressive and harmful traditional practice that should be stopped because it does no good. It does not even have the envisaged positive impact of reducing the so-called promiscuity of women. Happily, informants were aware of the efforts made at eliminating the traditional harmful practices against the female in Nigeria. As far as back 1994, the Nigerian Department of Women's Affairs had succeeded in getting the government to enact a decree outlawing female circumcision. Since 1999, states like Edo, Cross River, Enugu, Delta, Edo and Ogun States have

followed with the replication of the national law banning the practice of female circumcision (Ayenigbara, Aina, & Famakin, 2013; Ezenyeaku, Okeke, Chigbu & Ikeako, 2011; Onuh, 2006). Some non-governmental organisations have also complemented the government's effort. Organisations like "*Ndukaku"* (an Igbo word for 'Health is Better than Wealth'), the National Association of Women Journalists (NAWOJ), and the Women Action Research Organisation (WARO) in Enugu State, were among the strong advovates for the elimination of Female Genital Mutilation (FGM). Their efforts were directed at promoting community dialogue on the practice, addressing the cultural and socio-economic factors reinforcing the practice, and mobilising community action to end the obnoxious practice (Babalola *et al.,* 2006). The campaign is, in fact, not only a Nigerian affair. For over two decades, global interest has been focused on this remnant abhorrent of the Nigerian culture (Adeokun *et al.,* 2006; Babalola *et al.*, 2006).

Unfortunately, circumcision has remained a stubborn legacy of the past. Despite the remarkable strides achieved in increasing awareness about its negative impact on the health of women, studies still show its persistence in Nigeria (Abubakar, Iliyasu, Kabir, Uzoho, & Abdulkadir, 2004; Babalola, *et al.,* 2006; Ezenyeaku, Okeke, Chigbu, & Ikeako, 2011). More importantly, the practice is prominent in the South-East than in other parts of Nigeria going by documentation (Abubakar, Iliyasu, Kabir, Uzoho, & Abdulkadir, 2004). Some female informants corroborated this assertion made about the continuous practice of female circumcision in Nigeria especially in the South-East part of the country. The views of the female informants from the South-Eastern part of

Nigeria showed that there were socio-cultural factors behind the prominent existence of female circumcision in the area. Here are some of the typical views expressed:

> Till now, I still have the belief that if a lady is not circumcised she will become wayward. She will often be running after men. But later I got to know that it is a criminal offense to circumcise a lady. I was circumcised (Informant B10).

> I have a strong conviction that circumcision is okay, but I think the people who are against it don't know the consequences of not doing it that is the reason why they are campaigning against it. If they have witnessed what some ladies are going through today, they will stop the campaign against it. It is not because the ladies are not from good homes but it is because they have not been circumcised. I believe so much that circumcision helps stop risky sexual behaviour. I will have my daughter circumcised because if I was not circumcised, I will not be able to stay up till this moment without having sex (Informant B18).

Whatever the feelings of outside agents, it is evident from the information above that circumcision remains an age-old practice that is still highly valued in the South-Eastern part of Nigeria. People still believe and practice it and the practice has continued despite attempts at raising awareness about its detrimental effects. They also relate attempt to stop it to opening the door for sexual promiscuity among the females in their society.

4.3.3.5 Subservient Roles of Females

A number of views emerged on the subservient roles that females are made to accept in the society because of their gender. The young people admitted that the female folks

face many restrictions that the society operates as norms. Generally, in Nigeria, the movement of the females is restricted to the barest minimum. Some of the young people believe that restriction of movement is a good cultural practice that can reduce the potential exposure of the females to risky sexual behaviour that might lead to STIs. A few others feel otherwise suggesting that the act makes girls to be under-exposed to life educating experiences. They are therefore denied the sorts of "street intelligence" they need to cope with social situations.

> There is something called 'kule' which means that ladies must always be indoor. They don't go out often. When they eventually come out, you just admire them and the same thing applies with housewives too. They cover every part of their body, sometimes even the face and you don't see anything to admire. They are in purdah. Some of those that cover are married or dowries have been paid on them. The reason why they cover every part of their body is because they believe that their body belongs only to their husbands and people must not feast their eyes on it. For a girl that does not go out she can never be sexually exposed and for a girl that covers up her whole body there is no way that she will entice members of the opposite sex. (Informant B7)

> In some homes, girls are not allowed to step out of their homes once they return from school. This principle may affect the girl because when she has the opportunity to step out she might be exposed to bad things of the society. (Informant B3)

In addition to the above views, another informant gave further clarifications:

> The Hausa culture also minimizes the contact between boys and girls. The family house is [being] demarcated into two sections; a particular segment belongs to the males and the other wing belongs to the girls. Boys do not play together with girls; they play separately. In [the] Hausa homes, girls

> have restrictions on the places they can enter and boys too do not have the freedom to enter any room that belongs to the ladies except that the girl is the sister from the same mother and father. (Informant B5)

Testimonies like these make vivid the primary reason for restricting movements of young ladies in some parts of the country. It stems more religion rather than a social mechanism to prevent her from indulging in risky sexual behaviour. Furthermore, there is an element of gender bias as the restrictive culture curtails only the single girls and married women while boys and men enjoy freedom of movement without hindrance. Even as an adult, it is a predominant aspect of the Nigerian culture that a married woman must secure the permission of her husband to go out. Venturing out without such permission can incur the wrath of the husband and may lead to marital dispute.

> In the northern part of Kaduna, women are seen as their husbands' property because they provide everything for the wives as well as the children's need. Anything that the husband says must be followed without hesitation. The culture of the northern parts of Kaduna limits the movement of the women. The culture of restriction of movement affects mostly the married women than the singles . . . . [The] women must be at home [at] almost all the time and (exist) only for the pleasure of their husbands. (Informant B9)

In other ways, females are made to play demeaning roles because of their being subservient. Some parts of Nigeria have the unedifying culture of using young females as objects of entertainment. No one feels scandalised by it, asking a lady to be an object of sexual gratification to a visiting guest. Informant B 31 was miffed with this practice, saw it as a risky venture, and was repulsive to the socio-cultural practice with the tendencies of leading to an increase and spread of STIs:

> My people in Tiv land, Benue State also have a culture in which whenever a male visitor comes to visit the family, the wife or daughter of the house owner is used to entertain the visitor as an appreciation; meaning that the wife or daughter will have sexual relationship with the visitor. Some interior parts of Tiv land still practice this norm but civilization is gradually eradicating the practice. I personally feel that the practice in Tiv land is fuelling STIs (Informant B9).

According to informant B9, this practice is usually kept secret within the family yet the entire community is aware of it as it is a communal more. A "free-for-all" sex as the practice connotes, certainly, is a risky enterprise to the contraction and spread of STIs. Exposure of young ladies to dangers like this shows the vestiges of the different kinds of discriminatory attitudes and behaviours that some customs and traditions are still inflicting on the Nigerian girl-child because of their helplessness. No matter the pretences, the Nigerian society still considers the girl child and women as inferior beings. Omadjohwoefe (2011) was assertive that in the Nigerian society, male were generally given higher value and authority and even received higher rewards than their female counterparts, while female folks continue to be made to be subservient to the authority of the males irrespective of their desires and wants. The only consolation is that Nigeria is not the only country where inequality is still a basic issue confronting women. A World Health Organisation (WHO) study in 2009 did in fact alert that in many countries and societies around the world, women and girls are treated as socially inferior.

4.3.4 Civilisation

Civilisation is about change; the attainment of a higher level of social, economic, cultural and spiritual status by a society. Civilisation brings about transformation of the human, material and spiritual resources of the society. In Nigeria, in some areas of her national life, civilisation has made a remarkable impact on the lives of people. Some perspectives have been changed and a number of values modified. Civilisation influences people – their thinking, their approach, and their relationship with themselves and their environment. But quite often – and this is not peculiar to the Nigerian society alone – the clash or conflict between civilisation and culture or tradition has always tended to be an on-going affair. While civilisation professes change, tradition and culture preaches maintenance of the status quo. In the light of this study that centres on cultural sensitivity, understanding civilisation as an intervening variable on the sexual behaviour of young people is an imperative towards improving STIs preventive campaign in Nigeria. From the Nvivo analysis, two issues that are cross-cutting with civilisation and whose outcome affects sexual behaviour of the youth in Nigeria are – the challenges of modernization and cultural identity. The relationship is as depicted diagrammatically below while further explanation of the concepts follows thereafter.

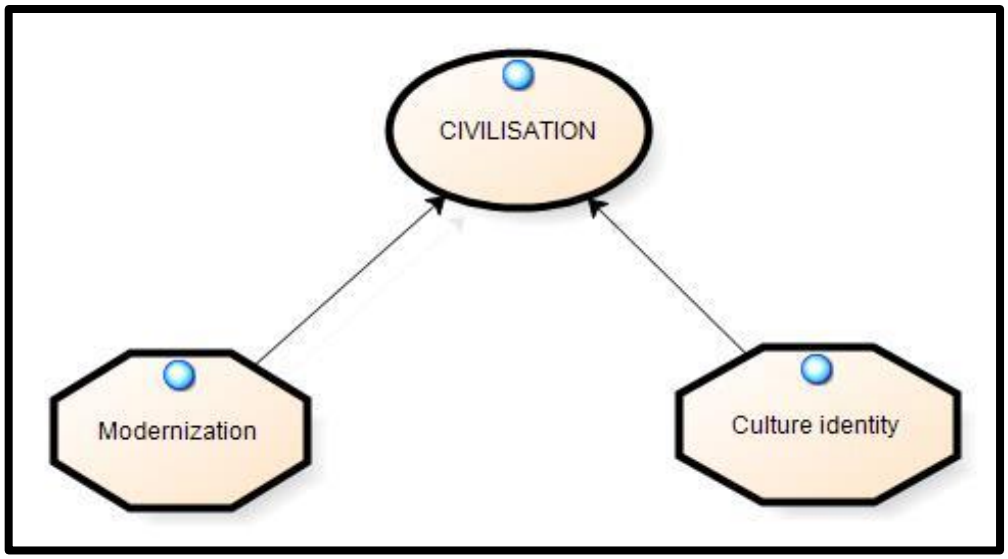

Figure 4.6. Civilisation in STIs preventive campaign

4.3.4.1 Modernisation

One term that kept being conspicuously repeated by the informants during the interviews was – "modernisation". As far as the young people were concerned, their existential reality in time and space was between the two opposing ends of – "old" and "modern". Thus, most of their referents concerning the culture was in the context of "old" – "the old culture," "the old tradition," "the old marriage system," et cetera. The time era they were referring to as the "olden days" referred to pre-colonial, colonial and immediate after independence periods. Nigeria became independent on October 1, 1960, close to fifty-four years ago. Relatively speaking, Nigeria is a young nation. But what the discussion with the informants brought to the fore was the fact that there had been a remarkable impact on Nigerian culture foisted by civilisation. And this civilisation cannot be divorced from Western influences, indeed, which had had profound influences on Nigerians and Nigeria.

The first emerging evidence from the data in the study revealed that civilisation has led to the erosion of the knowledge about the cultural past by the young people. Young people are almost repudiating the so-called ways of the past. This assertion is reflected by the views below:

> Besides, most people do not really reckon with the old tradition anymore because its potency has reduced. Normally due to civilization, most people don't listen to traditions. They don't feel it's working again especially in my own culture. They believe to abstain is old people's sermon. The culture gives advice to youths like us. People who are true to themselves abstain as the culture preaches especially when they are married. (Informant B16)

> Due to the introduction of western culture itself, people have been trying to waive away the influence of culture itself on the people in the community. Well for now I don't think the traditional culture really have a say due to the introduction of the media. (Informant B8)

> In those days, a single woman might give birth to twelve children, I have a friend, they are ten in number from one mother; but now the ladies we have will just give birth to one or two and she says she doesn't want more kids, so some traditions are fading out. Guys of today want to impregnate their wives before getting married because there are some marriages of several years without a child. It was not like this before. Another issue is that if a lady keeps herself till her wedding night only to find out that the man is impotent or sterile or a combination of the two; what will she do? Divorce him? (Informant B10*)*

It is evident from the above assertions that culture does not have potency like it used to have in the olden days. Culture is today beset with multifaceted challenges – pollution, dilution, and at times complete revision. Not a few young people were categorical that

culture has to be dynamic, that it has to be with the modern time and age. This study found that cultural imperialism has eaten deep into Nigeria, the effect of which is corrosion of the cultural values of the past. It is as worse as to the extent of young Nigerians viewing the Nigerian culture as been inferior (if not backward) with that of the West. To be modernised – and be sophisticated – is for the Nigerian youth to imbibe Western ideas, cultivate European or American tastes, dress and talk like the youths from the West. What is Nigerian – values, etiquette, manners, fashion, social relations, et cetera – is "old-fashioned" and "backward. Whatever is from the West represents "modernity" and "civilisation". As one of the informants – B2 – said the pollution of the Nigerian culture by the West has had several consequences as it has promoted fornication, indecent dressing by females, and crave for materialism. Hear what a number of the members of the new age generation said:

> …we have grown wings, we want to go in line with what the white folks are doing, and we make a mess of it. I think what is important is protection because… religious aspect is not helping… (Informant B4)

> In the northern part of Nigeria . . . westernization and civilization has eaten deep into every culture. Before now girls can't be hand shaken neither can they be hugged. It is not possible to be casual friends with them…Civilization has gradually started to erode the Hausa sexuality culture. Money has started to play a huge role in enticing girls. Hausa girls now go to clubs, the will come from home with hijab and dump the hijab inside her bag and change her clothes in between two cars before entering a club. They also sew their natives in a very classy and sexy ways that is suitable for a club. They have also devised ways of also enjoying themselves. Overtime the culture of keeping ladies indoors and men not

> giving in to sex before marriage is gradually dying a natural death. (Informant B7)

One clarification that should be made is that modernisation appears to have had overwhelming influence on the urban centres compared to the rural areas. Elements of retaining the "old values" can still be found in the villages and other urban centres' backyard. The implication is that there is a need to segment STIs messages to suit different categories of people. This imperative is further supported by the sweeping change that has occurred to the attitude of many of the young people concerning the moral and cultural exhortations of the past in the areas of sexuality and sex. Take for example, the question of abstinence that has been so much in focus and public discourse as the best approach to preventing STIs among the youths. As far as informant B 30 is concerned such a moral precept is simply hypocritical of the new age. The informant explained that young people believe that to abstain is old people's sermon hence they do not see the traditional prescription as working again. There are further complications besides the youth rejection of the ways of the past. As Tunde and Olukoya (2008) explained that Westernisation has created a major cultural identity problem for the young Nigerians.

4.3.4.2 Culture Identity

That there is a cultural identity crisis among the young Nigerians is not a question in contention. What the controversy is, to what extent has, or, is the conflict influencing their sexual behaviour and their predisposition to STIs? The first thing to know is that

there is disconnect between the young people and the sexual mores of their culture. Their statements typified this:

> I don't live in my hometown in Kogi State that is why I don't really know so much about the culture that relates to sexual behaviour. Civilisation has taken over the culture of people in my area. People get married in the normal way. I didn't grow up to know anything about the culture of my place. I don't even have any idea at all. The only culture I know about is the religious culture. (Informant A18)

> I was born and bred in Lagos so I don't really have knowledge about my culture. I don't speak Yoruba. I don't know. I don't know. (Informant A13)

The last bit of Informant A13's opinion – "I don't know. I don't know" – shows how acute the problem of disconnectedness has become between today's youth and the Nigerian culture as tier identifier markers. Many are those things that they ought to know but do not know because those things are seen as relics of the past, or not taught to them by their parents. Ironically, their new ways of life differ so much from the tested and used approaches of the past. This is with particular reference to the issue of sex and sexuality where the gap is wide between the Nigerian of the old and the new Nigerian of modern age and era. The new Nigerian is a creature with a totally redefined cultural identity marker from the past. That was made plain through the sample views of Informants A13 and A18. Both the views and the attitudinal disposition of their speakers constitute a critical challenge to managing the sexual orientation of a generation whose guardianship lacks the authority of the past.

4.4 Theme Two: Message Conceptualization in STIs Communication Campaign

Communication is at the heart of effecting behaviour change. The conceptualization and dissemination of a well-tailored message is an important factor in STIs prevention and education across the world. The importance placed on STIs, therefore, has made it important to employ effective communication in order to put the epidemic under control. Consequently, disseminating appropriate messages to people from different cultures and of different socio-economic backgrounds has become an important aspect of STIs preventive communication.

This study explored how STIs messages should be conceptualized; thereby helping to answer research question two of this study. This is with a view of understanding the perspectives of both STIs positive and negative young people, and how such can play salient role in the STIs preventive communication. Further attempt was made to find out the young people's attitude towards STIs with the ultimate view of seeing how the existing STIs preventive campaigns can be improved upon. Unequivocally, the general opinion emanating from the study indicates communication gaps still existing in STIs' campaign in Nigeria. To the STIs' positive individuals, one of the over-arching or pressing issues is – stigmatization. Overall, as depicted in Figure 4.7 below, seven sub-themes were teased out as critical to communication and message flow in STIs. They are attitude towards people, diagnosis and symptoms, language, portrayal of STIs message, influence, knowledge and attitude towards STIs and adequacy of message. An understanding of these factors is necessary because of their import to successful communication of STIs messages.

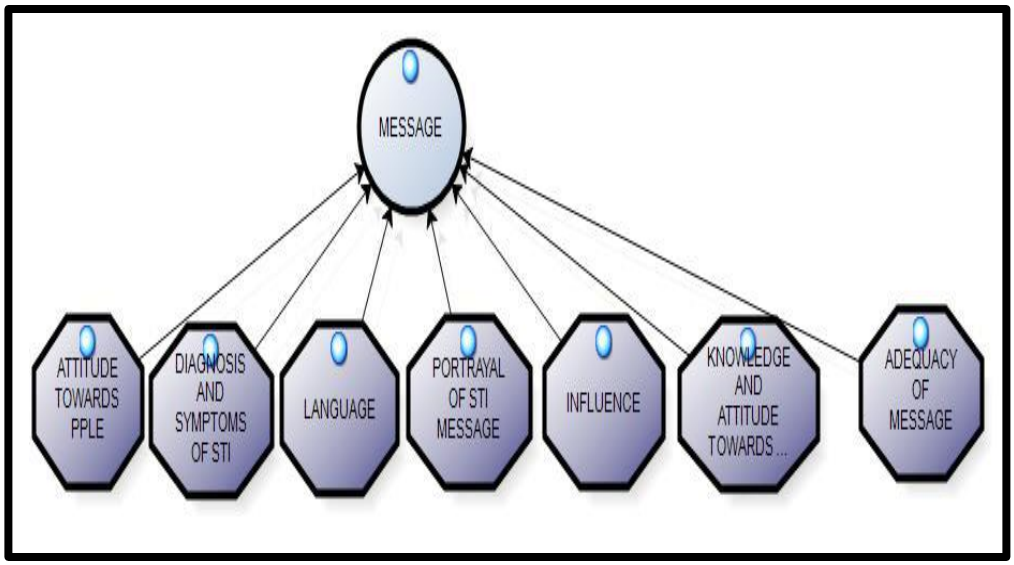

Figure 4.7. Main theme and sub-themes of message in STIs communication

4.4.1 Attitude towards People

Why is attitude to people of significance in the STIs communication discussion? It is because it is a double-edged sword: the right attitude can encourage people to come out in the open, while conversely the wrong attitude can drive it underground. The commonest of the wrong attitudes is – stigmatisation (ridiculing or avoiding a sufferer because of the person's known health status). Unfortunately, many young people living with STIs particularly HIV/AIDS have to bear this burden in Nigeria. They described "stigmatisation" as one of the greatest challenges they face after confirming their HIV status. A probable cause-and-effect relationship precipitated by this negative attitude of the public from the interview complicates the open disclosures by many of the STIs positive interviewees that had problems of disclosing their status to their spouses, family members, friends, employers and landlords. Hence, to an extent, the existence and

prevalence of HIV/AIDS in Nigeria still suffer from “secrecy”; the reluctance by the sufferers to own up to their status publicly.

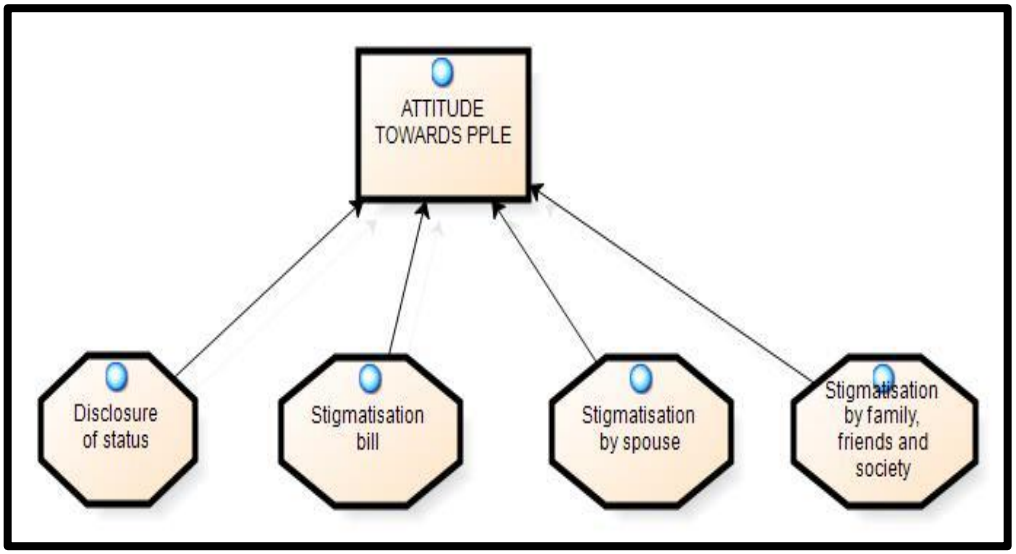

Figure 4.8. Attitude towards people in STIs preventive communication campaign.

4.4.1.1 Disclosure of Status

A by-product of the climate of stigmatisation regarding the STIs is the emotional predicament in which a sufferer is placed. In most cases, it is a situation of Catch-22 for the victim. Head or tail, the possibility of winning is slim. To admit openly to be STIs positive is to become a candidate for stigmatisation and public ridicule. To hide status, is to expose close relatives to danger along with the burden of being assuaged everyday with serious emotional load, including guilt-complex where spouses are involved. Data from this study did reveal that disclosure of HIV status is, in fact, a difficult emotional task for the sufferer. There is always a serious doubt about either support or rejection. Because the fear of rejection is real, there is always reluctance to disclose or share status with close family members. Besides the disease contracted generates fear of its own,

communication with the needed first line support group is laden with serious anxiety. Most times, sufferers go through tensed periods of self-doubt. There is a lot to learn from the testimonies of some of the informants on the grave consequences that the lack of open communication for fear of rejection breeds.

> My former husband has been infected for a long time and he didn't tell me about it. He hid that fact from me till he died of the infection. After his death, one of his friends took me to the hospital and I was tested positive. I was always falling ill and getting well. When my former husband died, I was told that he was infected with the HIV disease and that he contracted the disease before he married me. Since, when I was told that I was infected, I have been treating myself. (Informant A12)

> My husband too was infected with HIV. He was terribly sick then but he did not disclose to me until he was about to die. About a year after his death, I also fell ill. My husband was so reluctant to tell me about his status and I feel the reason for his action is because of stigmatization. He didn't get any treatment too. I only told one of my children about my status. Since I have started taking my drugs, I have been looking very healthy. (Informant A15)

The two cases illustrate how serious open and honest communication is vital in matters concerning the STIs. Partners have to be courageous in overcoming the possible fear of rejection through open acknowledgment of their status to their spouses. Not doing so as in the present circumstance is delaying unavoidable grief. Whether the fear is of rejection or abandonment, there is no justification for it. Unfortunately, that happens to be the reality: that people are reluctant to disclose their status to spouses, sexual partners, and family members, which continue to stimulate the growth of STIs (Cloete *et al.*, 2010 and Admassu, 2000). In the words of informant A1, "it is very difficult to tell

my lover about my HIV status; I'm still looking for the right time to tell her." Yet, he had not ceased having unprotected sex with her. And perhaps as discovered by Stein, Freedberg, Sullivan, Savetsky, Levenson, Hingson, & Samet (1998), he is also one of those non-disclosers who do not usually use condoms which makes sexual partners of HIV infected persons to continue to be at risk of HIV contraction. It is evident from the above experiences that there is a big challenge when individuals not only refuse to communicate faithfully their status but continue to deny their status by having unprotected sexual intercourse with their partners. The logical result is extending the prevalence of STIs.

One vital question though, to whom STIs' positive individuals are likely to turn first after the decision to disclose their status? Majority of the informants chose "selective sources", the preference varying from one sufferer to the other. The deciding factor on the first person to take into confidence depends on who will give the much needed emotional support at that critical point in the life of the individual. The testimonies underneath from informants who had gone through the tense moment in their lives show how their anxious moments were finally resolved:

> I didn't tell anyone except my former husband. I couldn't tell my parents too because of their health status. My mother is hypertensive and my father has diabetes. I don't want them to be worried about me. I didn't even tell my brother and sister because I don't what them to use it against me because I don't want to be disappointed. I told some of my friends that I feel I can confide in. (Informant A3)

> When I learnt about my HIV status in 2007, I felt so sad. I had to tell some of my family members (brothers, sisters, father, mother and aunty) that I am close to in order to make my heart lighter. I was lucky that I was not discriminated against. (Informant A12)

For Informant 4 however, no period could the worse point in life than the time she chose to make her status known. It was two weeks to her wedding and no sooner than she told her Pastor that he took the decision to cancel her wedding. Then the question of telling her parents followed:

> I didn't tell my dad about the incidence, I only told him that my wedding has been shifted due to some logistics but I told my mum. My parents have separated a long time ago; I stay with my mother. I didn't tell any of my siblings too. (Informant A4)

It is apparent that the environment is still not conducive to encourage the disclosure of HIV status. It is a herculean task for HIV/AIDS positive individuals to communicate their feelings. Those who brave the odds carefully select those to bring into confidence. But this emotional siege is being broken by the Network of People Living with HIV/AIDS (NPLWH) in Nigeria. It is encouraging open admission and as verified by the interview with the members of this group, they were not ashamed of disclosing their status to the public. In addition, through their advocacy, they are widening public enlightenment about the diseases. The NGO through jingles, radio and television programmes have expanded information, education and communication to people in rural and urban areas. Their aim is to give hope and kindle the necessary support for people living with HIV/AIDS. They hope the barriers to effective public communication on the disease can be lifted by encouraging self-admission on the part of sufferers:

> I have told the whole world about my status. I told my aunty that I have HIV because I had to stop the herbal drugs they were giving to me. My children are aware and they have been there for me. They are highly supportive. I told my neighbours and went on TV stations. (Informant A8)

> I got married to an HIV positive lady and our children are negative. HIV is not the end of the world for any individual. An HIV positive individual can still live a normal healthy life if he/she takes all the necessary mediations. They need to be recognized in the society today. My HIV status is a stepping stone for me; it made me to be recognized among my peers in the society. My educational qualifications would not have given the leverage that HIV has given to me today. (Informant A2)

> I am a public figure as far as HIV is concerned. I have talked about it in newspaper, radio and television. I have done jingles in the past. Infact some people feel that I am paid to talk about it. I talk about it as if it is a normal thing. (Informant A16).

The summary of what needs to be done and how it should be done is eloquently painted by yet Informant A16 in this opinion that:

> The issue of disclosure and acceptance is a very big issue. Many people still find it difficult to disclose their status to people. They should not hide it. Then people who are positive should be accepted. We should all look at the issue of stigmatization and see it as a challenge that must be tackled. People who are positive should have their capacity built. If it is built, they will know that if they disclose, it will help them with a lot of things like access to information, healthcare facilities and the taking actions. It will also help against infecting others. When people don't disclose, they don't have access to all the stuffs (Informant A16)

4.4.1.2 Stigmatisation Bill

Once again, there is need to return to the issue of stigmatisation because majority of the HIV positive informants identified it as a major challenge (Cloete *et al.,* 2010). Several factors such as ignorance or lack of understanding of the disease, misconceptions about its modes of transmission, poor access to treatment, irresponsible media reporting, the current incurability of AIDS, were aiding the prejudice and the "negative tagging" of HIV/AIDS carriers. So profound was the adverse effect of stigmatisation that one of the HIV positive interviewees pleaded passionately with policy makers to address the issue through appropriate legislation:

> We are proposing that people should be charged to court for stigmatization. We already have a lawyer for this particular purpose and we are seriously working towards achieving this goal. If anyone is stigmatized against, those people should be dealt with. (Informant A20)

Against this background, stigmatization of people living with HIV/AIDS is a burning issue in the Nigerian society and its effect cannot be divorced from precipitating negative implications for the HIV/AIDS campaign in particular and the STIs in general. The summary of the scenario is that AIDS related stigma remains one of the barriers that have to be curbed in order to curtail the further spread of the disease. Even among those who are aware of their HIV positive status, there is need for awareness and enlightenment education, bolster their courage to own up, to prevent their spreading the disease (Peltzer, Nzewi, & Mohan, 2004).

Nigeria has to step up efforts towards achieving risk reduction concerning the HIV/AIDS and other STIs. The Federal Government of Nigeria promulgated an anti-stigmatization law on April 10, 2014 at the instance of the several appeals by the PLWHA (Ihekweazu, 2014). The law made it clear that discrimination against HIV/AIDS patients had become illegal in Nigeria. Apart from making it an offence to discriminate against those living with or affected by the HIV/AIDS in Nigeria, it is also unlawful for any individual to disclose the status of an infected person, which he or she obtains in confidence. The punishment for the unlawful act is a fine of half a million Naira (Equivalent of RM10,000) or one-year jail term. Furthermore, the law makes it an offence for any employer, institution, body or individual to require an HIV test as a pre-condition to employment, or access to public/private services, or opportunities. It further made it an offence for any educational institution, private or public, to demand HIV/AIDS testing, as part of its routine medical testing requirements for admission or accreditation of learners. The law further stipulates that every person living with HIV/AIDS shall be assured of his/her freedom from unlawful termination of his or her employment due to his or her status. Nonetheless, there are still reservations concerning the proper attitude that those who are STIs negative should display towards people particularly living with HIV/AIDS. This is evident from the following submissions they made:

> If I know anyone who is HIV positive, I will have pity for the man because I know that very soon he/she will die and if the person is a lady then I know that she is not some one that I can have any intimate relationship with. I will be very careful with that kind of person if he is my friend. I will make sure that I avoid any body contact with him. It will affect my relationship with him because there are some discussions we can never share again like maybe

his sexual life. I will also not want people to refer to me as a friend of an HIV carrier. They will think that I also have the disease because they might think that we must have shared so many things together. People will assume that maybe my HIV has not developed. (Informant B9)

If I know someone who is HIV positive, honestly I will avoid him or her because I am not sure that I wouldn't get the virus from him or her. I will be scared of him because I might be thinking that because he has the virus he might want to infect someone else with it. He might pierce himself with a needle and stab me with it. So I will be very careful with such a person, you can't trust people anymore. I don't think I will go near him again. I will also stop any interaction with such a person because people might feel that I also have the virus. There is this popular saying that birds of the same feather flock together. I will be scared because I will be thinking of any possibility that I might contract the virus from him; I wouldn't eat with him again neither will I hug him and I will not shake hands with him again. I will be glad to interact with the person on phone. I will still behave this way despite the information that I have heard about the virus. (Informant B5)

No matter how much campaigns they produce about not stigmatizing against HIV positive people, the truth is that there is a limit to what I can do with such a person. We are humans, forget about education. Education is ….you cannot take away that aspect of you being human, no matter what you learn in life. There are times that you being natural and being a creature of God actually takes over being educated. (Informant B7)

Yes, there will be stigma attached to STIs person because in my kindred they will believe the person got it through sex… you know in the kindred you have all the grandmothers and fathers. They will not even go close to the person. They believe the only way to contract such disease is through sex. For youths like us we are told in school through all these campaign that

> people should not run away from somebody that has HIV/AIDS. I told my grandmother about this and she started cursing the people who passed across such information. (Informant B18)

The deduction from these perspectives is clear: educated young people still nurse serious reservations about people living with HIV/AIDS. This finding accords with the study of Lau and Tsui (2005) where 42% of the respondents in that study avoid physical contact with PLWHA because they believe that they contracted the disease because of their promiscuity. The affliction, therefore, is the punishment for their immoral life style. It is only in a few cases, and this concern STIs negative young people, that people express that STIs positive people deserve understanding and respectable treatment.

> If I come across someone with HIV, I will not discriminate against the person because there is possibility that he may not have contracted it through sex. (Informant B11)

Overall, however, stigmatisation stands as a sore issue for the wrong reason that many Nigerians believe that people contract the HIV/AIDS through sexual recklessness.

4.4.1.3 Stigmatisation by Spouse

If the general public is spurred by ignorance and ill-will to stigmatise those who are HIV/AIDS positive, what can be said to account for the disdain of spouses to their partners who have contracted the disease? Afterall, the person that is supposed to be closest to one is one's husband or wife. And one of the injunctions of marriage is to support one's spouse "for better and for worse, in good health and in sickness," till death

do they apart. Yet, the data arising from the study shows that several married couples found it difficu

lt to disclose their HIV status to their spouses. For women, it is particularly a tough and daunting task to disclose being HIV positive to their husbands. Women, in the Nigerian patriarchal system are culturally and socially disadvantaged; they are often economically dependent with no voice in the area of decision-making. This weak existence engenders a vulnerability, the result of which is fear of abandonment or being thrown out of their matrimonial homes once their diagnosis is known. Here is one of the classic cases of such reactions:

> My former husband pretended to be caring when he realised that I was HIV positive. Later, he started complaining that the money he was spending on medication is becoming too much burden for him to cope. He later abandoned me with my parents and I didn't see him again. After some time I got better, now I am remarried to another man who is negative. I met him in an NGO meeting like this. He knows a lot of things about HIV. (Informant A3)

The pathetic side to the spousal stigmatisation is that it is mostly gender based. Women are the highest recipients of the "worse" treatment as testified to by Informant 6. Ironically, women tend to show compassion, much more prepared to tolerate their partners on learning their HIV status. This lack of support from men is however not a general trend. Informants A9, A12, and A19, cases were instructive. On their husbands learning about their HIV status, not only did they show understanding, they provided the

best care and support. One of the informants was unrestrained in her sentiments of how marvellously her husband had responded to her plight:

> When I was told I have HIV, immediately I got home I called my husband that I have something to tell him. I told him that I went to the hospital and I was tested HIV positive and my husband started laughing. I asked him why he was mocking me and he said the way I said it made him laugh. I later told him to go for a test. My husband assured that the virus will not cause any problem between us. He gave me all his support. He did the test twice and the result was negative. Whenever we want to have sex I usually force him to use condom and he used to assure me that it is one type of disease that will kill every individual. Sometimes, he does not use the condom (Informant A7)

It has to be affirmed that there is no better confidence-building or assuring therapy comparable to spousal support in the management of HIV/AIDS carriers. Take for example the situation of a pregnant HIV positive woman who was confronted with the burden of what to do after the delivery of their babies:

> At that point in time, my husband was so supportive and he cared for me. He advised me not to tell anyone about my status; but later on, I told my mother and brother. Some colleagues of mine in my work place also discovered when I gave birth and my babies had to be given special medications because of my status (Informant A19).

A contrasting situation was that of another HIV positive pregnant woman faced with a conflict that she had to manoeuvre around. The tight-corner she was arose because:

> My father and brother are aware of the issue but my in-laws are not aware. The reason why I didn't tell them is that they might force my husband to divorce me because my husband is negative. When I gave birth to my twins

> I didn't want to breastfeed them so that I wouldn't transmit the virus to them. It was after my mother-in-law came and the pressure was too much that I started breastfeeding them. I was silently praying that my babies would not be infected with the virus. Thank God they were not infected. (Informant A9)

From the views expressed above, support of the spouse cannot be discounted if there is to be encouragement of married couples who are HIV positive. This is particularly important in encouraging women to disclose their status.

4.4.1.4 Stigmatisation by Family, Friends and Society

If husbands denounce wives and wives disdain husbands for contracting HIV, is it surprising that families, friends, medical personnel and religious leaders, all engage in the "blame game"? The reality is that that is the sad truth. Every segment of these important lines of support – families, friends, medical personnel, religious leaders, and the society as a whole, – is guilty of having denied the vital support needed at one point or the other. Impeccable evidence exists from the data gathered from the experiences of many HIV positive informants that this has almost turned to a norm in the Nigerian society. Majority of the informants admitted having suffered the agonies of denunciation from families, friends, medical personnel, religious leaders, and the society as a whole. Some informants who would have wished to confide their status to close family members, relations or friends could not do so because they thought it ill-advised. As already narrated, the case of Informant 4 whose planned wedding was cancelled was a point. Because she was honest to reveal her HIV status, she paid dearly for it. It was a pre-requisite in her church that intending couples should undertake HIV test before the

marriage could be solemnized. As it turned out, she tested positive. And the penalty was for her marriage to be put off – two weeks when she should walked through the aisle. She could only weep for her sorrow. And she did – wept profusely when the reality struck her:

> As a result of my status, my pastor cancelled off our wedding. He announced to the whole congregation of the church that the reason our wedding was being cancelled is because I tested positive to HIV test. Our church frowns at fornication. Though I am not a virgin, I was in a relationship before I met my proposed husband. I never had sex with my proposed husband because we were following the church's doctrine. My mother went to beg the pastors in the church, she told them that the disease is manageable and that they should save her face and that of the family. The pastor disagreed with her and insisted that the wedding can't be possible. My fiancé is the type that is close to the pastors so he does anything they tell him to do. After the ugly episode, some of my friends called me to ask if it was true. It is because of this stigmatization that I stopped going to the church, I realized that most of my friends in the church were running away from me. Sometimes I feel like committing suicide because I don't know how I am going to survive this ordeal. I am even thinking of moving out of the area that I live. (Informant A4)

For somebody that is down, religion could be a stabilising influence, yet in the circumstance of what has happened, it is acting the other way round. Rejection is a painful experience that can lead to demoralization and hopelessness. Negative attitudes like that drive STIs underground. Unfortunately, from indications, religious leaders do not have the knowledge regarding the nature and management of STIs. As Otolok-Tanga, Atuyambe, Murphy, Ringheim and Woldehanna (2007) have discovered, through their acts of omission and commission, religious leaders do contribute to the climate of

HIV/AIDS stigmatisation in the society. They believe their (the religious leaders) inadequate knowledge, moralistic perspectives, and doctrinal preaching about sin and death, are all contributory factors to their making steep the stigma graph in Nigeria.

Lucky that Informant A4 did not contemplate suicide despite the stigmatization she went through among her friends in her place of worship. Suicide has been established as one of the possible risks that may be promoted when disclosures are met with rejection. Individuals with weak character have been known to consider suicide as a last-resort to escaping from terminal illness, especially when confronted with stigma rather than support (Hackl, Somlai, Kelly, & Kalichman, 1997; Kalichman *et al.*, 2009).

Another issue of concern is about health care professionals also stigmatising STIs positive people. Two different accounts presented below share unsettling experiences of Informants A2 and A9:

> I was taken to the hospital where series of medical tests were conducted on me; that was when it was discovered that I was HIV positive. The hospital management ejected me immediately from their premises after asking me to call my family members. They did not disclose my status to me rather they told me family member when they eventually came around. (Informant A2)

> The medical doctor that attended to me the day the test was conducted told me that I will die if I do not tell someone about my status. I was later referred to a general hospital for treatment. (Informant A9)

In summary, it can be deduced that people living with HIV/AIDS are stigmatised by the different segments of the society. Even those who are supposed to be their primary care-

givers are not excluded. This stigmatisation affects them psychologically. In turn, it also conditions their attitude towards members of the society. This finding also tallies with the study conducted by Adebanjo, Bamgbala and Oyediran (2003) which shows that the attitude of nurses and laboratories attendants towards HIV positive individuals was poor. The perception of this category of health workers is that the PLWHA are responsible for their illness and the HIV/AIDS is a punishment for their promiscuous life. But the known fact is that it is not only through sexual contact that HIV/AIDS and even STIs are contracted. Misconceptions are serious fallacy requiring the deployment of massive dose of information, education and communication to correct them.

4.4.2 Diagnosis and Symptoms

What relationships do diagnostic method and the symptoms manifestation have with preventive communication of Sexual Transmitted Infections (STIs)? The first step is to clarify the misconceptions often surrounding the STIs. Put simply, STIs are a group of infections similar to one another owing to the fact that they can be contracted through sexual contact. STIs have become an acceptable term of common usage instead of the previous STD (Sexually Transmitted Diseases) terminology used to describe the range of diseases that once fell into the category of infection spread through human copulation. Sexual infections are asymptomatic because individuals might not know they have contracted the infections. However, not all STIs are contracted through sex but sexual activity remains the commonest way of spreading the infection. The HIV/AIDS infection, for instance, is caused by contact with body fluid or blood of an infected person. As a result, it is important to know the transmission method of STIs. The

knowledge of the symptoms of STIs is one of the most important prerequisites for early treatment. Different people manifest different symptoms and ability to correctly evaluate symptoms and properly diagnose the ailments will assist immeasurably in the conceptualization and design of STIs messages. Owing to the importance of mother-to-child transmission, pregnancy is isolated as a deliberate area of focus in the discussion of cultural sensitivity regarding the diagnostic and symptomatic analysis of STIs in Nigeria before focusing on the perceptual framework surrounding the other symptoms in general. The diagram below highlights the connective links of the issues in discussion.

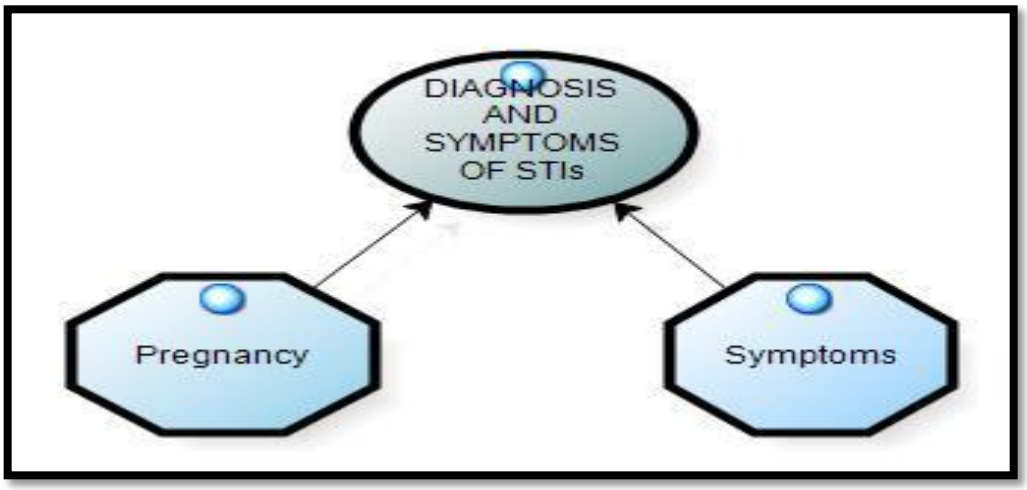

Figure 4.9. Diagnosis and symptoms in STIs preventive communication

4.4.2.1 Pregnancy

Pregnancy marks a distinctive period in the life of a woman. It has its own implications and complications to every woman. Generally, however, there are medical, physical, psychological, social and economic challenges involved with differing coping mechanism different among the women. When these challenges are compounded with

STIs, complexity can arise. As discovered from the interviews with STIs positive women who were once pregnant, the manner of reaction on learning the news was different. Some learn about their diagnosis during the ante-natal period. Others get to know about their status after their deliveries or at the post-natal stage. In all of these processes, from period of conception, to early part of the pregnancy, and running to late and subsequent time of putting to bed, informants lay claim to experiencing different kinds of symptoms. A common occurrence among quite a number is that they did not discover their status until they began their ante-natal care.

> I was diagnosed of HIV in 2010 when I was pregnant. I was on bed rest in hospital because I used to have frequent complications during my previous pregnancies. Several tests were carried out on me and it was discovered that I had HIV. I delivered the baby but the baby later died after five months. (Informant A19)

> I discover I have HIV since 2010 and I was pregnant by that time, I did nothing when I heard I had the disease because I knew that if I cry the situation will not change (Informant A7).

> I had my first baby at the age of 20 and I waited for 3years before I had my next pregnancy. It was during my second pregnancy ante-natal that I discovered that I was HIV positive (Informant A9)

A parallel was the case of another informant who contracted the infection after safely delivering her baby at a hospital. It was a case of negligence on the part of the hospital management as she narrated:

> I am angry that I am infected with the disease. I got the disease through a private hospital in Mile 2. I contracted the disease through child birth. The

> woman who gave birth before I gave birth was positive. I contracted the disease from her because the woman was not properly cleaned up and the sharp objects were not sterilized. I started having problems after I gave birth to my baby. The baby later died (Informant A14).

But not so for Informant A6, who it took her baby's frequent ill health to discover her status:

> I am nurse in a private hospital. I was diagnosed of HIV on February 16, 2012. I knew through my first child. He was always falling sick and I used several drugs for him but he was not getting better. Several symptoms were manifesting on his body such as rashes, blisters, spots etc. My mother later suggested that he should undergo several medical tests. That was when it was discovered that my baby was HIV positive. I also conducted my own medical test and I was also positive (Informant A6).

There are many questions being raised about how serious have been the efforts at the targeting of pregnant women in the STIs preventive communication. If it is pardonable for a woman to learn of her status during ante-natal clinic, it is, certainly, indefensible for such to be delayed until after child birth.

4.4.2.2 Symptoms

If those with the benefit of access to professionals with knowledge suffered delay in knowing about their status, what could be said of ordinary Nigerians' ability to correctly interpret the STIs' symptoms? Unfortunately, because the symptoms have no standard or universal ways of manifesting, there is a deficit of knowledge among the populace. From the experiences of Informants, the route is different for individuals. What is familiar is

that everyone goes through various types of sicknesses until the stage is reached when there is confirmation. Three informants relayed their experiences:

> I discovered my status just a month ago. I discovered that I was purging and I was losing weight. I told my doctor that I wanted to do a HIV test and I was tested positive. The doctor later directed me to this place and [where] I redid the test and I was confirmed positive again (Informant A1).

> I was falling sick in the year 2000; after several diagnostic tests it was confirmed that I am HIV positive. The symptoms that manifested were diarrhoea, loss of weight, and my hair was falling off (Informant A8).

> Before I knew my HIV status, I was down with tuberculosis and malaria. Several tests were conducted on me which led to discovery of my status as an HIV positive individual. (Informant A3).

One of the informants who discovered her HIV status just two weeks before her supposed wedding day stated that up till the period of this in-depth interview she was feeling hale and hearty. She tells the researcher her experience:

> My church asked myself and my fiancé to undergo an HIV test. It is one of the prerequisites that a member of the church must fulfil before being joined in holy matrimony. The result of the HIV test showed that I am positive while my fiancé is negative. We never had sex together throughout the period that we dated. The wedding was called off because of this discovery. Till this moment, I don't feel sick at all, I still feel I am a normal person. I think I came across it from my past sexual relationships, I mean I used to have unprotected sex (Informant A4).

Illiteracy regarding how STIs, particularly HIV/AIDS, manifest their different symptoms in people is evident rife among the general population in Nigeria. This has to be corrected. Hence, it is important for young people to be sensitised about the asymptomatic nature of some STIs. And this is what has made the issue of language – both as a tool and weapon – important to this study. It is the next subject focused upon.

4.4.3 Language

Language as the medium of expression connects a group of people within a community sharing a common cultural tradition within a geographical entity. The use of the local languages of people is an important strategy which contributes to the effectiveness of the STIs preventive communication campaign. Based on the thematic analysis using application in Nvivo 10 software, the relevance of language as a concept in communicating STIs campaign message becomes a self-evident imperative. What makes language relevant? And of what importance is, particularly local language? These two elements create the boundary of language in the relationship with the STIs preventive communication. They are explored below.

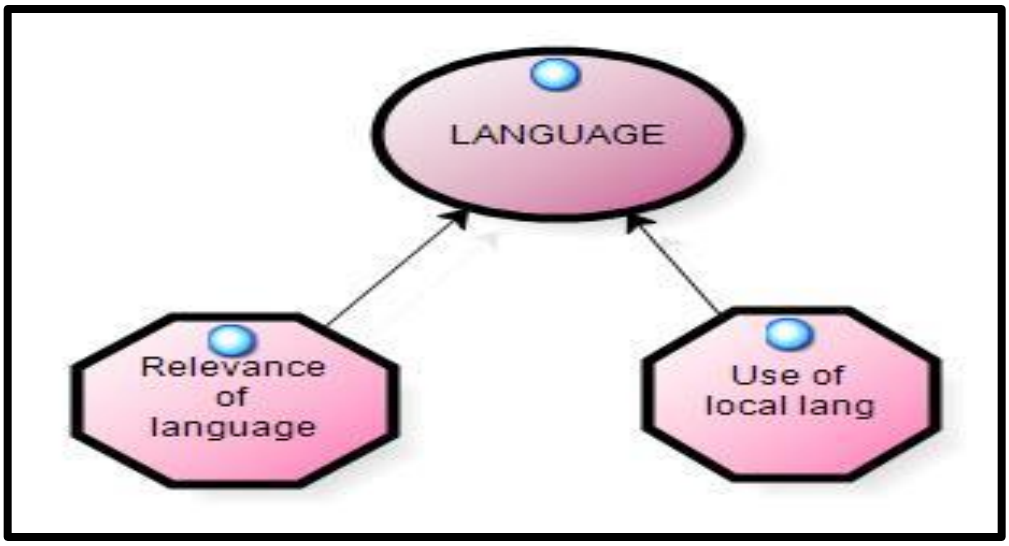

Figure 4.10. Language in STIs preventive communication campaign in Nigeria

4.4.3.1 Relevance of Language

Language's importance lies in the fact that it gives everyone a sense of belonging. It enables shared-meaning and shared understanding even individual's perspectives are dissimilar. The young people interviewed indicated that their local language is a very important aspect of their culture; it gives disseminated messages more meaning within a frame of reference. They believe that their local language gives them a feeling of belonging, creates a ready identification with the information being disseminated compared with when messages are disseminated in English language. For STIs' messages therefore, some of the informants explained the necessity for using local language:

> Language is vital because it gives a sense of belonging for everyone. For instance, if I meet someone for the first time and I discover that he/she is a native speaker of my language. I will start to communicate with him or her

in our indigenous language even though I know he understands English. Language fosters friendship and it helps to sustain relationships. It is not everyone that understands the official language that is why there is a need to understand the audience. For instance, in Abeokuta, there is a need for campaign planners to do proper research because it is a Yoruba land and most people here are illiterates. So I believe we should understand the audience to know the kind of language to use. I believe language is very necessary. Language will have impact on me because it has the capacity to capture my attention (Informant B3).

Language is very important in the STI advert. English is what everybody speaks, but our indigenous language is an identity… it is very important. If you are in a place you have to identify yourself with your environment, but what will identify you to anyone that you belong to that environment is the language. Language is important (Informant A10).

I have not heard of HIV advertisements in Yoruba language, I hear the English one frequently. I feel that Yoruba advertisement is better for those that don't understand English. However, there are some people that don't understand Yoruba too, therefore there is a need to use other languages in Nigeria (Informant A19).

I have listened to advertisements on radio in both Yoruba and English. If the language of people is used, it will make the understanding of the messages to be deeper and rich (Informant A20).

Yoruba language was used for the STIs message. I prefer the Yoruba version of the STIs messages as compared to the English ones (Informant B2).

> Using the local language to disseminate STIs communication will make people to understand the messages better and faster. People heed more to warnings when it is spoken in the local dialects than when it is said in a language that is regarded as not their mother tongue. Our local language carries more impact and weight than English (Informant B5).

What else needs to be said to demonstrate the utility of appropriate language as an important vehicle in the dissemination of STIs preventive messages? It is a matter that has been proven beyond theoretical and empirical doubt in communication. Indeed, myriad is the academic and scholarly opinions that have identified the use of local languages as effective way of communicating social change to individuals. We examine the potential benefit of disseminating STIs messages in the language of the people, which is, using their local language.

4.4.3.2 Use of Local Language

There are two dimensions connected with the use of local language in STIs messages in Nigeria. The first is the acknowledgment by most informants of the existence of STIs messages in the three Nigerian main languages in Nigeria: Hausa, Igbo and Yoruba. The second is the inadequacy this poses in view of the fact that there are over 500 languages in the country. The effect is that the reliance on the three main languages has denied the widespread awareness of the STIs in the dialects, which are the languages of communication at the grassroots level. According to the informants, it is a rarity encountering the messages in their localities. It means that the local populace, including youths in these communities do not have the privilege of learning first-hand about STIs, as well. This is a big gap in the efforts at communicating STIs prevention messages in

the nooks and crannies of Nigeria. Accounts of experiences may differ, but the issue being called attention to is virtually the same:

> Other languages must be used. I have not heard of any advert in my local language. It might be there in Ogoja but since am in Lagos, I have not seen any advert in my local language (Informant A13).

> I have not seen any STI advert campaign that uses Egun, Yoruba or any local language. The only ones I have seen are English (Informant B15).

> I have seen the cultural element of dressing but I have not seen the advert in Igbo language or any other language (Informant B18).

> I have never seen any HIV advert in Yoruba. I will understand both advert in both Yoruba and English but I will understand the advert in Yoruba better (Informant A1).

> I have never seen HIV campaign in Idoma language but I have seen in Hausa language (Informant B9).

However, some other informants identified that they are only exposed to STIs messages in the major languages in Nigeria. Informant A6 explained that he has seen STIs advertisements in both Yoruba and English languages; however, there are no traces of Nigeria culture in them. Also, informant B14 also explained that he has seen advertisement in Hausa language.

It was noted that the indigenous languages that the informants were exposed to were the three main languages in Nigeria, which are Yoruba, Hausa and Igbo. They are not exposed to STIs messages in other dialects in the country. The language used to communicate STIs messages could be a barrier in itself, especially if it is not situated

within the context of the people and the environment they are meant to reach. Communicators have to be aware that the language they used could be misinterpreted in the light of the cultural background of the young people. The fact that there are over 500 indigenous languages in Nigeria makes achieving the task of incorporating local language in design of STIs message to be a herculean task, yet there can be no running away from the challenge if the battle against STIs is to be extensively fought in Nigeria. The educated and the illiterate young population must be reached and the language of doing that is their "mother-tongue".

4.4.4 Portrayal of STIs Message

Message portrayal is at the heart of behaviour change communication. Effective message goes beyond what is said, how it is said, the vehicle used in saying it. Crucial is the impressions that are created in the minds of those that are exposed to the message.

The mass media are powerful agents of information because the messages they disseminated reach diversified audience and different segments of the population. The messages create different impressions on the people; they shape their minds differently because they have individual differences. What elements can be discerned to be critical to the specific issue of mass media portrayal of STIs' messages in Nigeria? From Fig. 4.10 four of such critical factors can be discovered. They are the presentation of the diseases as "youth disease", the level of creativity involved in the messages, the issues of involvement of people in STIs' messages conceptualisation, and the "hidden" nature of presenting STIs in derogatory terms. These elements severally and collectively can be deduced from the ways STIs' messages have been portrayed in Nigeria. We start the

examination of these issues by looking at people's involvement in message conceptualisation

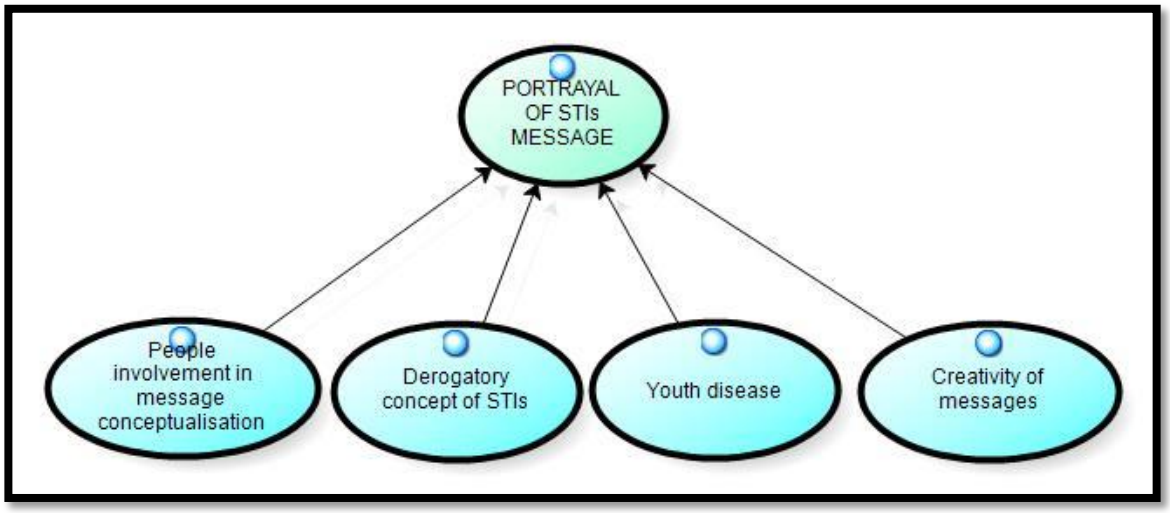

Figure 4.11. Portrayal of STIs message in STIs preventive communication campaign

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4.4.4.1 People involvement in Message Conceptualisation

Why is people's involvement in message conceptualisation important? It is simply because it is vital to know the perspectives of the audience that the message intends to reach, understand their social, language and psychological framework, that could make the evolved resonate with them. Not a few informants see this as part of the missing gaps in the way that the STIs' messages are being portrayed through the media in Nigeria. They believe that there is a need for campaign planners to involve young people, to learn and share their experiences, perspectives and worldviews. Both the STIs positive and negative can bring informed perspectives to the STIs' prevention message design because they wear the shoe and know where it pinches. According to them, the

structures through which the involvement of the youths can be achieved are already in existence. Some of them include the PLWHA, the counselling and support groups, the peer education and discussion networks, the various civil, faith-based and community coalitions. They insist that innovation is urgently required to correct the current situation whereby:

> I think very few people are involved in the campaign design and that is why it is not making the desired impact. Everybody is supposed to be involved. It is supposed to be like a network of campaign involving everyone… (Informant B4)

One HIV/AIDS informant, specifically, clamours for the mass media to go beyond its traditional reporting mode of sensationalising issues pertaining to HIV/AIDS. They (the media) need a new orientation that will involve them working with HIV positive individuals. It is one way of increasing the positive portrayal of information about the diseases, a means to put the right tonal mark on the messages getting across to the people, the end of which will lead to the eventual success of the STIs reduction campaign in Nigeria. Informant 2 echoes it so loudly that:

> The media should work with people that are positive. They can work with people that are living with the virus. It is when the media work with the people that are living with the virus that something can be done. (Informant A2)

Incidentally, there is nothing novel about what the informants are saying or calling for. As far back as 1997, the United Nations Populations Information Network did clamour for youth involvement in the planning of services meant for them. In order to have broad

inputs, it was suggested that several individuals such as parents, teachers and community leaders be brought together along with the youth themselves to develop strategies that could meet the needs of the young adults. Avenues like community workshops through which the attitudes of young people towards their sexuality with a view to discovering approaches tailored to fashioning services would meet their specific needs were further recommended by United Nations Populations Information Network. Unfortunately, this suggestion remained what it was: a mere rhetoric. With the Nigerian experience, it means concrete efforts were required to work the talks.

4.4.4.2 Derogatory Concept of STIs

One of the aspect in which the lack of involvement of the youth in the conceptualisation of the media messages was visible is the derogatory undertones contained in some of the advertisements that the young people were exposed to. The effect of the belittling or offensive message was to give wrong perspective on the issues being campaigned against, particularly HIV/AIDS. An informant observes thus:

> Mass media created the perception that HIV/AIDS is a killer disease and that those who are promiscuous are mostly affected. The HIV advertisements say that majority of people with HIV/AIDS got it through casual sex and that has shaped our mentality that it is people that flirt that contract the virus and this has also heightened our fear for the virus. (Informant B5)

From other informants also came similar depressing observations:

> The message just tells people to be careful about sex; that is the only message I could incur from the advert. I don't see the message too often.

> The way the message is put too looks like it's only through sex one can get the diseases. They don't talk about how it can be managed. (Informant B18)

> The pictures on the internet create so much fear in me that I pray I wouldn't be a victim. They put the before AIDS and after AIDS pictures online. The pictures are for those that are not treating themselves. If that fear is in you, you will be thinking the way I am thinking. I have the perception that majority of those who are HIV positive got it through sex. I think the media contributed in a very large extent to that perception and it is the reason why people are stigmatizing against those who are HIV positive. (Informant B7)

Half-truths and inaccuracies colour perception, and in the case of HIV/AIDS, they have induced fear and contempt in the public. Presenting HIV/AIDS as an infection of the promiscuous young cannot but incite public condescension against those who have contracted the disease in Nigeria. Sadly, as Mawadza (2004) discovered, the environment is replete with "stigmatising language" in the media, educational materials, songs, poetry and individuals as the chief sources. Daily, people encounter these offensive publications and hear it in daily discourse. Similarly, Wusu (2011) study on sexual health content of mass media in Nigeria revealed that virtually every sexual issue was portrayed in the negative light by the media. There is therefore a big challenge in Nigeria with regard to media orientation, philosophy, ethics and social responsibility as regards STIs communication. These are issues of professionalism that must be balanced with the overriding national interest of Nigeria. The media have to be sensitive and responsible, committed, dedicated, professional and socially responsible, as change agents and as opinion moulders, if they are to make effective contributions to the cause

of development of healthy Nigerians. It does not appear that the new era will dawn overnight going by the view of Informant B7:

> Presently, the media are trying to correct the negative perception and the stigmatization of HIV people ….but humans are supposed to be dynamic but we are now becoming static when it comes to HIV/AIDS. They are trying to correct the perception but the harms have been done already and it will take a very long time for it to be corrected. They have scared people away from HIV positive people already. (Informant B7)

4.4.4.3 Youth disease

This third leg of the square peg that is being put in the wrong hole of inappropriate media portrayal of STIs requires no extensive discussion. As apparent from the exploration of the last three elements in this section, STIs have largely been presented as a youth disease. Rightly, of course, young people disdained the stereotype. They disliked the image and imagery painted of the youth in the mass media campaign messages. Some of the young people deplored the false claim rampant in the media, especially on HIV/AIDS, typecasting the youth as the only set of people who are susceptible to the infection.

> What I think critically is that, young people are often used for the campaign. I want to see elderly people too. You know using them maybe for drama. The use of young people makes us to believe that it is only youths that are involved in risky sexual behaviour. (Informant B3)

> The mass media made me believe then that it is men that give women the infection but when I got here (hospital) for treatment, I saw that it is not only adolescents that have the disease. Several people such as babies, children, married couples, old people are all living with HIV/AIDS. (Informant A11)

> The inadequacy of the adverts is that they mostly make use of the youths. They should also let people know that married couples too can contract the disease. The adverts are only talking to the youths on how to prevent themselves. I feel they should also create a scenario in which married couples went to the hospital only for them to discover that they have contracted the disease. They should create instances that couples do not involve themselves in extra marital affair. Maybe the husband went to barb his hair and he got the infection it. They should also let us know how married couples can also manage the disease effectively. They should not limit it to the youths alone. Some elderly people will tell you that it is the children of now-a-days that contract the disease mostly. They did not know that the disease can be contracted through the use of sharp object. The advertisements give us the impression that it is only young unmarried people that can get HIV. (Informant B8)

While it is true that the young people are the most vulnerable to sexually transmitted infections, including HIV/AIDS because they are sexually active and mostly unmarried. However, it is a wrong claim to associate them as the only segment of the population predisposed to such risks (Katz, Fortenberry, Zimet, Blythe, & Orr, 2000). Quite a number of adverse effects that the false claim can instigate has been identified to warrant any repeating. The important addition that should be made is that when communication conceptualization is based on faulty assumption, ab initio, its effectiveness has already been compromised.

4.4.4.4 Creativity

Creativity is inevitable to a message that intends to persuade a recipient to effect a change of his/her previously held opinion. To what extent are the STIs' messages

creative? Do they move recipients to action? The straightforward answer is, No! Some may, but a large majority are not. From the available evidence, criticisms against many of these media messages range from lacking in creativity to being ambiguous sometimes. The consequence is that the messages, at times, become complex for the ordinary average person to understand. Rather aim for the ordinary, average person, it appears the focus tends to be more on those whose status is above the average or close to the middle class:

> The advert is okay and enough for me and I think anybody of my status can get the central message of the advert. A person of lesser status may not have a comprehensive understanding of the message due to the low academic qualifications. (Informant B1)

There are those who however dismiss many of the messages as totally lacking in creativity:

> The contents of the adverts are too common place; imagine they place a lady's picture and a guy's picture with no word and the lady is backing the guy. The campaign should not be a hit and hiss campaign because people will forget… It should be something creative and impactful. I might not be able to create something creative now but there should be something that when people see it, they will say waoh! They should create something new and attractive not something that is common and boring. (Informant B10)

Two points need to be reiterated to close this section. The first is the fact that media messages have to be creative in order for them to have a lasting influence on the young people. The second reason is that advertisements/messages need to imbibe the culture of the people, which demands conscious efforts as beautifully summed up by one of the informants:

> You shouldn't just frame up a message and take it to the North for instance because they have a different beliefs about things. So you have to go to the

> North to get information on how they do things, their views about that thing, their opinions and perceptions when you bring out the message, they will embrace it. The same thing goes with the Eastern part of the country. You shouldn't just cook up something and throw at people, they may not embrace it. (Informant B10).

4.4.5 Influence

Influence is important to STIs preventive communication campaign because it determines those that the media messages have to target, and how the messages should be designed if they are to be influenced. The three planks on which youth influence rests are: the family, society and the peer group. All the three exert pressure on them in an overwhelming way. Influence is the ability of an individual to effect a behavioural change in another person. Sometimes, this can be positive. At another time, it can be negative. So, people are influenced in positive and negative ways. Positive occurs when someone is changed along a desirable constructive behaviour or path while negative influence achieves the exact opposite. Informants share different views on the influence or impact of family members, friends and society as a whole on their sexual behaviour.

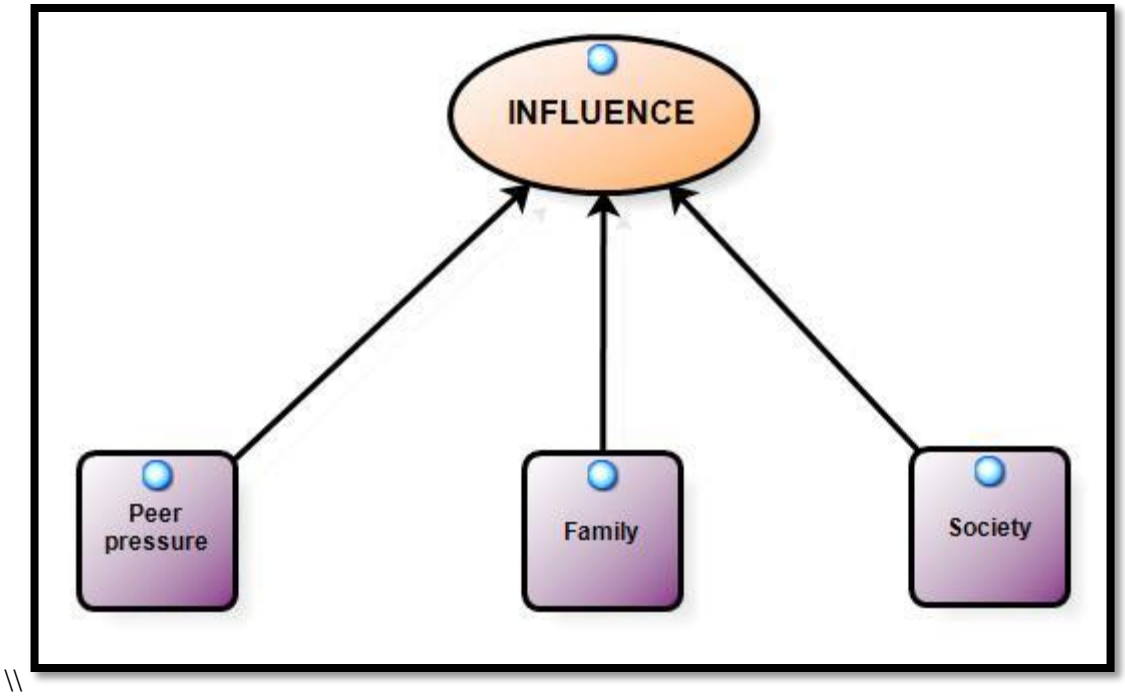

Figure 4.12. Influence in STIs Preventive Campaign

4.4.5.1 Peer Pressure

To begin this examination of influence on the sexual behaviour of youths in Nigeria, we start with the peer group. The findings from this study show that peer influence is strong; it exercises solid impact on the sexual behaviour of young people. Particularly with regard to risky sexual behaviour, informants disclosed that having good friends who are morally upright reduce the risk of their involvement in dangerous sexual behaviour. The exact opposite occurs with morally bankrupt friends. They are dangers as they pose grave risks to becoming vulnerable to exploring hazardous sexual adventures. Neither one, nor two informants are of the same mind on this issue:

> Peer pressure makes people to involve in risky sexual behaviour. Young people want to belong in a particular clique and he/she might want people to

> see him/her as someone who are very social and jovial. People portray someone who is not sexually active as someone who is not smart.(Informant B5)
>
> …friends around have also influenced me. Sometimes, they tell me "franklin you dey dull yourself"(you are not enjoying yourself). Whenever they see a girl they try to persuade me to go and talk to the girl. I will just tell them it's not my style. Especially the female folks they will be telling me I'm too cold. Though all these comments have not been able to change my attitude towards sex that is why I don't listen to them. (Informant B16).
>
> I fall in love with one of my classmates, though he was good to me, we always play together, one day he invited me to his house and we stated kissing and romancing, later he penetrated me. A week later, I stated feeling some itching in my private part. This made me to visit the hospital and the doctor confirmed that I have gonorrhoea (Informant A5)
>
> Sometimes, I can just decide I want to stay away from sex but the community is not helping matters. I am not referring to the whole community, but some members of the community like friends. If they don't see you with male friends, they will be asking me that when did you join the scripture union and all that. (Informant B17)

Peers are very strong influence. Indeed, there are many indigenous Nigerian proverbs showing the important roles that friends play in the lives of an individual. "Show me your friends and I would tell you who you are," says one proverb. Another say, "birds of the same feather flock together." Beyond the observation and feelings, the study of Potard, Courtois, & Rusch (2008) and Temin, *et al.* (1999) put paid that such an idea was mere sentiment lacking scientific prove. The outcome of their different studies

reveal that young people with weak character and who want to live up to the expectation of their friends have been found in higher proportion to submit to early sexual initiation and continuity. Identical result but from an opposing end was made by Jessor (1991) who discovered that young people who moved with morally upright peers were not easily influenced to be involved in risky sexual behaviours. Similar studies conducted by Blum and Mmari, 2005; Lengwe, 2010; Moodley, 2007 all made categorical statements that young people's sexual activity was influenced by their peers, especially if those friends were sexually active. Furthermore, Pengpid and Peltzer (2008) found that young people aged between 19 and 35 were more influenced by their peers than any other group to engage in risky behaviour.

The big question is about how parents can strengthen the will of their children to prevent their children from becoming easy prey to incorrigible friends. The answer according to one of the informants lies in parents striving to educate their children adequately on important sexual issues. Unfortunately, it did not start that way for these informants:

> For instance, my parents do not sit me down and tell me about the things I need to know therefore most of the sexual information are gotten from my peers. These peers of mine gave me negative information that would have had negative consequences on me. Most young people involve themselves in this act because they want to experience what it is to be sexually active. (Informant B8)

> My friends told me that it is not good for a lady to be a virgin at the age of 23… there was even a day that I heard something that if you are still a virgin at the age of 20 you will have problems when you get married. This gave me a lot of serious concern because I am so scared of pain and I don't

> want to have problems when I get married. I later asked my aunt and she was so furious with me for having such bad friends. My Aunt wanted to meet those friends of mine but I didn't allow her to. She also told me that it was a lie. Imagine if I wasn't curios and starts asking questions I may have gone to do something wrong and all that. (Informant B10)

It is evident from the above sentiments that many young people have been misled based on the information that they got from their peers. It is also worthy to note that young people held a wide array of misinformation on their reproductive health. While some misinformation might be considered relatively harmless, it is important to note that some misinformation reflects the individual's concept of reality. Therefore, it is important for parent to expose young people to the appropriate and adequate sexual information before they become misled by their peers outside the home.

Another contrary views expressed by these young people reflected that some young people have self-efficacy hence they don't allow their peers to have an overwhelming influence on them. An informant expressed that:

> My friends have no influence on me because whenever they start saying things like that I shy away from it because it sounds irritating to me. I feel it's something that should be said privately not something you broadcast publicly especially the way and aspect of it they talk about. (Informant B13)

4.4.5.2 Family

Both in fact and from overwhelming prove of literature, the family remains the bedrock of a properly nurtured young adult. Equally, confirming is the experience of STIs negative young people from this study. Most described the relationship with their parents especially their mothers as one of their protective factors. These young people alluded further that living with parents and having a close relationship with them created a social protection mechanism for their lives. As such, they had no need to seek affection or emotional support from outside. Whatever is the strength of character, the tenacity to ward off wrong influence, and/or ability to grow into socially responsible young adults, they owe the debts to:

> My mother influences me… you know the normal mother and son discussion… be careful, avoid unwanted pregnancy. It has effect on me because I don't want to hurt her; I adore and respect her… My dad is free… because he feels you are old enough to know what to do for myself (Informant B4).

> My mother has an overriding influence on me. She told me that a woman is not dependable and that the character of a lady is more important than the beauty. My friends have so much influence on me but I still think about my decision before I do anything at all. Their influences do not have so much over-riding influence on me (Informant B2).

> I will rate the influence at 60%... dad is not always at home. But mum is always there to talk to me about the dangers of indulging in bad behaviours such as casual sex… mum, she is the sole engineer of everything (Informant B1).

> And my mother always calls me to tell me remember where you come from. She will say I shouldn't impregnate a girl. So, because of her I have refused to indulge in sex for now (Informant B16).

Without undermining the role of fathers, majority of the informants identified mothers as having strong hold on children. This should be less surprising in African cultural context where the father is usually presented as an "authority-figure" compared to the mother who is supposed to be the "social equalizer", whose femininity provides stabilising influence in the home. The accounts show that mothers can, and do, have serious impact in providing good nature and nurture to children, particularly influencing them in cultivating responsible attitudinal and social behaviour. Even as one informant claims that his mother's exhortation does not extend to enjoining him not to have sex with the opposite sex but to "be careful" of them, the injunction is still a good lesson to inculcate. There is, therefore, no way to discount that if young people have the significant motherly support, they are less likely to involve in risky sexual behaviour that could lead to sexually transmitted infection(s).

Ironically, there are instances where the family that is supposed to be the bulwark of support turn out to be the very opposite of becoming a destructive agent in the life of its greatest resource. Some of the informants, indeed, traced their early induction into sex to acts of culpability on the part of their parents.

> My family influenced me to commit fornication. I came from a family of nine and I am the eldest daughter in the family. Due to the abject poverty in the family especially when our father died we were left with nothing, without any source of livelihood. I had to embark on prostitution in order to

> feed my brothers, my sisters and myself. Before I knew what was happening I had contracted HIV (Informant A8)
>
> My mother used to send me to sell "Fura"; most of my customers are men and one day I was convinced by one of my customers to have sex with him before I knew it I already contracted gonorrhoea (Informant A6)
>
> My father pushed me into the crises I am facing today. He always tell me to go and collect money from uncle T (One of our neighbours) and he started sleeping with me when I was 13 years old and I contracted STIs. (Informant A10)

Two unavoidable mutually inclusive issues that cannot be glossed over are – poverty and lack of a social security system to provide a safety net for economically disadvantaged and vulnerable families. We have seen here how these two evils have conspired to expose innocent children to sexual abuse and exploitation. Appropriate mechanisms – social, legal, cultural and economic – have to be developed to safeguard poor and exposed children at the risk of sexual exploitation. But in the meanwhile, it can be rightly asked, what prevented the children from opening up to their parents about their sad experience?

The finding in this study suggests that chances of children having the courage to have open discussion about their sexual experience with their parents tend to correspond with the level of educational qualifications of the parents themselves. Informants say they prefer to discuss such issues with their mothers, especially when their mothers are educated. But not all issues can be discussed. Males say they are reluctant to dialogue on

issues concerning the opposite sex with their mothers. The data in this study show that the type of conversation held by young people depends on the parents' educational qualifications. Informant B5, for example, said, "My mother has only secondary school education. I talk more with my friends but I consider myself as independent minded.'' Directly another informant admitted that ''… I don't discuss any sexual issues with my parents. They are not very educated. My pastor is someone that I easily talk to" (Informant B9). Besides direct influence of parents, other members of the family were also discovered to be influencing their risky sexual behaviour. Four informants – Informant A21, B15, B19 and A5 – all acknowledged the role their siblings play, which they say have positive influence on their risky sexual behaviour.

What should not be omitted is that parental monitoring and/or supervision of children is an effective weapon in protecting children from risky sexual behaviours. As a United States study on parental monitoring or supervision in relation to risky sexual behaviour revealed, parental monitoring and/or supervision, indeed, leads to a positive impact on young adults (Bettinger *et al.,* 2004; Broman 2007; Diclemente *et al.,* 2001; Miller, Forehand & Kotchick., 1999; Romer *et al.,* 1999; Ronsenthal *et al.,* 2001). A further study among 14 to 19 years old African American adolescents, confirmed that the high level of parental supervision, helped reduce incidence of gonorrhoea and chlamydia among them (Bettinger *et al.,* 2004). Broman (2007) also discovered that adolescents brought up with higher parental warmth show less likelihood of engaging in sex before marriage. Overwhelmingly, family remains a key influence in exposure to risky sexual behaviour among the young people.

4.4.5.3 Society

Is there a way to absolve that the larger society from guilt judging from the mass of evidence that has been adduced so far? No way, is the answer. Informants in this study have a damning verdict for the roles that the society plays in the lives of the youth. Hardly were they able to come up with a redeeming feature that can attenuate the negative perception of the society. The adjectives used in describing the state of the society were as uncomplimentary as their general views about nature and character of their environment. In no area of life were they able to spot an enriching society.

> My neighbourhood is wild; if I want to look at what is happening in my neighbourhood, I may do something resentful, worse, or extremely bad… the neighbourhood in terms of sexual activities has negative effects on me (Informant B4).

> We don't have neighbour. In our area we don't interact too much with people. I have people around me but I don't interact with them. I will be more notorious because they are bad people. They are bad people when you are talking about sex (Informant B3).

What has gone wrong? Some say the society is corrupt. Therefore, the young people cannot but be corrupt. Some blame the decadence on the negative media messages assailing the young. Some see uncontrollable materialism as the foundation for the destructive society. Those holding this opinion are echoing Obidoa, M'Lan and Schensul (2012), Oladepo and Fayemi (2011) and Temin *et al.* (1999), who see obsessive pecuniary or monetary drive as stimulus to irresponsible sexual relationship. However,

there is a contrary opinion that it is not in all circumstances that the society exerts negative influence on young people. For instance, an informant from the Northern part of Nigeria narrates how that society has mediated the sexual excesses or exuberance of its young people:

> ….this is not the way of life of people in Zaria, people will start to ask questions, they will want to know why two unmarried adults are living together as husband and wife. People will want to know whether they are going to get married or they are just living together just like that. If people of the opposite sex are seen together in suspicious and hidden places, people will raise eye brow. People will say things like; they are Muslims o! Such murmurings will generate curiosity and this piece of information may get to the hearing of both families and this can lead to bad reputation for that family. (Informant B12)

This virtue is a hallmark of the Nigerian culture of old. Everyone policed and held one another accountable. These virtues curtailed young people from risky sexual behaviour in the Nigerian society of old. The eagle eyes of every member of the society trailed every young person wherever they went.

4.4.6 Knowledge and Attitude towards STIs

Having examined some of the indicators crucial to making STIs preventive communication culturally sensitive; another factor which is quintessential to the process is the knowledge that young people have about STIs and how this knowledge shapes or conditions their attitude towards the diseases. Knowledge and attitude of young people is very imperative, if there is to be a good understanding of the dynamics influencing the STIs epidemic. The knowledge will help in assessing the changes that have occurred

over time as a result of previous preventive campaigns. On the other hand, understanding the knowledge gap and attitude of young people regarding STIs will give a blue prints on how to conceptualise subsequent preventive communication campaign. This will enhance the development of information that can persuade and motivate behavioural change among the target audience. What are these factors influencing knowledge and attitude of the young people to STIs?

The figure below summarizes the sub-theme and sub-sub themes that contribute to knowledge and attitude towards STIs preventive communication campaigns.

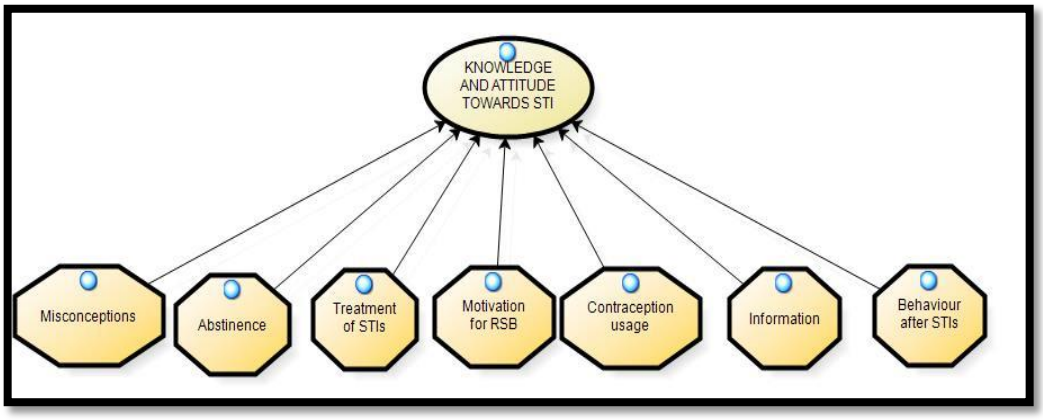

Figure 4.13. Knowledge and attitude toward STIs in STIs Preventive Communication Campaign

4.5.6.1 Misconceptions

Testing the knowledge and attitude of the informants on STIs show both the two groups of positive and negative young people having fundamental misconceptions about, particularly, the ways of contraction of the diseases. In many of the cases, the STIs'

positive interviewees tend to start from the atmosphere of denial, not believing about the existence of the disease to which they later became victim. Hear a sample of their opinions:

> I discovered my HIV status in 2005. Before I discovered about my HIV status, I never believed that the virus exist even though I have the basic information about it (Informant A2).

> What I know about HIV, here is not *Oyinbo* (white man) place, it is *Oyinbo* (white man) people that have those types of diseases, and I don't think people like us can get HIV. It is all those *Oyinbo* (white man) who sleep with animal and all… I cannot get it (Informant A10).

Denial is not restricted to the STIs positive individuals. The negative ones also share the same feelings as the excerpts of the interview below show:

> I don't believe one can just catch HIV through sexual intercourse. I'm not sure because my daddy has not told me that. My daddy does not even believe that there is HIV because… it is not when one has sex that HIV just comes. I even doubt the existence of HIV because I have not even seen an HIV person. I have not seen somebody that has gonorrhoea but I know for sure that gonorrhoea exist. Because my dad has always told me that people come to him to buy drugs for gonorrhoea but nobody has come for HIV drugs (Informant B18).

> The issue of gonorrhoea is an offset issue. We don't consider it as a disease anymore in our society. Either it has been eradicated using some kind of means or the coming of HIV has diminished the existence of gonorrhoea. Perhaps HIV is the advanced form of gonorrhoea. (Informant B14)

Doubt is a child of denial. Here we have seen young people in a state of denial, leading them to being doubtful, particularly of the existence of HIV/AIDS. This denial has led to their having wrong perception that HIV/AIDS is a disease only meant for the Europeans. Going by the response of Informant B18, parents still hold the ace in correctly educating and informing their children. Where parents are correctly informed, the probability of their ability to impart truthful knowledge about STIs on their young ones is high. But unfortunately, the reality is that so far, as Temin *et al.,* (1999) and Oladepo and Fayemi, (2011) warn in their studies, young people in Nigeria still have various misconceptions about STIs. This is a big danger given the level of sexual activeness of the group.

4.4.6.2 Abstinence

A flip side to the issues emanating from the misconception discussed above is abstinence. Evidently, if there is an issue on which religious leaders and the older members of the Nigerian society have a common agreement on, it is about abstinence. They insist youths should not engage in sex, exercise restraint until they are married. The reality is that few of the young people practice abstinence. While some of the informants claimed that they were virgins, others explained that they subsequently stopped sexual relationships out of personal convictions. Pertinent however was the need to understand the position of the young Nigerians about sex and thus the question explored their attitude towards sex. The answers varied thus:

> I don't see myself being at so much risk because I take care of myself very well; I don't go beyond my boundaries, at least I don't have a girlfriend, I never had a girlfriend. Particularly for me, I don't have a girlfriend but I have close female friends that we talk and sometimes shake hands. I have

> casual friends. I have not had sexual intercourse before with anyone. The reason maybe the way I was brought up. (Informant B1)
>
> I have a boyfriend, we have been dating for two years and he said our relationship is for marriage not just normal boy and girlfriend relationship. Besides, my religion is against sex before marriage. He is a graduate and a catholic too so he cooperates. We hug but kissing is out of the line. Before him, I had a relationship too but the thing about me is once I meet a guy who is interested in me, I give them rules and regulations. And if he is okay by it then we go ahead. (Informant B18)
>
> I have not practiced sexual activity before. I have never involved myself in sexual activity before. I don't go beyond kissing. I don't have anything to offer a lady. I can't feed myself two times in a day and I am still living under my parents. The fear and risk of having this virus can make me not to engage in any risky sexual behavior. Money is also a problem. I see relationship as if I'm ready for it, I will know. But for now all that I do is to abstain.(Informant B16)

Here we see good parental background, self-control and strong will exercising influence on the attitudes of young Nigerians to sex. There is also the question of poor financial status, fear of contracting infections, the desire to have the right partner as additional motivations to shun sexual activities. There are those however motivated by personal desire to discontinue sexual relationships after engaging in them.

> I did not stop because of the information from the media. At a particular period in life when you listen to certain program you will be prompt within yourself or you ask yourself certain questions: this act that I am involving myself in is it having any positive impact on my life or am I gaining anything from it. In the process of asking yourself these certain questions,

> you are prompt to sit down, think deep and look for a way forward to live a positive life.(Informant B8)

> I have friends that are ladies; I used to have sexual relationships with them, but currently am not sexually active. Because am… like I said am getting older I feel this pressing need of settling down so I don't think I have any need of sexual relationship now. I stopped say like 2 years now; I have abstained for the last two years… the sex thing is not just coming… I mean I have friends and we just shy away from these activities. (Informant B4)

We see that this situation is mixed grill. In one breath youth do not believe in abstinence. On the other hand, some show the inner capacity to restrain from sexual engagement with the opposite sex for a variety of reasons ranging from parental background, the fear of contracting infections, self-will and control, to their poor financial status. The irony is that these positive attitudes seem not to be widely distributed among the large segment of the younger population lest there would not be the issue of high prevalence of STIs that can only be contracted through risky sexual behaviours.

4.4.6.3 Treatment Seeking Behaviour

The study also explored the "treatment seeking behaviour" of STIs positive groups, that is, whether those infected would voluntarily look for medical treatment. This is important when related to the prevailing atmosphere of stigmatisation, misconceptions, denials, rejection, and the many more that still surround STIs in Nigeria. Majority of the HIV/AIDS positive informants said they had to sum up the courage to go for confirmatory test in another hospital before they accepted their fate. Incidentally, HIV/AIDS treatment in Nigeria is free. The treatment can be accessed in all state

hospitals across the country without payment. But the treatment of other STIs still attracts fees.

The treatment for HIV begins with a patient presenting a guarantor. The guarantor responsibility is to ensure that the patient complies with the treatment regimen, especially ensuring usage of anti-retroviral drugs. If there is discovery of the patient not conforming to the treatment regime, the guarantor's help is solicited to enforce compliance. The HIV patients are not only satisfied with the treatment process but expressed appreciation for the provision of free drugs. However, they feel displeased that they have to take the antiretroviral drugs for the rest of their lives. Another particular area of worry is being faithful to their appointments and follow-up consultations in the hospitals. For some, they are faced with hurdles. Informants 7 and 8 revealed that owing to the stigma that HIV/AIDS still attract in the society, they found it difficult to obtain the necessary permission in their work places whenever they have appointments in the hospital. The reason had to do with the fact that they did not want their fellow employees to know about their status because of the fear of being stigmatised and later dismissed. Therefore, they always attempt to find different convenient reasons or excuses to justify their absence from work in order to meet up with their appointments.

The treatment seeking behaviour of other STIs positive groups was explored. Sharply, this brought to the fore how young people, who contracted, especially gonorrhoea, treated themselves. This is one infection with serious stigma because it is known that it

can only be contracted through multiple sexual partners. In the Yoruba part of Nigeria, for instance, it is called “arun gbajumo” literally meaning “the disease of the elites”. Given below are the feelings of some of the informants:

> I had gonorrhoea when I was younger. I treated it with tablets and local herbs. I got the tablets from chemist. I used local herbs to flush it. The orthodox medications only reduced the disease but the local herbs one flushed everything away from my system. Since then I have been using protection (Informant A10).

> You know doctors, even when a problem cannot be solved, they will tell you it can be solved. They are meant to give us hope; my uncle told me that the best prescription for me is the traditional medicine because the doctors will only give me medicine that will reduce it and later on, it will come back in a harsher way, I decide to give the traditional medicine a trial and it worked very well (Informant A21).

> I had gonorrhoea, it was painful; I was peeing oyun (mucus) and it was very painful. I experienced it for 2 weeks. I did not go to the hospital because my mum told me that the treatment of traditional herbal doctors is faster than the orthodox medications. She took me to traditional herbal doctors who gave me some concoctions and it worked perfectly for me. We did not even plan to go to any hospital. Immediately I told her she took me there. It was not because of money, it is what thought is best for me. In 2 weeks, I had recovered from the infections (Informant A22).

> …as at March this year, I started feeling this itch. On a good day, I thought it was toilet infection because I used the school toilet. I went to get microtone cream from a pharmacy but there was no improvement. After this, I went to get an insertion tablet yet there was no improvement. It was at this point that I decided to go for a medical check-up at the diagnostic

> centre… remember, I told you we don't first go for a test. I went for the test and the doctor told me it was fungi infection and toilet infection. After spending so much money on pills, I even bought one "virgin flush, flucona" and it was reacting negatively on me. So I went to my nurse in the street and she was saying I was not supposed to use that; that it is for those in extreme condition that I should have gone for test first. (Informant A5)

Informant A5 elaborates further:

> After that the doctor told me that it was a fungi and toilet infection I took 'flagile' and some medications like that and it calm down a bit. But after my exams, I went to Lagos and it still came back again. This time it was very harsh and I even had blisters. I was having serious itching and blisters… I couldn't even recognize my private part because it was something else… there were different colours because the itching was very bad that I couldn't even walk well. I called my mum and told her everything and I also explained to my uncle who owns a diagnostics laboratory centre that does all the different tests. We did culture test, and when the result came out, he said it was Staphylococci, African canigitis and some other things, and toilet infection. He gave me medications. It didn't go away immediately; it even delayed my periods… I had irregular periods at that time. The thing lasted for two months and it is because I did not go for the main test that I should have gone for in the first instance (Informant A5)

Evidently, young people avoid hospitals in seeking treatment for highly embarrassing sexual infections like gonorrhoea and syphilis. A female informant said she didn't use the hospital because of the high probability of running into a familiar person. Some alluded this to the stigmatisation that they experienced in the past from medical practitioners, which had become a disincentive to patronise hospital for such treatment. For many of the afflicted, they prefer self-medications or getting treatment from

traditional herbal doctors. Hospitals are usually the last option. The male informants explained that the reason for preference of herbal treatment is that it is cheaper and faster from both the angle of service delivery and cure.

> When it comes to curing STIs I will recommend the traditional medications to anyone experiencing what I experienced. At the first instance, I wanted to go to the hospital but I was wondering what will I tell the doctor was wrong with me… when I went to the traditional herbal seller I didn't feel that way. Despite the fact that she didn't understand English so I went with someone who could speak her language and when I got there she said I should explain exactly what was wrong with me so she will mix the right medicine for me to avoid negative consequences. So I don't know if there is an English medicine that will work but the traditional medicine worked perfectly well for me. (Informant A21)

> The reason why young adults like me don't go to the hospital is because of shame and stigmatization. Another reason might be because we don't want to face the truth; also it might be because when you get to the laboratory you might feel you will meet someone you know there. (Informant A5)

Despite the feeling that self-medication is comparatively advantageous economically, there are potential dangers as evident in the experience of a female informant because it almost backfired on her.

> The infection lasted for two months and it was because I didn't go for proper medication and diagnosis test in the first instance. As students we would say we don't have money but at a point I was blaming myself because the money I spent on self-medications and other medications was more than what I would have spent if I had gone to hospital for real medication when I first noticed the symptoms. Normally it is toilet infection that bothers me but this one was a new dimension and after that I can say

> am better. I will advise anyone having such symptoms to go for a laboratory test in order to find out what is wrong instead of involving themselves in self-medications. (Informant A5)

Nigeria is deeply religious country where religion can be exploited for any purpose. The treatment of STIs treatment is not an exception. Recourse to prayers has been made in a rare case to use religion to treat the STIs, which according to a female informant became her last option when her condition was deteriorating.

> At a time I began to pray, that is why I said it is what you believe in that will work for you. When I started praying I told God to forgive me if I had done anything wrong because I couldn't understand what was happening to me again. (Informant A5)

Of course, the answer is unimportant because superstition and science both exist and have commingled for a long time. What is important is that the lesson is glaring that young Nigerians are aware orthodox treatment exists for STIs in the hospitals. It is also evident that they prefer to opt for self-medication and patronage of traditional health care providers.

Another established fact is that those who even favour orthodox care allege that it is slow in efficacy compare to the traditional system. The view of the Nigerian youth tallies with studies that have shown that young people tend to prefer self-medication instead of orthodox care as STIs health care services tend to be unavailable, unaffordable and inaccessible (Cherie & Berhane, 2012; Garcia, 2004; Mmari & Oseni, 2010; Temin, *et al.*, 1999; Warenius *et al.*, 2006; WHO, 2001).

Aptly, if contracting the disease brings personal shame and embarrassment, if treatment is expensive and prolonged, if cure takes time to come, what lesson does a victim learn at last concerning his/her unflattering past sexual behaviour? Informants A21 and A22 explained that after curing themselves from the infection, they make it a case of "once bitten, twice shy." Since they know that they cannot "stop sexual intercourse with their lovers", they had to make it a habit to "use protections" all the time because:

> That has not changed my sexual activity. Though it was a lesson to me and since then I protected myself with condom because that is the only protective measure I know. It did not make me abstain. The only lesson I learnt from it is to protect myself. (Informant A22)

> After the trauma, I felt that the ladies of today do not need any serious relationship therefore I decided to live a life of Casanova. Now I have girlfriends but I make sure I protect myself when having any sexual relationship with them. Considering what happened before, I have to avoid what happened before so now it's a constant thing. (Informant A21)

The wise learn from the mistakes of the foolish. Youth with multiple sexual partners had better learn that it saves them future sorrow if they take absolute precautions against risky sexual behaviour.

4.4.6.4 Motivation for Risky Sexual Behaviour

The study explored the reason why young people involve in risky sexual behaviour. This is important when related to the prevalence of STIs generally and HIV/AIDS particularly. Majority of the STIs negative individuals who are sexually active give different reason why they involve in risky sexual behaviour despite knowing the grave implications for their actions. Here are sample of their opinions:

However, if I have the intention of marrying a girl, I wouldn't use a condom with her. I have just one serious relationship that I hope will lead to marital bliss and we do have sex together. Therefore I don't use condom during her safe period. Prevention of pregnancy is the primary reason followed by prevention of infection. I know that it is possible for me to get sexual transmitted infection from my fiancé when I don't use condom but I do this because of the trust I have for her. But since i have had several unprotected sex with her and I have never had any infection, therefore this gives me more confidence to continue having unprotected sex with her (Informant B2)

The reason why some ladies or men will have sex without the use of protection is that sometimes they are either carried away with euphoria of having sex or they might prefer that flesh to flesh because it is more pleasurable. Some people believe that condom is of no use because it bursts during the process of intercourse. Also some girls believe that if a man uses a condom on her, he does not trust her and indirectly he is referring to her as a prostitute (Informant B5).

Young people tend not to use protection once they feel that they trust their partner and they believe he/she is morally upright. When they feel that they trust their partner so much they may not see any reason to use protection since she/he is having sex with him/her alone. It can also be because of personal reason, some people prefer to have sex without condom; they feel they get the maximum satisfaction through this means. In such situation we tend not to use protection (Informant B7).

> Some of them who knows of HIV are shy of going to buy the condom. They feel once you go to a pharmacy to buy a condom everybody knows what you want to do. The society exaggerates about people and once you say you are Hausa, you are attached to Islam and everyone believes you should be clean. In such a situation an average Hausa man will not want to be associated with such. Even when it comes to family planning they prefer the traditional means (Informant B12).

There is no doubt that young people still involve in risky sexual behaviour because of different reasons which range from trusting of their partner, pleasure derived from sexual intercourse, being shy of buying condoms from retailers etc. However, involvement in risky sexual behaviour is not restricted to STIs negative individuals only. Few of the STIs positive people also shared the same feelings as the excerpts of the interview below show:

> Talking about sex, it is like a swift force and when it comes on you, you can't think straight. I felt let us just do this and satisfy ourselves and go so at some point the pleasure just will not give me the time for protection. At that moment, it did not occur to me I could get infection. When it occurred to me was when I got it because that was the first time I got such infection…One will use condom because he/she wants to protect his/herself from infection. Some people don't like using condom at all, they prefer flesh to flesh because they believe it is more enjoyable. There was a girl I once had sex with and she said she doesn't like a guy using condom on her that she wouldn't enjoy it. (Informant A 21)

> Before I was confirmed positive, I had had STD in the past. It was gonorrhoea but that didn't stop me from having unprotected sex again. That was last year and I contracted gonorrhoea again this year. It is a whitish

> discharge from the penis. That was how I discovered I had a STI (Informant A1)

In addition, some of the STIs negative informants explained the reason why they will never involve themselves in risky sexual behaviour no matter how pleasurable sexual experience might be.

> I must state clearly that I wouldn't have sex without protection. As a young man that is learned to an extent, I know the implications of having sex without protection so I wouldn't have sex without protecting myself. I have a big dream ahead of me and I wouldn't want HIV/AIDS to shorten the dream (Informant B7).

> Some years back I did HIV test to know my status when I had a girlfriend that was very ill for a long time. She was also losing weight and she was scared that might have contracted HIV through a soldier boyfriend she had in the past. It was in the process of this problem that she told me about her past sexual life because she was scared of going to know her HIV status. This made me to go for HIV test and I tested negative, she later went for her own test too and she tested negative too. That experience made me to change my attitude towards risky sexual behavior because I could have contracted it from the girl then. The experience made me to realize that so many people are prone to the HIV virus, no one is safe (Informant B5)

Observably, there are several motivations why young people involve or would not involve in risky sexual behaviour. For instance, several scholars have explained that young people involve in risky sexual behaviour as a way to develop certain competencies or skills, to meet intimacy needs, or to cope with dysphoric mood (Chassin, Presson & Sherman, 1987; Cooper, 1994; Cooper, Shapiro, & Powers, 1998).

4.4.6.5 Contraception Usage

If sex had become a diet that the youth must feed themselves, why can they not take the precaution of employing the use of contraception? Afterall, there are wide range of

contraception methods today to which the young people are exposed to. In the first instance, it is hypocrisy not to admit deep knowledge of the variety of contraceptive methods among the young people. The question is, which of these methods is popular among the youths?

Firstly, the study reveals that young people are aware and use different preventive methods. Secondly, the goal of using the contraceptives is to prevent pregnancy and STIs. Thirdly, it emerged that young Nigerians make use of not only condoms but also withdrawal sexual method as well as hormonal contraception drugs. Fourthly, all the young Nigerians interviewed admitted condom to be the most popular contraceptive. Few of the ladies mentioned hormonal contraception drugs used immediately before or after sex for the prevention of pregnancy. Fifthly, the range of opinions expressed show that the type of relationship that young people are involved in determined whether they will use contraception at all, and the type of contraception to use.

> However, if I have the intention of marrying a girl, I wouldn't use a condom with her. I have just one serious relationship that I hope will lead to marital bliss and we do have sex together. We have been in this relationship for about three years. I started having sex with her after 5 months courtship and that shows that she is not the promiscuous type. We use condom once in a while and the main reason for using condom is to prevent pregnancy. I know that when a woman finishes her menstrual period it is easier for them to get pregnant for at least 3 days afterwards. Therefore I don't use condom during her safe period. (Informant B2)

> Young people tend not to use protection once they feel that they trust their partner and they believe he/she is morally upright. When they feel that they

> trust their partner so much they may not see any reason to use protection since she/he is having sex with him/her alone (Informant B7).

Carter *et al*. (2012) and Reis *et al.* (2013) were quite correct in their affirmation that the main reason why young adults use contraception was for protection against pregnancy not for HIV/AIDS infection.

The salient points raised in this concluding section highlighted the positive points that there is consciousness among the young people on the necessity to prevent the transmission of STIs which was buttressed by their choice of using contraceptives. Quite a large proportion of the informants – as typified by Informants B5, B6, B7, B9 and B10 – see contraceptives as a necessity even when there is mutual trust and love among lovers. The goal is to ensure absolute protection:

> I must state clearly that I wouldn't have sex without protection. As a young man that is learned to an extent, I know the implications of having sex without protection so I wouldn't have sex without protecting myself. I have a big dream ahead of me and I wouldn't want HIV/AIDS to shorten the dream. I have been using protection 100 percent since I started having sex. (Informant B7)

> I don't think I can have gonorrhoea. I have a boyfriend. We have been going out for like two years. He is working in Lagos while I school in Abeokuta. He has demanded sex from me before and we have had sex together. We prevented ourselves all the time. We use condom because I can't even count how many times we have had sex. He sometimes told me he didn't want to use condom and I refused because I wanted to protect myself from not just STIs but also pregnancy. You know pregnancy and schooling at the same time wouldn't be easy. I mean we are not married and I don't know if he is

faithful. Trusting him isn't the issue but whether I trust myself because I may decide not to go somewhere and before I know I change my mind; if I tell him I love him and some other guy I like comes around and I like him am likely going to leave… (Informant B10).

I have just one girlfriend. I do have not two girl friends at a time. I am a one girl person. I do have sex with my girlfriend and each time we do we always use condom. The girlfriends that I had in the past, I have always use condom with them anytime we were having sex. The primary reason for using condom is for the prevention of pregnancy. I have never thought about the fact that it can be used to prevent STIs. I have never contracted any STIs since I have been sexually active. (Informant6)

Before now I used to have impression that once a girl is good in character and from good home that means she is clean and safe. But now I have a different orientation on the whole issue. Some years back I did HIV test to know my status when I had a girlfriend that was very ill for a long time. She was also losing weight and she was scared that might have contracted HIV through a soldier boyfriend she had in the past. It was in the process of this problem that she told me about her past sexual life because she was scared of going to know her HIV status. This made me to go for HIV test and I tested negative. She later went for her own test too and she tested negative too. That experience made me to change my attitude towards risky sexual behaviour because I could have contracted it from the girl then. The experience made me to realize that so many people are prone to the HIV virus; no one is safe. (Informant B5)

Hausa people also try to prevent STIs traditionally by putting on igbadi (a waist chain) around their waist. They have this notion that if they want to have sex with a lady and she is already infected with a virus, the igbadi around their waist will signal to them that the lady is infected and the man

> will know that he has to quit. Some people even eat up some charm that will make them know if their sexual partner is STIs positive. The man will know if his penis refuses to erect or something just happened to cut the show or excitement somehow (Informant B5)

Whether relying on the time-honoured mode of modern-day contraceptives or the traditional version, the fact that there is positive appreciation of the dangers involved in unprotected sex is a good plank to build culturally sensitive STIs preventive communication on in Nigeria.

4.4.6.6 Information

This section looks at the information which young people build their knowledge about STIs. As it is frequently said, information is power, and when the young ones are empowered with correct knowledge of the nature and character of STIs, the inference can be made that they would most probably be able to act in effective ways that can help prevent their vulnerability to sexually transmitted infections.

The data from this study show that young Nigerians have more knowledge about HIV/AIDS. Unfortunately, this does not extend to other sexually transmitted infections. Majority of them know how HIV/AIDS is transmitted, that is it could be prevented with condoms and through abstinence. Such knowledge displayed about HIV/AIDS does not extend to gonorrhoea, syphilis, herpes, hepatitis B, which are equally as dangerous as STIs, to which they are vulnerable. It has to be acknowledged though that a few of the young people knew that herpes and hepatitis B virus are sexually transmitted. But how

much of correct information is at the disposal of these young ones? A sample is this offer of opinion on some of the diseases by the STIs positive individuals:

> What I know about HIV/AIDS is that it makes an individual to take medication often. I don't know about any type of STIs aside HIV. Using condom is the way to prevent HIV. I don't know the difference between HIV/AIDS and STIs (Informant A17).

> I know of HIV/AIDS and gonorrhoea. The symptoms of HIV/AIDS… once you are affected your body starts changing in the negative aspect like rashes; your lips starts changing to white and you start reducing in your weight (Informant A21).

> STI is the infection that individual contract through sex. I know of HIV, gonorrhoea, lice, and syphilis. That is all I know. HIV is the disease that a male can get from female and vice versa if they don't use preventive measure such as condom. It can also be prevented if the man do not release into the woman. Gonorrhoea can also be contracted through sex and also through sharing of towel and panties. The symptom is scratching of the private part. Lice have to do with insect that live in the head of people. It can later transmit to the body. Syphilis too is through sex and the symptom is scratching of the private part. Gonorrhoea manifests earlier on the male than the female (Informant A18).

> Actually, STI/STD is a disease that could be contracted via sexual relationship with people or by sharing sharp objects. I know very few… I think I know of herpes, the common HIV, those are the two, I remember right now. HIV is common due to huge awareness and its becoming rampant as it took us unawares. To me it is a virus contracted through sexual intercourse. It can't take life (Informant B4).

> STI are diseases that are transmitted sexually which are gonorrhoea, staphylococcus and HIV/AIDS. I don't know anything about staphylococcus but I know a little about gonorrhoea (Informant B5).

There is no doubt that the awareness rate of HIV/AIDS is high in Nigeria compared to other sexually transmitted diseases (Ayankogbe, Omotola, Inem, Ahmed & Manafa, 2003; Obiechina *et al.*, 2001). The same high level of awareness distinguishes Nigeria relative to other countries (Awang, Wong, Jani, & Low, 2013). In fact, HIV/AIDS enjoys high media attention and visibility in Nigeria. This is both good and bad. It is good because it has helped increase the depth of information available to the public. The bad side is that the under-reporting of other STIs has led to poor understanding of the various components of the diseases. With the paucity of information on them both public opinion and public policy are low. While interventions designed to increase knowledge of HIV have made a remarkable impact, the same cannot be said of other STIs. Yet, evidence exists that some of these under-reported sexually transmitted diseases have grave risk to the adolescent reproductive health. Consequently, efforts have to be made to encourage Nigerian media to step up their coverage and reportage of the STIs that have not enjoyed high media visibility. It is the way to beef up the information at the disposal of the youth, which will empower them in taking informed decision about their sexual behaviour.

4.4.6.7 Behaviour after STIs

The data from this study revealed that majority of young people who are STIs positive were not deterred from involving in sexual activities after discovering their STIs status.

However, the experience made them to be extremely careful when involving in sexual activities.

> After the trauma, I felt that the ladies of today do not need any serious relationship therefore I decided to live a life of Casanova. Now I have girlfriends but I make sure I protect myself when having any sexual relationship with them. Considering what happened before, I have to avoid what happened before so now it's a constant thing (Informant A21).

> That has not changed my sexual activity. Though it was a lesson to me and since then I protected myself with condom because that is the only protective measure I know. It did not make me abstain. The only lesson I learnt from it is to protect myself (Informant A22).

The salient point discovered in this section is that young people may not be able to stop their involvement in sexual activities but they can still be persuaded to protect themselves while involving themselves in the pleasurable sexual experiences.

4.4.7 Adequacy of Message

If as adduced that there is a mixture of ignorance and illiteracy on STIs among Nigerian youth, is the problem pertaining to the adequacy of the messages that the youths are being exposed to? Alternatively, do other factors account for the shortcoming? From the perspective that the essence of a message is to convey information, the answer will tilt more towards the former than the latter. Put aptly, there is problem with the adequacy of the messages being conveyed on STIs. Informants were honest by suggesting that the STIs information that they were exposed to is out-dated, while there is also over

saturation of HIV/AIDS messages being furnished to the public. The two factors are the issues at stake as in Fig. 4.13

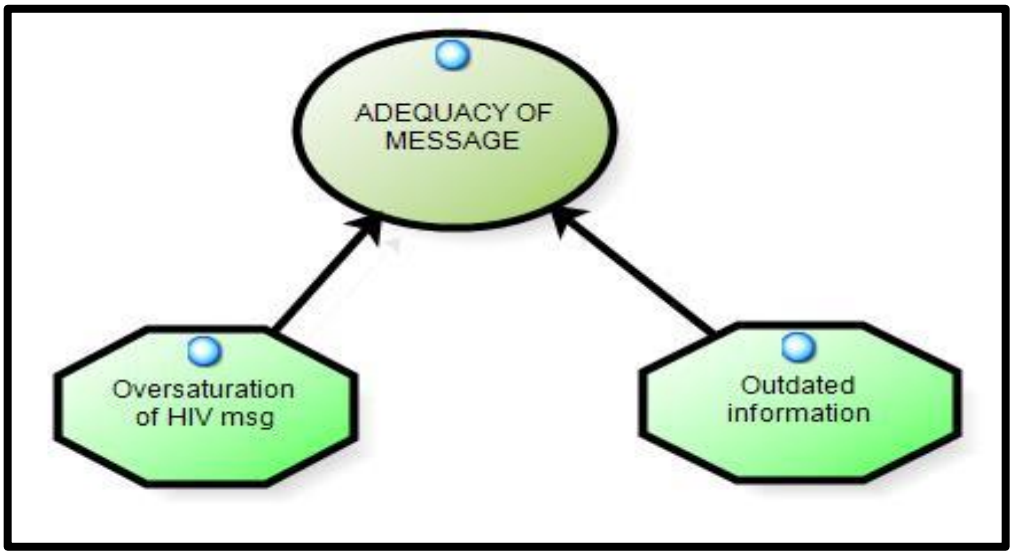

Figure 4.14. Adequacy of message in STIs Preventive Communication Campaign

4.4.7.2 Over-saturation of HIV/AIDS message

The question asked from the informants was which of the messages on STIs have they seen? A substantial percentage indicated the HIV/AIDS advertisements. Almost every one of them said they were not exposed to other forms of STIs' messages. The evidence of over-saturation of the public with HIV/AIDS messages was overwhelming. Many of the informants had perfect recall of the constancy with which they encountered information on HIV/AIDS through the media. This is evident from the following quotes:

> I have seen adverts on HIV by one of the health organizations. I can't remember if I have seen advertisements of other STIs, it is mainly on HIV… that's another weak point of the campaign… most people don't know of chlamydia, Herpes, gonorrhoea, and the likes. (Informant B4)

> I have seen advertisements on gonorrhoea and syphilis on television but it has been a very long time (7years ago). I see advertisements of HIV very often on the various mass media. (Informant B9)

Observably, there is nothing recent in this development. For, the imbalance in media focus and attention has, at varying times, been pointed by Obiechina, Nwosu,Okafor and Ikpeze (2001), Samkange-Zeeb, Spallek and Zeeb (2011) and Temin *et al*. (1999). They drew attention to the fact that majority of the young people had more knowledge of HIV/AIDS due to their exposure to mass media messages. It is evident from the above that concerted action is required on the part of the media practitioners, STIs campaign planners and policy makers to correct this anomaly. The gap has to be filled by balancing the media messages that the public is exposed to on STIs. This is the way to equip the younger population with information about the various STIs.

4.4.7.3 Out-dated Information

Even if the inherent imbalance is corrected, an additional problem must be solved. It pertains to ensuring that the information being purveyed is current. As at now, the view of many of the young Nigerians is that the public is fed with obsolete and out-dated messages. What they need is fresh and current information on STIs. Without this freshness, the messages would serve little purpose of educating and enlightening them. As claimed by informant A15, ‘‘I feel all the information that the mass media is disseminating are all stale news. There is no new information’’. A number of others such as informants A16 and B7 added more a critical note on the adequacy of the messages being disseminated:

> The information I had before I tested positive were minor ones like HIV is real. It was after I tested positive that I started having real information about the disease from the hospital. (Informant A16)

> The advertisements were only talking about abstinence. People need to know something better than what they are giving us. They should let us know everything important and also current information. The information that they are giving us is so obsolete. There is a need for more researches to be made that will put so much fear into people's mind. (Informant B7)

For the media, the challenge is for them to eschew the repetitive nature of their information. The information are not adding anything of substantial value to what many already know about STIs such as HIV/AIDS, which the public know is an infectious disease that can be contracted through sex, and that it is a killer disease. The young people advocated for innovation, such that media practitioners and STIs campaigns planners would come up with information that can fill the knowledge-gap of the young people. Amongst others, they look forward to the mass media messages focusing "more attention on the transmission of mother to child. It is important for every expectant mother to know this" (Informant A8). In the same way too is the problem of "Stigmatization [which] should be reduced in the society. The advert should address issues relating to that" (Informant A2). In a plain language, as a critical arm of the society, crucial to moulding opinion in the society, the Nigerian media too have a challenge to overcome if there is to be decompression of the continuous rising graph of STIs.

4.5 Theme 3: Media Channels in STIs Preventive Communication

The last but not the least of importance in the thematic focus of this study is on channels that are appropriate in the communication of the preventive messages on STIs. Why are media or channels used in communicating STIs preventive messages of importance? It is for the simple reason that they determine the probability of the recipients of the messages to be exposed to the messages disseminated. As used appropriately in this section, the media vehicles are like the blood arteries in the body supplying the vital ingredient to other parts of the body to function. Through the media vehicles, the people get the required information. The mass media have the capacity to reach a large proportion of the population. It is what has given them their distinctive advantage over the inter-personal communication. Hence, this theme substantially answers research question three.

The varieties of existing media can be grouped into the traditional mass media, the new media and the inter-personal communication channels. Every of these is amenable to, and being used, in communicating STIs preventive messages. The knowledge of the media or media mix through which young people derive their information, will determine the best route or media to disseminate information to them. Applying the Nvivo 10 Software in defining the thematic analysis of this section, three significant variables were settled for as intervening in the relationship between the media and the dissemination of STIs messages within the context of cultural sensitivity. The variables are: better media strategy, limitations of the mass media, and the intertwining issue of sources of STIs messages meant to be used by the media. How these issues interface with the communication of STIs preventive messages through the media and within the

framework of how the informants in this study see the outcome are explored below.

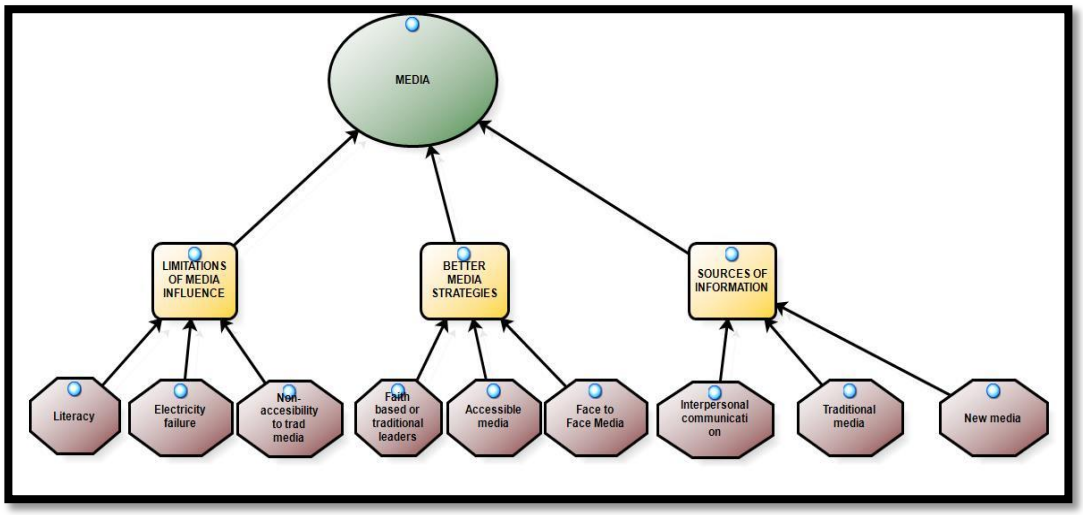

Figure 4.15. Main theme and sub-themes of media in STIs communication

Figure 4.15 presented above show how the three sub-themes that the media as a theme has generated. The first of these – limitations of the mass media – leads the exploration of the theme.

4.5.1 Limitations of Media Influence

The first important question is ascertaining whether the young Nigerians that the study focused on understand that the media do have limitations, which naturally are bound to affect the way the media meet their expectations. Their response, which cut across board of STIs positive and negative individual generated three issues or problems identified as constraints to the effectiveness of the media. The issues are: (a) literacy; (b) electricity failure and (c) non-accessibility to traditional media. The issues are graphically depicted

below.

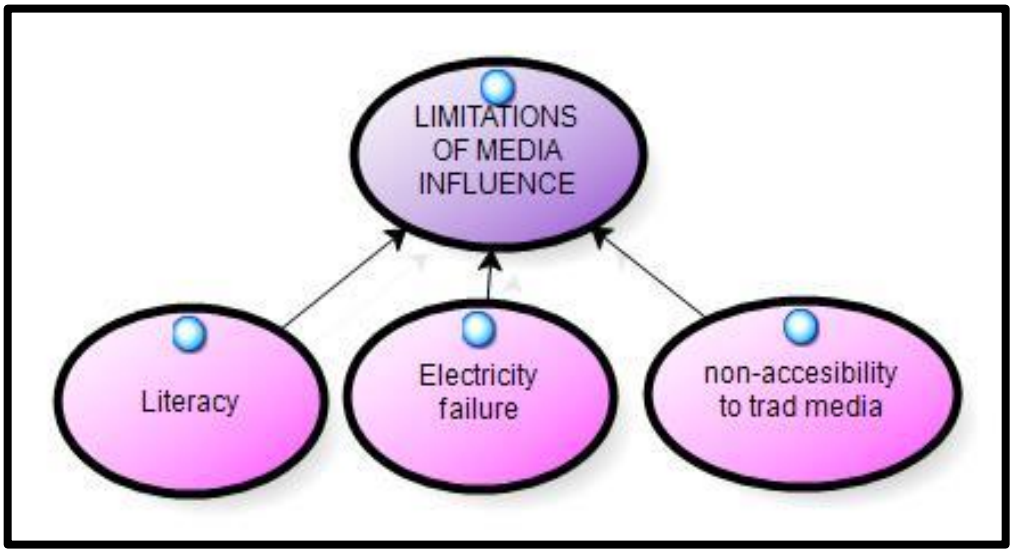

Figure 4.16. Limitations of Media Influence in STIs Preventive Communication Campaign

4.5.1.1 Literacy

Beginning with literacy, informants (both STI negative and positive) expressed that their level of education determines their access to the information disseminated by the mass media. Naturally, illiteracy precluded those who cannot read and write from certain media. For this category of people, the media generally have low utility as regards their information consumption ability. Unexpectedly, the print medium was rated the lowest because of its inherent disadvantage to the illiterate population. Informant 9 asserted that the print medium has the greatest disadvantage because it is in written format and some people cannot read. Unfortunately, the number of indigenous language or community-based publications in Nigeria is extremely low. Consequently, the print medium lacks the potential benefit of wide penetration among the population. It is an elitist medium

with no appeal to the mainstream population. The level of information derived from it is low as testified by informant B1 whose view goes thus: "The advert don't have much impact; if one is uneducated, he/she may not be able to decode the advert or even read the language." Another informant (Informant 9) emphasised that "The main disadvantage of the print media is that not everyone can have access to it and not everyone can read and write"

Without over-stressing the point, it is important that STIs campaign planners be judicious in the media choice. The prudent use of resources dictates that media selection be based on rational consideration of the media that young people can have unrestricted access to. Furthermore, language is important. Many of the informants expressed the view that they simply did not understand programmes broadcasted in English language though they were exposed to them. Exposure to, and reception of, information are two different things. The objective of any information is to arm every potential individual with facts. It is therefore important that all bottlenecks hampering effective reception of media message be eliminated. The experience of the women from Igueben village is instructive. Ovbiebo (2011) found out this group of Nigerian rural women remained vulnerable to HIV/AIDS because they were not being communicated with in the language they understood. They therefore lacked the education and knowledge that could have made them take reasonable precautionary measures against the disease. Massiah (1997) discovered the same thing about the women of Plateau State in Nigeria. The lack of literacy to access information and knowledge rendered them to continue to

be preys to diseases which had known cure and prevention methods. Nigeria has to break this jinx of perpetuating ignorance in the midst of knowledge.

4.5.1.2 Electricity Failure

The notoriety of the Nigerian energy sector with the constant electricity outages is well known. Of what relevance is this to STIs preventive communication? It is because it affects the people's access to the broadcast media. The broadcast media – radio and television – are powerful instruments of change. Apart from combining sight and sound, radio in particular, is cheap and pervasive because of its reach and capacity to reach a wide audience including the rural dwellers. Unfortunately, the epileptic supply of electricity curtails the ability of the people to have access to the broadcast media. According to Informants A15, A6 and A13 electricity constitutes the main hurdle in their accessibility to television and radio messages, which are free, cheap and convenient way of getting information on STIs. Informant A6 put the issue in its right perspective as the informant affirmed that though television serves as a good vehicle of communication, however, gaining full access to it is restricted because of the financial implications of constantly fuelling a generator to supply the needed electricity to power the gadget. This adverse effect of poor and inadequate electricity supply has been found by Nwagwu (2007) as a major factor obstructing the effectiveness of the broadcast media as vehicles of passing across the reproductive health information to young people, which could have assisted them in making informed choices.

4.5.1.3 Non-accessibility to mass media

The last of this tripod pertains to non-accessibility to the mass media by the people. To clear the ambiguity that may surround this issue, the question of non-accessibility is about obstacles coming from the people themselves in making use of the mass media as the vehicles for them to be informed, educated and enlightened on issues of personal and public importance. In the first group are informants who indicated that they rarely use the traditional mass media because of their tight work schedule. Informant A12 typified this group of people. She is HIV positive but maintains that as a trader it is a luxury for her to use the mass media. Besides the pressure from her daily vocation, other competing engagements from her various domestic and business obligations take the greatest part of her time. Hence, she hardly has the time to devote to the media, which has not assisted in her obtaining first-hand information from the media.

> I don't listen to radio at all so I don't hear adverts. I sell clothes which are ankara and lace. I don't really watch the television but it is one or two people who tell me about HIV and AIDS. I go out in the morning and come back in the night so I don't watch TV at all. There are so many people that talk to me about HIV, which is how I get to know about information regarding the disease. Most of the time, I don't listen to radio neither do I watch television. (Informant A12)

Informant A12 is not alone; there are others in the group with the same argument of time constraint as limiting their access to mass media information. However, slightly different from this group, is the class of those who selectively use the media. The orientation of this group is to use the media as occasions demand. The reasons for the selection of

programme to watch or listen to differ among the group as testified to by the excerpts below:

> I don't watch television neither do I listen to radio. I only listen to a particular programme of radio on Tuesdays and I watch only home video on DVD. I do not have the luxury of watching television or listening to radio because I get back from work very late. (Informant A20)

> I cannot be taking transistor radio around with me because I am not an old man. It is only old people and those Hausas that have radio as their companion. I only listen to music that I downloaded on my memory card of my phone. I do not use the radio on my phone to listen to any news or current affairs…..The only thing that I regularly listen to on the radio is the newspaper headline that is being broadcasted at 9 a.m. daily. (Informant B B6)

> Though I don't watch the television very often… I watch it whenever I want to watch my favourite programmes… I don't read newspapers… I get opportunity to read newspapers when my dad is back from his work station; I don't listen to radio because I don't have one. (Informant B1)

The third group are those whose lack of access arises owing to being away from home. Majority of this category of people are students in the tertiary institutions, they complain that they do not have a television or radio set while some of them explained that they have limited financial resources to buy newspapers. As informants in this group say:

> Have I been exposed to STI advertisements before? I can't remember. I have seen advert on HIV/AIDS before but I can't remember seeing that of other STIs! Let me say the last time I saw it was the last time I watched television and that was last year when I was at home. I don't have television

> or radio in my apartment in school but I sometimes read newspaper in the school library. (Informant B13)
>
> It has been long I seen these adverts because i don't have a television in school that I can watch. (Informant B3)
>
> The only time I watch television is when I am back at home. Even at home we rarely watch local television stations we majorly watch satellite television and sometimes I listen to news on my radio. (Informant B10)

There is no running away from it that young people do not have adequate access to the media. The reasons are varied and multi-dimensional. However, the effect is the same, in the sense that STIs preventive messages are being lost to this segment of the population.

4.5.2 Better Media Strategies

Behaviour Change Communication (BCC) is about changing behaviour whose pivot is the media. With an effective media, BCC brings effective change to knowledge, attitude, and behaviour of the people. It (BCC) rests strongly on the use of multiple media, that is, a variety of media types, mixed and combined in different proportions, depending on a chosen medium's inherent strength and potentials. At the back of BCC, is message penetration and reinforcement in ways that reach and influence the target audience (Piotrow *et al.,* 1997). This section explored how media strategies can be culturally used towards improving the STIs campaigns in Nigeria. The diagram below highlights the connective links of the issues in discussion.

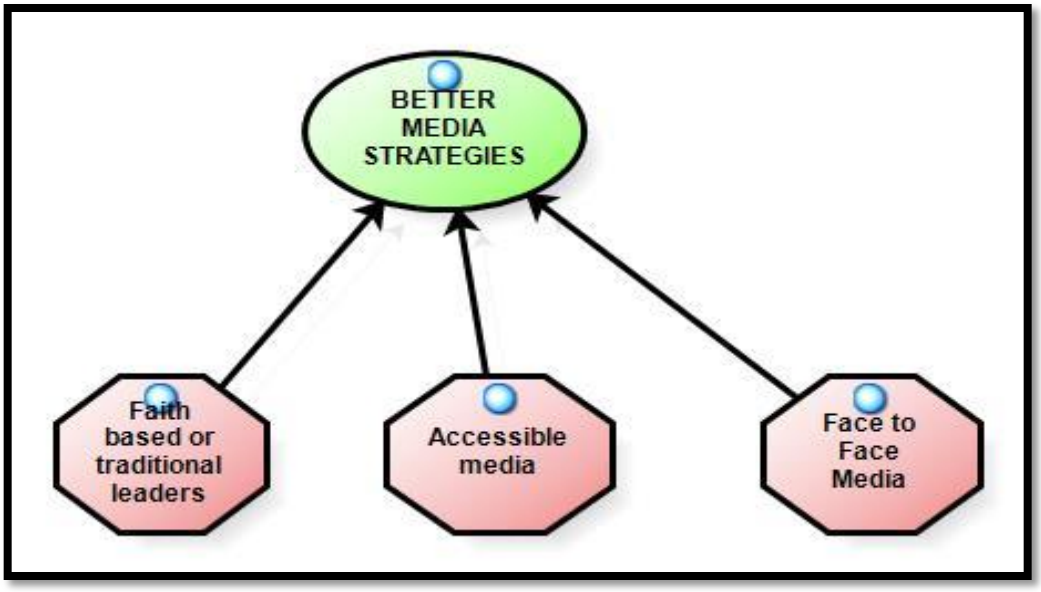

Figure 4.17. Better Media Strategies in STIs Preventive Communication Campaign

4.5.2.1 Faith-Based and Traditional Leaders

Some of the informants however advocated incorporating faith-based and traditional institutions, saying that they provide better vehicles to disseminate STIs messages in Nigeria. They explained that people are easily swayed by the opinion of the religious and traditional leaders. Nevertheless, the point was made that selection has to be done in a circumspect manner, ensuring that only religious and traditional leaders with influence and integrity are chosen for the STIs campaign exercise.

> . . . Nigerians are religious people and they always believe in whatever their pastors tell them. The religious people can talk from their pulpit or through the various religious programmes… on television and radio. (Informant B9)

> The use of traditional rulers and religious leaders must be encouraged. These leaders must be used to pass message concerning HIV to people, since they are responsible and well respected people of the society. (Informant A2)

> The use of channels such as the traditional rulers and imams can make a remarkable impact because of the strong hold that these people have on their subjects. The have better approaches to reach those people in a way that the message will be effective. (Informant B12)

Informant B12 further explained that people will be tremendously convinced by the words of the religious and traditional leaders because they do not have confidence in the words that come out of the mouth of government personnel and foreigners. He explained that numerous failed promises from government personnel are the reason why people are sceptical. He also stressed that the people also have suspicion for foreigners; hence it is advisable for campaign planners to use someone who looks like people that the message is meant for.

> The people don't trust the government or NGOs so there is no need to bring in the government. An educated fellow like me may be able to understand the motive of government but ordinary people on the street are suspicious of every idea of the white men. People believe more in the Nigerian people than that of the outside people (Informant B12)

Similarly, the findings on religion and protective behaviours towards AIDS in rural Senegal revealed that religion has the tendency to modulate preventive behaviours (Lagarde, *et al.,* 2000). With the convincing evidence from Senegal, Nigeria can borrow a leaf on how to put the religious institution to good use in containing her rapidly growing STIs population. The recommendation that evolved therefore was that efforts should be intensified to involve religious leaders at the local level in the bid at curtailing STIs like HIV/AIDS (Lagarde, *et al.,* 2000).

4.5.2.2 Accessible Media

Despite the fact that face to face communication has proven to be an effective weapon, other media's potentials will also have to be exploited in order to arrive at the required rich media mix. The informant explained that STIs campaign will be more effective if campaign planners make use of some accessible media. To the informants, accessible media refers to media vehicles which are easy in terms of accessibility and availability thereby demanding little or no effort. According to some of the informants, whatever the limitations confronting the radio at present, it is still a vital and versatile medium in behaviour change communication. As Informants A21, B2, B1 and B3 rightly observed, radio remains a medium of strategic importance because of its economic value to them. This is evident from the opinion of Informant B3:

> . . . is suitable . . . because of [its] accessibility and portability. We can listen to radio even through my phone . . . . Even we students have phones with radio. We can listen to it even in the class. Television is expensive. Radio is…. an effective means of disseminating information on STIs messages. (Informant B3)

Furthermore, in terms of comparison:

> Considering the different mass media . . . TV, radio, newspaper, etc. the most effective ones have been radio and TV. The newspaper has not been able to do this very well because exposure to newspaper is limited to businessmen and the older people and few of our male youths only buy sport newspaper. (Informant B1)

Actually, amazing has been the results achieved when the effectiveness of the radio as a tool of achieving behaviour change was measured. A study conducted by Karlyn (2001) showed that radio campaign contributed to individuals changing their sexual behaviour. Similar startling result was recorded by the study conducted by Bessinger, Katende and Gupta in 2004. Their results indicated that the exposure to behaviour change messages especially through the radio had strong influence on the people having higher condom knowledge and eventually resolving to use the protective contraception.

In addition, the data in the study shows that television still retains its prime respect as one of the best forms of communication of STIs preventive message. The attraction of television may not cut across all age groups or socio-economic class, but to its patrons, it is still the incomparable medium of audio and vision qualities which made outstanding. Its advocates found its ability to reach the illiterate and the educated, the young and the old, the rich and the poor, admirable. Television has the capacity to make STIs information to be more comprehensible as a result of its qualities of sound and picture; it can excite the illiterate dramatically and it draws out the educated powerfully, too. Informant A6 adds that, ‘‘…there is no house in Lagos that does not have a television set, so a lot of people can learn through it.’’ But it is not just Lagos or other cities and big towns in Nigeria that television is pervasive. In fact, there is hardly any part or home in Nigeria where television is a scarce commodity or luxurious family possession.

The views of informants B17, A19, B8 and A13 also seem to support the preference for television as the best form of communication on STIs issues. Informant B8 expressed

that television remains the best medium because of its capacity to show the effect that HIV particularly has on people. Similarly, Informant B17 also said that television is the best medium; however his main regret about the choice of the medium was the inconsistent electricity in Nigeria. He argued that this problem restricts the access that people have to the medium. Despite the setback mentioned by informant B17, informant A13 explained that television is a good form of communication because Nigerians do not have a good reading culture; hence, they are easily attracted to captivating pictures that give them information that they need at a glance.

Now, to the contemporary media – the social media – whose discussion is indispensable because of the revolution it has created in the world of communication and the way people relate. Not only that the social media has redefined media use and reach, it has added additional value of spontaneity and cross-cultural projection of issue. Popular platforms like the Facebook, Twitter, Badoo, Whatsapp and the internet generally, apart from connecting at a touch of a button to millions of young adults, they also provide a welter of health information at an incredible quantity and quality (Korda & Itani, 2013; Neiger et al., 2012) They are veritable means through which information on STIs can reach young adults. It would not have one of the greatest surprises if young Nigerians have failed to identify them as part of the basket of the best media outlets to connect with them. With an almost unanimity, especially among informants at the tertiary institutions, they identified the social media as sources through which they access information, particularly, the internet, which they say command wide usage among them. To Informant A2,

> Young people are very active on the social media. It is very important for governments to bombard people with STIs information on (sic) these avenues. (Informant A2)

Informant B13, who is also a student of a tertiary institution, was full of gestures throughout the interview corroborated the statement made by the above informant. However she has additional information to share, she coughs and said:

> ….the best media to use is social media like facebook, badoo, twitter and bbm because if I say radio and television I may not get the information well. The traditional media have tried but the efforts have to be improved on. Their messages should not only be restricted to HIV/AIDS, they should also talk about other diseases, like gonorrhoea and the likes. (Informant B13)

There is no doubt that internet may facilitate health promotion among people. It is true as Bull, McFarlane and King (2001) did discover. The proviso is that used singly it may not achieve maximum effect. The study revealed that it needs to be augmented with other sources in the provision of STIs information. And this stands to reason because recipients have wide latitude in the choice to read or discountenance such mails. The same care is required in the use of mobile phones, which received endorsement of some of the informants. Informant A4, for instance, believed that the potential of the mobile phone lay in the fact that almost everyone has one. As he pointed out:

> The government agencies in charge of HIV can get the information across to people through their phones. MTN does something like that called health tips. (Informant A1)

But the question he failed to answer is the fact that not every mobile phone user is literate. Therefore, the ability to read the short message service (sms) will be limited.

Indeed, the findings of Akinfaderin-Agarau, Chirtau, Ekponimo and Power (2012) have settled the puzzle. In that study, the researchers discovered that young people in Nigeria despite their huge ownership of mobile phones, they do not use them to access reproductive health information and services. Among the barriers they discovered, were cost of service, poor marketing and publicity, socio-cultural beliefs as well as infrastructural/network quality. The answer again is neither here or there. It simply reiterates the fact made earlier that no one medium offers the excellent vehicle in undertaking a behaviour change communication. Rather a combination of media confers the best possibility.

Pamphlets, brochures, campaigns, news coverage, internet, social media, mobile phones, workshops, rallies, seminars, festivals, in fact, the range of available media is endless. In the words of Informant B4, to which no other better summary could be found,

> The government should be involved; banks, transporters, advertising agencies, media, school authority, religious bodies, etc. should be involved. I have a strong belief that what one sees every day and everywhere has a considerable impact… but STI campaign is a monopoly of few organizations… the channels are not adequate and the message is not getting to everybody. Let older people be involved in the campaign it should not be a youth thing alone… they should have like a seminar, go to communities talk to people, show them the impact and consequences of STIs especially HIV/AIDS. It may not be advisable to show them visuals because young people may take the negative aspect of the visuals… interpersonal communications generally. (Informant B4)

Similarly, informant B11 also explained the several strategies through which STIs information can be effectively passed across to people:

> Information on HIV can also be passed across to people through the Imams in the mosques and also through group communication. In order to ensure that people listen to the information that is about to be passed across to people in the viewing centre, the organisers of the campaigns will pay for the fee of each individual. The information on STI is normally passed across to the young men just before the start of the football. Aside this strategy another strategy is the Hausa films. It can be used because normally a lot of people have interest in watching Hausa film. Also in schools they can have HIV club like the press clubs. They can be asked to present shorts dramas on HIV during children's day or important programmes. All these strategies will help a lot. In anything you are doing that involves people, there is a need to motivate people to listen attentively to what you are talking about. Another good strategy is to show a short film on STIs just before the beginning of a football match that has been paid for in viewing centres. This strategy is very strategic because it will make the people to give them their listening ears. The polio vaccination did something similar to that when they give the people a mosquito net once they bring their children to get the polio vaccination. (Informant B11)

In support of this assertion, Keller and Brown (2002) argued that the various mass media can potentially change the way people think about sex through a variety of channels-small media (e.g., pamphlets, brochures, and the Internet) and mass media and in a variety of formats such as campaigns, news coverage, and educational messages inserted into regular entertainment programming.

4.5.2.3 Face to Face Media

The data analysis shows a sizeable number of informants believe that face to face communication is more suitable compared to the traditional mass media. The reason for this assertion by STIs positive informants, who are also members of one of the HIV support group, revealed that inter-personal communication is more amenable to sharing sensitive information like STIs though the channels of reaching the audience may be varied. From the informant's experience:

> The messages can be passed across through street campaigns. I have participated in such campaigns on several occasions. I participated in the one organised on HIV day celebration last year. At the street shows, we distributed flyers, share T-shirts, and distribute condoms. During the street show procession some people could not believe that people like me is HIV positive, they were telling themselves that we were doing the rally because of the monetary gains. The truth is that some people do not believe that HIV still exists. We have gone to brothels to campaign to the prostitutes. This street shows is very effective because we meet people physically and we talk with them. We were also advised to bring anyone in our neighbourhood that manifests any symptoms of HIV to the hospital. Some people believe that if they were taken to hospital and it was discovered they are positive, they would be detained in the hospital ward. I have taken several people to hospitals, and they were tested positive, and some of them have been taking their drugs regularly. There was a particular man that I advised to go to hospital but he said he wouldn't go to see the doctor. The man later died. (Informant A15)

Informants B10 and B6 corroborated the view shared by the above informant on this point. The two informants stressed the importance of making use of face to face

communication in the dissemination of STIs messages. Informant B10 affirmed that the use of traditional mass media is not enough. According to him, the use of face to face communication vehicles are more impactful because when people listen to STIs messages in a seminar or workshop they can ask lots of questions during the question and answer session. In a simple but firm statement, informant B6 said:

> I say this is the best form of message dissemination because most people do not have the opportunity to be exposed to information on radio and television. Most people are so busy, they are always on the move and this prevents them from having access to information on radio and television.

As previously indicated, BCC thrives on appropriate media mix. The argument that face to face communication is effective in the dissemination of STIs messages is valid and incontrovertible. The strategy has proven effective in some circumstances. For instance, the use of face to face communication creates better impact when people can listen and ask questions as in seminars or workshops. Such interaction affords the participating individuals the opportunity for reflection and introspection when they get home. They can also pass the information to their friends and family members, and thus help quick diffusion of information and messages. A study by Sznitman *et al.* (2011), indeed, show that Community-based STIs Counselling programme can achieve significantly, however, its effect can be short-lived in terms of reducing the sexual risk behaviour of already STIs-positive youths. A complimentary study by Muchini (2011) in Zimbabwe similarly found that behaviour change can occur through increased interpersonal communication, as the experiment on AIDS had proven. Through personal exposure to AIDS, it was discovered that participants in the experiment gained a better understanding of HIV/AIDS transmission methods.

4.5.3 Sources of Information

Agreed that a consensus may be formed around the issue of the need to mix the media as the best strategy in STIs' behaviour change communication, there still remains the cogent subject of sources through which young people derive their information. To have a good media mix is to combine the chosen media in the right proportion that will guarantee their effectiveness and economy of usage. It is the reason that this sub-theme examining sources through which young people are exposed to STIs messages is important. The three sub-themes that emerged from the discussion revolved around the three usual categorisations made of the media in mass communication, that is, the traditional and new media as well as inter-personal channels of communication. The broad interaction that the three categories have in determining the sources of information appealing to the young people is graphically presented hereunder. First, the study established that young people preferred multiple information sources, a variety of media, which infers a media mix. On the second question that is the kernel of this section, the informants identify all the three categories of the media as sources of obtaining information. But as to which of the categories of the media is the most popular source of obtaining information among them, there is no unanimity. What obtains is that individual preferences mediate their media use as sources. Consequently, some depend on new media, a number on traditional media, while there are also those in love with interpersonal communication.

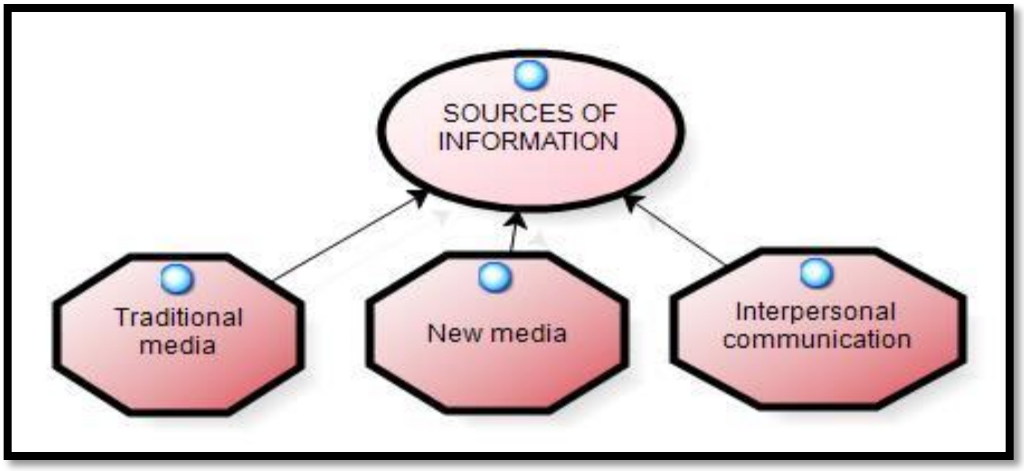

Figure 4.18. Sources of information on STIs preventive communication campaign

4.5.3.1 Traditional Mass Media

Though the least rated, the traditional mass media symbolise an undying avenues or sources of information to young Nigerians. Traditional media, principally, print (newspapers and magazines) and electronic (radio and television) still have their cores values as agents of information and education of attraction to the informants. Informants to whom the traditional media represent the sources of their acquiring information extolled their virtues, especially in the area of providing the much needed enlightenment on the STIs. As a few of them recalled:

> I have heard so many enlightenment programmes in Hausa language on radio, television and even in hospitals. I use radio mostly in Lagos but not in Ilorin. I don't like the radio programmes in Ilorin. (Informant B5)

> I had information on gonorrhea and syphilis through the various magazines, newspapers, booklet and flyers. I use radio often in order to get myself acquainted with news and current affairs. I use it mostly when I am on motion. I watch television especially news. I read newspapers and also surf

> the internet. I don't buy newspapers but my parents do, I also read it in the library. Out of all these media, I use the internet and newspapers on a daily basis. (Informant B9)
>
> I got my own information about STI via television, radio and sometimes newspaper especially when I was doing my SIWES (Students Industrial Work Experience Scheme). (Informant B16)

A necessary addition however is that the film, especially the home video, is also becoming a medium or source of information. Dramatic, moving and didactic, informants like Informant B16 see the storyline of the home videos as a point of attraction which provided information on STIs even though in a subliminal way. The criticism trailing those sources is that often they portray STIs' positive individuals in a negative way. Informant B16 explained further that the superficial treatment of the diseases could be found in the limited knowledge of the home videos producers and scriptwriters about the nature and causes of STIs. Overall, majority of the young people voted that the traditional media are still significant sources of information to them which is in accord with the findings of Mwambete and Mtaturu (2006), who discovered that majority of the young people whose opinion were sought rated television and radio as the most common sources of information to them.

4.5.3.2 New Media

Unexpectedly, the new media featured prominently in the choice of the informants. Many say the new media have become their veritable tools of learning about STIs. But which of the new media have caught the fancy or attraction of the informants?

Informants B7, B19 and A5 explained that the internet remains the most popular source of information to the youths. As apparent below, they offer some descriptions regarding the use young people make of internet:

> Any time I need information on things like this I always go to the internet to find out. Most of the information that I have on issues like these are what I read on the internet and what people talk about. I use the internet most of the time. I always go online to check anything that I need. I don't use television, radio or newspapers. (Informant B7).

> I got the knowledge about the STI I know in the school, internet, even when I was at home, I Google search about them. (Informant B19)

> …I often browse the internet from time to time… I know them to be HIV and syphilis. Last night while surfing the net I saw the likes of trichonomiasis, they can be gotten either via oral sex, via normal intercourse…. (Informant A5)

It is evident from the above that, one, the internet enjoys an unfettered popularity among the younger generation. Two, the internet has also become a sort of mobile library to the youth through which they find out the information they required. Is there anything startling that today's youth have become "the internet generation"? No, is the categorical answer. Levine (2011) had sounded the warning that the lives of young people are presently revolved around the internet. Levine was not alone as Jones and Biddlecom (2011) too further added that young people nowadays preferred the use of internet because of the anonymity it provided. Whatever may be the reasons, the reality is that the internet has become a popular vehicle through which the youth derive information.

4.5.3.3 Inter-Personal Communication

When it comes to the inter-personal communication, a slight shift is observed in the use of this means. Seemingly, the mode enjoys some form of popularity among the young people that are STIs positive. From the activities of the support groups to seminars including interaction with medical caregivers at the hospitals, the STIs positive individuals have had their needs for information met. The testimonials they provide bear stamps of diverse personal experiences:

> The means through which I get information on HIV are the seminars and workshops that I attend in different parts of the country and also here in my town. I am a member of the HIV support group and we try to enlighten ourselves on various things that are happening as it pertains to HIV and other challenges that our members are facing as a result of their status. (Informant A20)

> There are so many people that talk to me about HIV, which is how I get to know about information regarding the disease. Most of the time, I don't listen to radio neither do I watch television. I only listen to doctors that treat us in the hospital and the pharmacists that give us drugs. (Informant A12)

Besides making the general acknowledgment about the value of inter-personal communication to the STIs' positive individuals, the point has to be made that a lot of confidence is placed on the opinion and advice of the medical caregivers. Indeed, there is much trust reposed in the medical practitioners than the mass media. We learned this as well from the work of Hogan and Palmer (2005) and Mimiaga *et al.* (2010) concerning the information preference of the PLWHA. The studies revealed that PLWHA relied on health professionals for STIs related information than on print or

other media sources. Interestingly, the trend was also common with STIs' negative informants with some of them recalling that the foundation was laid as far back as their schooldays from their encounters of participating in symposia that had left them with life-changing experiences regarding the STIs. Two examples of those with such good foundation bared their minds below:

> I have been exposed to campaigns that were brought to my school by one of the students' association body from University of Ilorin. Then I was in SS 2. They gave us lectures about HIV, how it is contracted, how it can be prevented and other things like that. (Informant B1)

> How I got to know about STI…first there was a seminar I attended in my SS3. Then I had no idea about the disease until that seminar. (Informant A21)

There is a reminder from all these that inter-personal communication bears significant impact on the lives of the young. When the sources are credible and knowledgeable, the influence they wield is immeasurable. For the young still in school, particularly, there might not be a better avenue of sowing an enduring life-long lesson on issues pertaining to sex and sexuality than the school environment opening the knowledge inherent in extra-curricular activities like lectures, seminars etc. Nigeria must open a new vista if her quest is to make the future safer against the STIs. One secure way to go is to take to heart the suggestion of Jones, Biddlecom, Hebert, & Milner (2011) from their study that young people found schools to be a trusted source of sexual information. Therefore, the government, campaign planners, non-governmental organisations, school authorities, indeed, every and all social agents must rise to the challenge of exploiting the

opportunities inherent in the country's educational system to expand the frontier of STIs education.

4.6 Chapter Summary

Forty-one informants who were both STIs positive and negative participated in this study. The discussion and analysis was based on three thematic areas and a large number of sub-themes. Through the perceptions, views, opinions and understanding of the informants, analysis were made concerning how the core issue of cultural sensitivity had interfaced with, applied to, or reflected, in the STIs preventive messages that were being disseminated in Nigeria. Significantly, the Nigerian experience in respecting cultural sensitivity in the design and dissemination of STIs messages show that *the* different aspects of the Nigerian culture affect the health of her people in diversified ways with some helping positively others negatively. The four major areas where culture and STIs had shown nexus or influence range from religion, values and taboos, practice and civilisation. They all influenced communication of STIs messages in Nigeria. Evidence showed that religion could be a potent tool in passing on life-changing information such as STIs preventive message to young people. Moreover, Nigerian youths still see values and taboos as powerful influence regulating socially acceptable behaviour in the society. Evidence showed that young people in Nigeria still treasure and value virginity, even if there being one were in doubt. Other cultural norms that are practiced such as polygamy, female circumcision and the use of women for sexual gratification all had effect of making women to be susceptible to STIs.

The data in the study also revealed that educated young people still nurse serious reservations about people living with HIV/AIDS as they avoid physical contact with them. As a result of this many young people living with STIs identified "stigmatisation" as one of their greatest challenges. Of all the STIs, result from the study showed that young Nigerians tend to have more and better knowledge about the HIV/AIDS. There were also evidences that show that misconceptions were still rife about the ways of contracting STIs. Also, developing from this is the fact that STIs messages are mainly conceptualised in three main languages in Nigeria which are Hausa, Igbo and Yoruba. Many of the informants criticized the non-production of the messages in their different local dialects, which would have helped create mass awareness at the grassroots level. There is also criticism of the presentation of STIs as "youth disease" and employment of other derogatory terms and imageries. Another discernible missing gap in the planning and design of STIs' messages in Nigeria had been the non-involvement of young people who are living with STIs.

There were also clamour for the mass media to go beyond their observed traditional reporting mode of sensationalising issues pertaining to HIV/AIDS as well as the "stigmatising language" that have become common-place in the educational materials, songs, poetry and the like. Public distortion of the truth wrongly presenting young people as the only segment of the population predisposed to the sexually transmitted infections, including HIV/AIDS have to be corrected in order to give accurate picture of STIs in Nigeria. There was also the discovery that peer influence was strong and exercising profound influence on the sexual behaviour of the young.

The situation about abstinence as a way containing STIs was a mixed grill. The majority of the youth on one hand did not practise abstinence while on the other hand many who contracted STIs like gonorrhoea and syphilis, rather than visiting hospitals usually resort to self-medications or traditional herbal medicine. Though the young people were aware of the usage of different contraception, the goal was more to prevent pregnancy rather than STIs. The study established that young people preferred multiple information sources. They identified that all the three categories of the media as sources of obtaining information. Consequently, some depend on new media, a number on traditional media, while there are also those who desired interpersonal communication. These are some of the cogent issues thrown up by this study. The next chapter attempts a brief discussion on the findings of the study.

CHAPTER FIVE

DISCUSSION OF FINDINGS

5.1 Introduction

The aim of this study was to look into the issue of cultural sensitivity in STIs preventive communication campaign in Nigeria. This was the objective of examining how culture could be used to improve STIs campaign design and planning. Obviously, there had been previous efforts in the direction by eminent scholars and researchers that had benefited this current study immensely. The main aims of this current study are four which are specifically meant or directed towards:

1. To investigate the elements of culture that best contribute to effective health communication preventive messages on STIs in Nigeria;
2. To identify the best strategies in terms of cultural appropriateness towards the achievement of cultural sensitivity in message design on STIs;
3. To explore the culturally appropriate media for effective dissemination of STIs preventive messages to young people in Nigeria; and,
4. To examine how culturally based health communication can affect STIs preventive campaign.

The last chapter had witnessed copious presentation of answers to the key research questions enabled by the data collected from the field exercise involving extensive in-depth interviews with informants having direct bearing on the research focus. From the themes that emerged in the codification exercise, the interplay of facts and empirical evidence had led to analysis of what the perception, views and opinions of the

informants were in relation to many of the issues that the thematic focus employed in the study had thrown up. Broad and extensive were these factors that singly or through interconnectedness having significant impact on the cultural sensitivity of STIs preventive communication campaign in Nigeria. This chapter amplifies the discussion of the findings of the research in order to deepen further the understanding of the important nexus between those variables considered as indispensable parameters in relation to the net effect exerted toward making STIs communication in Nigeria to be culturally sensitive. The discussion follows the order of the research questions with a progression on how the elements or sub-themes emerging from each theme provide answers to the research questions.

5.2 Cultural Elements in STIs Preventive Communication Campaign

The first question sought to find the cultural elements that positively and negatively influenced STIs in Nigeria. The search threw up four major themes – religion, values and taboos, practice and civilisation – that were having impact on the communication of STIs campaign in Nigeria. This discussion elaborates the findings with regard to the role of each of these sub-themes in STIs prevention in Nigeria.

5.2.1 Religion in STIs Preventive Communication Campaign

As the data revealed, the young people saw religion as having the capacity to protect youths from engaging in sexual risk behaviour. Nigeria's two major religions – Christianity and Islam – were found not to tolerate fornication or other immoral sexual behaviour. Most informants agreed that religion being an aspect of the people's culture

had a positive impact on young people, especially those of them who were religious conscious. Consequently, religion had the potential to prevent risky sexual behaviour or pre-marital sex among them.

Majority of the young people reported that the commitment they had had to their faith had empowered them to overcome the motivation to engage in risky sexual behaviour that had often led to STIs. In addition, the adherence to religious tenets had also inculcated in the youths abilities to decipher right from wrong. To a reasonable extent, religion had therefore encouraged young Nigerians to choose between right and wrong behaviour. Used positively, it is an instrument to curtail risky sexual behaviours among the youth.

There were however limitations. One of the emerging shortcomings of religion has to do with its inability to act singly as a restraint to individuals engaging in immoral or risky sexual behaviour. Compounding the problem has been acts of sexual impropriety on the part of religious bodies and individuals that had publicly questioned the honesty of purpose of religion as a moral restraining hand on immoral sexual behaviour. The attendant consequence was to make sexual relations and restraint a matter of personal decision and/or conviction. Despite the shortcomings of religion, it can still be asserted that religion has the capacity to curb the risky sexual behaviour of young people.

The issue of the cognitive traits of individuals is also part of the equation to empower individuals from engaging in risky sexual behaviour. According to few of the

informants, this suggests that an individual's internal locus of control rather than external events such as religion can be a strong determinant to effect control on some young people to prevent them from involving in risky sexual behaviour. The findings of this study corroborate the findings by HEAIDS (2010) which found that cognitive traits are protective factors against involvement in sexual activities. However, the result of Lengwe (2010) shows that cognitive trait is not significantly related to sexual behaviour. Therefore, religion is a vital tool to use in passing on life-changing information to the people (Ahmad & Harrison, 2007). Unequivocally, STIs can have a remarkable impact on the young people through religious channel.

The prospect of fusing religion with culture to contain the rising STIs in Nigeria emerged in respect of the Hausa people of northern Nigeria who were principally Moslems and whose life revolved around the Holy Quran, the Holy book of Islam. Hence, the presumption was that the Holy Quran contained injunctions that could be adapted to induce positive attitude towards STIs in the area. Also, the Hausa informants advocated that the STIs preventive communication campaign could be more impactful if it was disseminated through the various trusted religious leaders in the country. The obvious implication arising from the positions suggested that the inclusion of religion and the virtues they taught in STIs campaign would result in more positive seeking behavioural change among young people from the Northern part of Nigeria. The conclusion can be made therefore that religion is one of the cultural attributes that can be used to discourage majority of the young people from involving in risky sexual behaviour.

5.2.2 Values and Taboos in STIs Preventive Communication Campaign

The study established that modernization has not diminished the values placed on virginity within the Nigerian society. Virginity accords a lot of respect to young females because it brings honour and admiration among peers, family, future husband and the in-laws. The esteem in which the society holds virginity is further demonstrated by the fact that the family of the groom sometimes gives gifts to the bride to celebrate her virtuosity (Ebire & Ola, 2014). Logically, promoting and encouraging virginity as a virtue can dissuade young people from early sexual intercourse thereby protecting them from risky sexual behaviour. This way, reduction in the prevalence of STIs in the Nigerian society can be attained. As Oyefara (2013) and Ebire and Ola (2014) elucidated virginity as a heritage in Nigeria which can be used to promote the prevention of STIs transmission in Nigeria. The utilisation of this element of culture in the STIs preventive campaign may spur young people to cultivate this positive behaviour thereby reducing their predisposition to STIs.

Another feature that can be incorporated into the "honour virginity to reduce STIs" campaign is to relate it to family pride and use that as an awareness theme among the young people. This can be tied to challenging the sense of responsibility of the youth. Youths who preserve their virginity as well as those with responsible sexual behaviour can be celebrated through awareness creating campaign with a view to use them as models to motivate other young men and women to imbibe the correct sexual values. STIs preventive campaign planners thus have to innovate on ideas that promote family

pride that can be derived from a virtuous life among young people in the design of STIs preventive communication campaign.

Other emergent development from the cultural norms and taboos pertained to the importance of married women upholding their marital vows because of the consequences attached to STIs. The irony of this was the permissiveness enjoyed by married men in terms of the liberty to involve in extra marital affairs which in one way or the other was contributing to the spread of STIs. As Turshen, 1991 (in Ebisi, 2012) discovered, this cultural practice encouraged Nigerian men to keep concubines and indulge in multiple sexual relationships resulting in the increase of STIs. Based on the experiences shared by the informants, it is obvious that the flexibility in the cultural norms between a man and woman makes STIs to strive easily. As a result, it is important for STIs preventive campaign to emphasize control of this negative aspect of the Nigerian culture that is having implication on the reduction of STIs in Nigeria. A particular aspect of the Nigerian culture that can be adapted as theme concerned the practice in the eastern part of the country where the consequences for a woman committing adultery can be severe. The repercussion can be as severe as causing supernatural afflictions for the husband, if she is pregnant it can result in prolonged delivery or degenerate into infantile fertility.

However, the question of the discriminatory nature of the moral codes and taboos that favour men against women has to be addressed. If infidelity is sternly frowned upon in women why should it be sunnily encouraged in men? The disparity will not help in

checking STIs in Nigeria, more so given the fact that polygamy is still an extant practice. These are some of the outstanding issues pertaining to faithfulness in marriage, which bear effect on how cultural sensitive approach can be used in tackling the upsurge of STIs in Nigeria. Therefore, faithfulness in marriage and the consequences of spousal unfaithfulness are two contrasting attributes of culture that can be used in STIs preventive campaign.

Though based on superstition and fear, nevertheless, these two elements can be invoked to appeal to the young females, both married and single, to curb them from risky sexual behaviour that eventually leads to the spread of STIs in Nigeria. With appropriate messages woven around them, they have the potential to effect behavioural change that have the strong possibility to reduce the prevalence of STIs transmission in Nigeria.

5.2.3 Cultural Practices in STIs Communication

As already indicated in the last chapter, some existing traditional practices were promoting social cohesion and unity while others were having negative influence on the physical and psychological health of individuals. It was noted that some cultural practices in Nigeria were promoting, sustaining and fanning the spread of HIV/AIDS because those culpable practices condoned extra-marital activities of men in Nigeria. Across the three ethnic groups, men had the liberty and dominance over sexual issues in the home. While sexual immorality is frowned upon in women, men still have the liberty to enjoy sexual philandering. The sad development is the after-effect does not exclude the women. The potential of wives contracting infections from their husbands was high

yet they dared not raise a voice of protest without incurring dire consequences. Smith (2007) revealed the pathetic situation of women in Nigeria, submitting that marriage was no avenue to prevent a faithful married woman from contracting HIV or other STIs. Inequality at the home that divides sexual morality along gender line is an issue that has to be fought in the Nigerian society. Quite apparent is the fact that the subservient role that most Nigeria women are bearing is encouraging the spread and prevalence of STIs.

As obtained in the Northern part of Nigeria, for instance, *kuule*, which is a cultural practice restricts the movement of women. Women do not have freedom of movement as they are compelled to seek their husbands' permission before venturing out of the home. On the surface level, there is nothing wrong with this ancient practice. It can be argued that the restriction can actually limit the vulnerability of women risky sexual behaviour that can result in STIs. Viewed against the inequality of the cultural mores that see nothing wrong in restricting men's movements the same way, then the unjustifiability of the rule becomes obvious. What it simply means is that men's movement cannot be questioned, including what they do when they hang out, which at times, involve extra-marital relationships, the result that may lead to contraction of STIs, which may eventually spread to their spouses. Smith (2010) observed that this over-restriction of women's freedom was pervasive in all Nigerian cultures has its net effects of making women voiceless as well as mere sex objects.

It is possible from cradle to grave for a typical Nigerian female to be denied making personal decision about her sexuality and sex life. In her parent's house, she lives under

their absolute rules as the custom demands. As a spinster or young adult, she contends with the society's expectations. As a married woman, the culture sets the boundary of what her sex life should be, from role as a wife to her behaviour as a sex partner to her husband. The freedom to act wisely, prudently, and in her best interest in terms of her sexual life is denied her (Smith, 2010). Nigerian females are more vulnerable to STIs because they can be exploited sexually. Indeed, as data from the study revealed, the gender inequality in Nigeria had the adverse consequence of making women to be powerless in all areas of their sexuality, even extending to reproductive health decisions that affect their lives.

Indeed, an unpleasant discovery, which in other cultures, might be considered as unjust, barbaric and insulting to womanhood, was the cultural norm of the Tiv people of the North-Central part of Nigeria whereby women were used to entertain guests. This cultural practice has a great tendency of increasing the prevalence of STIs, not just in the area but in Nigeria as whole. Both visitors and guests can become carriers of infections resulting from the unsafe casual sex. Therefore, there is a need for campaign planners to dissuade such cultural practices that have the tendency of increasing STIs in the Nigerian society.

The same relentless campaign needs to be explicit on some negative implications of another cultural relic from Nigerian past: polygamy. Polygamy is practised among all the ethnic groups in Nigeria irrespective of religion. Related to STIs, it is counter-productive. Though prevalent in the Hausa culture, polygamy is present in other cultures

with varying reasons. From the findings as elaborated in Chapter Four, it is obvious that polygamy is a tradition that tends to promote promiscuous lifestyle among men. However, what values do polygamy symbolise in the Nigerian culture?

The data in the study revealed that polygamy is seen as a means of demonstrating wealth and prosperity which is measured in the number of wives a man has, which ultimately determines the respect and accolade that he gets from the society. But not only men of means practice it; cases of less endowed, lower class people, and parents also marrying wives for their sons abound. Protagonists of polygamy believe its positive side is that it helps to reduce risky sexual behaviour of a man. The reason is that he can always meet his sexual desire at any time since he has access to more than one woman. Antagonists counter that believe by saying that the inherent danger far outweighs the meeting of the sexual pleasure of the man for the simple reason that once one of the wives or the husband is infected with STIs, the infction spreads faster in the household.

The other side to the argument is that recent studies have shown that the polygamous nature of a man does not correlate with the curbing of extra-marital affairs among the males in the Nigerian society. Rather, it has tended to breed increase and spread of the disease (STIs) (Azuonwu, Obire, Putheti, & Ekene, 2010; Iyayi, Igbinomwanhia, Bardi, & Iyayi, 2011; Owuamanam & Bankole, 2013). The point to make is that while it is not possible to proscribe polygamy totally in the Nigerian society, it is important for STIs preventive campaign planners to ensure that young people and people in the society understand the consequences attendant to the practice and also employ them to play safe

in all their sexual dealings. The knowledge of the consequences might create awareness and motivate reduction of the prevalence of risky sexual behaviour by people in multiple sexual relationships to take precautionary safe sex concerning STIs.

An adjunct to this is the practice of early-child marriage prominent in the Northern part of Nigeria. Girls are married off to elderly men at a tender age with or without their consent. This child-bride, who is barely an adult, is thrown into the rigours of a family life that she is ill-equipped to confront. Often, the cultural practice has led to the prevalence of STIs and HIV/AIDS. This negates the notion behind early marriage. Early marriage is contemplated as a panacea to risky sexual behaviour among young women with the tendencies of liberal taste. Erulkar and Bello (2007) established some of the grave consequences that have been discovered as attending early marriage in the Northern Nigeria. One was that the reproductive systems of the young girls were usually not mature for sexual activities therefore subjecting them to the susceptibility of tears and abrasions that made the contraction of HIV/AIDS easier. Secondly, was that the early and/or forced marriage was predisposing the young wives to seek love and affection from outside their matrimonial homes since their husbands were not their choice for marriage. The consequence from the dual acts was aiding the spread of STIs. While it can be concluded that early marriage has its positive and negative aspects, all, which can be used to prevent STIs among young people, it is important for campaign planners to avail people's knowledge of the known negative consequences of the practice while encouraging people to imbibe attributes, found to be positive.

While early marriage seems to be the battle to be fought in the North, widow-inheritance is a major cultural practice in the Eastern part of Nigeria demanding concerted action. The practice involves brothers-in-law or any male relative inheriting the wives of their late brothers or relation, with or without the woman's consent. Where the woman refuses bluntly, she is denied the inheritance of her late husband's property as well as being sent out of her home without taking any item of property. Undoubtedly, widowhood-inheritance culture remains one of the vestiges of supremacy, the subjugation of women, and the denial of women of their rights by men in the Igbo culture. When a woman is inherited, no test is conducted to know the sexual health status of the inheritor (Gausset, 2001). Nor can a woman dare to ask for such verification in order to be sure that she is safe before accepting to extend the sexual relationship. It is not therefore surprising that the cultural practice cannot be dissociated from increase in the STIs. Onyekuru (2011) confirmed the suffering of the widows compared to their male counterparts in the Igbo culture, a point requiring that campaign planners engage in the sensitization of the negative effects of widowhood inheritance practice. People have to be encouraged to shun this cultural practice that negates the right of the individual to make her sexual decision.

The same collective aversion of the people has to be raised against the female genital mutilation which is still practiced in various parts of the country. The rationale for the practice was the presumption that the traditional act would decrease the sexual libido of females. As a result, their vulnerability to risky sexual behaviour would be contained. The consequence was that in infancy, the girls were circumcised. At other times, the

tradition waited for girl prior to becoming a bride. Then, she is subjected to the harmful traditional practice. Several states in Nigeria have proclaimed that the practice is illegal by enacting appropriate laws. Nevertheless, it has remained an old habit refusing to die, especially in the Igbo area of the country. From this study, a large proportion of the informants from the South-East Nigeria are in support of the practice. This was coming a decade after Abubakar, Iliyasu, Kabir, Uzoho and Abdulkadir in 2004 had documented cases of female genital mutilation is highest in the South-East than in any other part of Nigeria. The practice is not only alive but persisting in Nigeria as the present and past studies have shown (Abubakar, Iliyasu, Kabir, Uzoho & Abdulkadir, 2004; Babalola, et al., 2006; Ezenyeaku, Okeke, Chigbu, & Ikeako, 2011).

The interesting part is that the young girls are not revolted by the traditional practice but they see it as helping them to maintain their virginity. This view has very strong implication for designing STIs preventive communication in the area. It is also an instructive lesson for STIs campaign planners on the futility of fighting against traditions rooted in strong beliefs and cultures even if they do not fit into the Western models of modernity and civilization. Using the information to the advantage of intended communication would mean avoiding antagonising their perception of female genital mutilation rather than attempting to confront their strongly held belief, no matter how vulnerable their culture is to STIs. Therefore, attempts should be made to adapt such practices in ways that blend its local cultural values with the change envisaged in the behaviour. As at now, and from the mass of evidence that several studies have shown, fighting against female genital mutilation in the eastern part of Nigeria can be a waste of

resources. Consequently, whatever change desired has to adapt this cultural practice within the dynamics that suit the local context of the people.

5.2.4 Civilization in STIs Preventive Communication Campaign

It is well that civilization has not left unchanged the life of the Nigerian youth. The pitfall however is that it has their perspectives – more negatively than positively – in their relationship with the different Nigerian cultures. Civilisation has subsumed their cultural identity to the point that their knowledge of the past, acceptance of the values taught, and reflecting this in their lives, have been lost to what they euphemistically see as the "modern age". Nowadays, Nigerian youths want to be more European that the Europeans, making them "cultural hermaphrodites". Their identity has been recklessly altered. They know not their values and the values they know are not their own. They love to practice and imitate the European's ways of life that run contrary to Nigerian traditions and culture.

As "cultural hybrids", they are strewn between the Western culture that they see as modern and the Nigerian culture that they dislike as being backward and old fashioned. All the cherished values of the past that have helped Nigeria and Nigerians to be on the path of morality, decency, honour and integrity are therefore spurned. A recent study by Ebire and Ola (2014) painted a gloomy picture of how the Nigerian society had gone into such much disarray that, today, there is hardly a pristine culture left to which to hold a young Nigerian accountable. Without a cultural renaissance, it will be difficult to reclaim some of the lost Nigerian cultural glories that had promoted responsible sexual

control and relations in the past. This absence of calling attention to the good cultural values of the past was one of the reasons why young people preferred to imitate Western ideas and ideals that had led to the compromising of the ethos of the past concerning sexual relationships. Nigeria STIs campaign planners must take this missing gap in the present orientation of the enlightenment efforts into consideration for a new dawn to break in efforts at curtailing STIs among the younger population of the country.

As these apostles of the new age are fond of saying, "this is a new age, a new generation" and to meet at the point of need is to have an intersection area where elements shaping their new cultural identity are taken into consideration. This is the crux of the matter concerning how STIs preventive communication can target this new breed. It is a must for such communication to speak their language, be full of images and imageries, whose trademark is that of this "modern" generation. It is the way to go to make preventive communication receptive to this generation known for their liberal approach to sex along with their famed spirit of adventure in risky sexual behaviour.

The challenge for the STIs preventive communication would now have to find ways of reaching these young Nigerians that have become a hybrid of the Western culture and Nigerian up-bringing. It is a tight-rope that has to be walked given the cultural identity problems that have to be resolved.

5.3 Message Conceptualization in STIs Preventive Communication Campaigns

While examining the field result on the above in the last chapter, as a preamble, the point was made that message conceptualization was at the heart of the behaviour change endeavour. It was emphasised that conceptualization and dissemination of well-tailored messages constituted important planks in STIs prevention and education. Highlighted therefore was the significance of employing effective communication in order to put the epidemic under control. Attempt was made to show how STIs messages should be conceptualized. In this wise, it was stressed that the perspectives of both STIs positive and negative young people should be understood in message conceptualization, find out their attitude towards STIs with a view to improving the existing STIs preventive campaigns. We did say that the general opinion emanating from the study tend to point to existence of communication gaps in STIs' campaign in Nigeria. Stigmatization was identified as one of the main problems. The seven other sub-themes influencing STIs communication and message flow in STIs were subsequently identified and discussed. Recalling them once again, they (the sub-themes) were listed as diagnosis and symptoms, influence, language, knowledge and attitude, attitude of people, portrayal of STIs message, and adequacy of message. A little bit more is said about these factors below because of their import to successful communication of STIs messages.

5.3.1 Attitude towards People in STIs Preventive Communication Campaign

As argued by the data from this study, stigmatization remains a major burden the Nigerian society is imposing on people with STIs particularly those that are living with HIV/AIDS. In *pari passu*, stigmatisation has to be given the same level of intensive

public education. The data in the study revealed wide discrimination against the HIV positive individuals. Some of the informants stated that the problem had created the fear of disclosing or owing up to their status, even to their spouses. The reason was because of the likelihood of the spouse or partner abandoning them. At home, they were unwanted, in office barely tolerated, and in the larger society despised. Cases of dismissal by employers, denial of permission for medical treatment, disparagement by health works, and ejection from homes by spouses had all been the plight of people living with HIV/AIDS. The HIV positive informants recounted their experiences of the spectre of being abandoned by even friends and family members once they discovered their status. It is becoming evident that the non-disclosure of status is one of the reasons for the prevalence of HIV/AIDS in Nigeria. This also have the same effect of encouraging prevalence of HIV/AIDS. Despite the good step of making the treatment free in major government hospitals across the country, stigmatisation remains a burden in Nigeria.

Nigeria is caught in the trap discovered by Cloete *et al.* (2010) and Admassu (2000) that people became reluctant to disclose their status where there was fear of being rejected by those spouses, sexual partners, and family members. The informants claimed that they prefer to keep their status to themselves than risk stigmatization. There are also those with wrong and immoral motive, which was not to die alone by ensuring that they spread the virus to innocent ones.

Therefore, strategic concerted efforts must be made by campaign planners to deconstruct the myths and misconceptions surrounding the stigmatisation issue. If stigmatization does not encourage people to come into the open to seek medical attention needed; it will not make the Nigerian situation any better. Government, therefore, needs not only to enact the right laws but also follow up with policies and programmes that will adequately change the antagonistic attitude of the people to People Living with HIV/AIDS (PLWHA).

Counterbalancing this incredulous act on the part of a minority was the widely reported acute emotional distress bore by a vast majority of those often despised, disowned and neglected on the account of their HIV status. One illustrated how she was on the verge of suicide when her proposed wedding was cancelled barely two weeks to the event by her pastor because her HIV status was discovered. There were also cases of those forced to endure the ridicule of medical personnel after they had known their status. Others talked of work place difficult encounters in having their routine medical check-up because they could not disclose their status to their employers and colleagues because of the apparent attendant stigmatisation. These cases show how stigmatisation is broadly affecting people who are living with HIV, the result of which is to make them think twice before opening their mouths to let others know about their health status. Yet, it is incontrovertible that the disclosure of status is important in the fight against the prevalence of STIs in Nigeria. Therefore, it is important for STIs preventive campaign planners to make people understand the serious consequences of stigmatisation. The non-disclosure of STIs status drives underground those suffering the afflictions (which is

dangerous to their spouses and all those with sexual contacts with them) as well as under-reporting or knowing the extent of the diseases, which have fatal consequences to good planning and policy making in ways that can safeguard the health of the public, young and old, from the prevalence of STIs.

A positive step already taken by the Federal Government was the promulgation of an anti-stigmatization law. The law sought to protect the right of PLWHA (People Living with HIV/AIDS) against stigmatization and discrimination in the society. According to the law, it is an offence to discriminate against those living with or affected by the HIV and AIDS in Nigeria. The punishment for any individual disclosing the status of an infected person, which might have been obtained in confidence, was a fine of N.5million or a one-year jail term. Unequivocally, the bill, if effectively implemented, would go a long way in reducing the stigmatisation that young people face in the society. In addition, the implementation of the law would go a long way in demystifying the intensity of the stigmatisation in the Nigerian society. The bold step therefore is a timely development, which can bring a remarkable change to the behaviour of people towards PLWHA.

One area that husbands' tenacity in supporting their wives can assist further in the open communication about the HIV status of married women is by eliminating the fear of the in-laws presently nudging many of them. The reason is that with the husbands standing firm by their wives, the fear that they (the women) can be ejected from their homes, or their husbands pressurised to divorce them, by their in-laws can be eliminated. With this,

there can be a better open communication about not just HIV/AIDS but also other STIs. It is a tough battle to be faced with a life-long illness; but it is worse when succour is denied from where it should come from. Religious leaders would need enlightenment on how to strike a healthy balance in this area.

This attitude of people towards PLWHA will be imperative in the conceiving and designing of effective preventive campaigns on STIs. The infusion of confidence-building information as regards the negative attitude of people, to be less antagonistic and ridiculing of STIs positive individuals, would be a major step to achieve behavioural change among the people. There are great advancements that have been made in the treatment of HIV/AIDS that need not make it any longer a disease to avoid, neglect, and subject its sufferers to abandonment or cruel mental and physical treatment. All these will have to be featured in a well-designed STIs preventive communication aiming to change the prevailing attitude of Nigerians and reduce the stigmatisation that is driving the open reporting and admission of the disease. Appropriate legislation combined with the necessary institutional framework would be an addition mechanism to propel STIs being openly communicated in Nigeria.

5.3.2 Diagnosis and Symptoms in STIs Preventive Communication Campaigns

How does STIs, particularly get diagnosed in Nigeria? Similarly, too, what are the feelings that infected people go through before their eventual diagnosis? From the results obtained from many HIV/AIDS positive female informants, they knew their status for the first time after going for ante-natal check-up. These rose many questions

on how serious are the efforts of STIs campaign planers at targeting pregnant women in the STIs preventive communication. The findings revealed that up to the time of learning about their status, they did not know the implications of the knowing their HIV/AIDS status during pregnancy. This shows the need to strategically position STIs preventive campaign towards encouraging women to know their HIV status during the period of pregnancy because the knowledge of it will not only determine the nature of the ante-natal treatment they receive in hospital but it will restore early confidence in them about themselves and their unborn children.

Other HIV positive informants explained also the symptoms they experienced sequel to discovering their status, which include but not limited to diarrhoea, hair breakage, loss of weight, tuberculosis, to mention the prominent ones. One of the informants mentioned that she did not experience any symptom prior to detecting her status. This shows that HIV/AIDS can be asymptomatic in some individuals while manifesting different symptoms in other people.

In addition to the above findings, some STIs positive informants said they contracted the HIV/AIDS in the hospitals from the use of unsterilized objects. If it is pardonable for a woman to learn of her status during ante-natal clinic, it is, certainly, indefensible for such to be delayed until after child birth. Pregnancy has a long gestation period – nine months! For a woman to have surrendered herself to the care of health care givers, and yet only to learn much later about her risk to life-threatening ailment, bespeak of unpardonable professional negligence, and a shameful national incompetence. An

informant explained that it is worse when professional negligence led to the putting of an innocent life at an irredeemable risk. This is an indictment of health personnel for negligence, whose unwholesome practice contributed to the spread of HIV/AIDS in the country. It is both shameful and critical that Nigeria has become much more pro-active in the management of STIs; the current lackadaisical approach that is exposing mothers, "would-be mothers"," newly-born" and infants to preventable risks is unacceptable. Letting government, professional bodies like that of doctors, nurses and other health workers, as well as the generality of Nigerians know the duty they owe their nationals will put to an end the sacrificing of innocent lives to STIs. Therefore, there is a need for medical and other health workers to be sensitized on the need to take adequate precaution and safety measures, including the use of sterilized and safe equipment in the treatment of people. Holding health professionals accountable for professional negligence will also go a long way in reducing the culture of contraction of STIs such as HIV/AIDS in the medical institutions.

5.3.3 Language

The point had earlier been made that the value of language in the communication of STIs give people a sense of belonging by permitting shared-meaning and shared-understanding in the individuals' perspectives. Unfortunately, the study established that most of the STIs' campaigns that the young people were exposed to were designed in English language. The few that were in local languages were in the three major languages in Nigeria. A major observation was the absence of conceptualising STIs preventive communication campaign in the other local dialects. Informants further

revealed that they only had opportunity of being exposed to STIs preventive campaigns in an ethnic language whenever they were within the geographic area where that language was spoken. As a consequence, people living in other parts of the country only managed to be exposed to STIs campaign designed in their local language in their places of origin rather than in communities which they were residing. Language rather than serving as an aid to effective STIs preventive campaigns turn to be barriers. With people not having the required awareness and sensitisation, the STIs campaigns were thus recording ineffectiveness in the public domain.

On the other hand, irrespective of the education level of young Nigerians, their preference was for STIs messages in their local language. They emphasized that they preferred these messages in the local language because local languages have a rich meaning and creates better impact on them. As the data indicated therefore, language is one of the explicit or surface manifestations of culture that can assist in the accomplishment of a cultural sensitive intervention. Mkhulisi (1999) accords language a top priority in communication design because of its potential to empower the individual through giving him/her a right to experience his/her language rights. Many informants, unfortunately, reported a different experience, meaning that the STIs messages, the way they are right now, were being lost on a sizable number of their target audience. Similarly, Chimbutane (2012) argued that STIs education and prevention strategies can be turned into a success story by incorporating the linguistic norms of their recipients into the messages being disseminated.

The unavoidable conclusion is that STIs campaign planners need to consolidate on the positive attributes of the language of the people by maximally utilising them in planning, designing and disseminating STIs preventive campaign messages. Without imbibing this self-recommending effort, STIs preventive communication campaign will continue to be a wasted effort in the case of Nigeria. Adopting the indigenous languages is justified by this urgent need to stem the prevalence of STIs across the length and breadth of Nigeria. With them, STIs preventive communication campaign would become better understood and effective too.

5.3.4 Portrayal of STIs message in STIs Preventive Communication Campaign

Language is one thing while perception is another issue entirely. So, in what way does the intended message audience perceive portrayal of STIs in the preventive communication campaign? To the understanding of the young people, the data collected indicated that STIs is being portrayed as an infection that affects only the young people. They (the young people) explained that campaign planners were not letting the public to know that the categories of people who can be infected were not strictly limited to young people. To them, most of the STIs campaigns used young people as the models for the campaign programme and this had the tendency of making majority of the people to have the wrong perception that HIV/AIDS was purely a youth disease. The campaigns did not correctly give the information that old people as well as infants, too, could also contract HIV/AIDS. Katz, Fortenberry, Zimet, Blythe and Orr (2000) did make similar observation that often the most vulnerable group portrayed as far as HIV and STIs were concerned, were the youths.

In addition, criticisms have also been levelled against the mass media of deepening the stereotypical impression that HIV/AIDS was not only sexually transmitted but it is contracted by people who are highly promiscuous while underplaying the potential of its being contracted through sharing of sharp objects. The stereotyping, it is believed, has been one of the reasons why the society wrongly perceives the PLWHA as promiscuous individuals. This finding tallies with an earlier study of Lau and Tsui (2005) which showed 42% of the informants in the research avoiding physical contact with PLWHA. Similarly, data from the study show that some HIV negative informants believed that the situation of HIV positive people resulted from their past promiscuous life style. As far as the informants were concerned, the affliction was therefore a punishment for the immoral life style. Without further equivocation, the STIs preventive communication campaign in Nigeria needs to emphasize that contraction of STIs results not only from immoral life style but can be contracted through the several other means.

The other side of the data revealed that the STIs messages were placing more emphasis on the risk factors, illuminating more young people's active sex life, and that they were the group engaging more in risky sexual behaviour. The generalisation is simplistic and fallacious. While it is right that STIs messages should focus the sexually active youth, at the same time attention should also be paid on those who have cultivated the positive usage of abstinence as a measure of avoiding the possible outcomes from sexual unpleasantness. STIs prevention efforts will make little or no impact if only the efforts were concentrated or emphasising safer sex or risk reduction. Abstinence ought to be

given high visibility as the safest course of action to prevent STIs. Therefore, there is a need to balance the nuance of messages, striking a healthy balance between risk reduction campaign and the promotion of abstinence as options for the young people. One-sided messages, harping on risk reduction, make young people who are sexually inactive to fail to connect with the prevention campaigns. After all, they can be right to argue that, "I'm not concerned; the message is not for me, sex for now is out of it!" For instance, how do messages campaigning against multiple sexual partners, unprotected sex, and transactional sex make meaning to such sexually inactive young men and women? Therefore, there is a need for the STIs campaigns to take into consideration the varieties of audience, their nature and perception in the design of STIs preventive communication campaign.

That same concept would also have to apply to eliminating derogatory terms and language as well as obvious or inadvertent bias in STIs preventive campaign messages conceptualisation. Many of the PLWHA complained of the use of these derogatory terms and ideas that were giving wrong and negative perceptions to those exposed to the messages. Particularly, they observed that the kernel of the messages hardly promote young people's positive values that could further encourage them to lead a positive life. For those with HIV, this approach had a drawback, which was alienating them from the campaign. They simply saw no positive value which encourages their situation. Unfortunately, the conceptualisation of the STIs messages was often done with no involvement of the target audience like the STIs positive individuals. The consequence was that a large number of the STIs preventive campaigns that young people were

exposed to, failed to address the realities of their situation. It was one of the reasons given as accounting for the spread of STIs in Nigeria. To put the solution in the right perspective, the advocacy was for involvement of people who have experienced or experiencing STIs infections in the conceptualisation of the various messages. In other words, let the views, opinions, experiences and perceptions of the sufferers influence the STIs preventive communication campaign. Afterall, as one African proverb says, "only the wearer of the shoe knows where it pinches!"

5.3.5 Influence in STIs Preventive Communication Campaign

Where do we begin to look to, concerning those forces influencing the spread of STIs in Nigeria? The first, going by the findings from this research, is the family. The family, one way or the other, encourages the spread of STIs. From documented instances, there have been occasions when family members encourage their wards to go into prostitution in order to get the required income to sustain the family. The erosion of family values in the latter case coupled with many known others have the negative effects of corrupting the lives of the young people. There have been situations in which parents cannot give proper upbringing to their children, which make them (the children) to go on the streets to fend for themselves. Children exposed to this difficult circumstance, particularly young girls, have the ill luck of being abused and violated sexually. During the period of fending for themselves, cases abound of children being exposed to moral and social delinquencies including exposure to risky sexual behaviours that may subsequently lead to their contracting STIs.

The widespread poverty obviously is wreaking a serious havoc in contributing to the spread of STIs. As the data in the study shows that some parents ask their children to hawk goods at a very early age for survival of the family. In the Northern part of Nigeria, for instance, under-age children are thrown into the streets to beg for alms, hawk goods, and do all sorts of menial jobs that expose them to all sorts of street hazards including early sex in a bid to survive that thereby leads to the spread of STIs. STIs preventive campaign will have to take these economic, social and cultural indices perpetuating the vulnerability of the young ones into consideration in designing appropriate response to the STIs challenges in Nigeria. A point that should be emphasised is the need to discourage children being used as pawns for survival by parents. The street does not, and cannot, offer any safety to an innocent child. What this also boils down to, is that the Nigerian government has to work seriously to improve the conditions of living of the people. Nigeria has vast and huge resources to meet the basic needs of her people. Her need is the enactment and implementation of the right policies and programmes that can have positive impact in the lives of her people, especially her teeming young population.

A subset of the influence of the family on STIs is the result showing that mothers, to a large extent, have great roles to play. As the primary caregiver in the home, mothers exert positive influence on the children. Most of the informants, who admitted restraining from risky sexual behaviour in this study, attributed their disposition to their mothers. The same valuable role of mothers was discovered in similar studies conducted in the United States that measured parental monitoring or supervision in relation to risky

sexual behaviour. Bettinger *et al.* (2004), Broman (2007), Diclemente *et al.* (2001), Miller, Forehand & Kotchick. (1999); Romer *et al.* (1999) and Ronsenthal *et al.*(2001) all spoke with one voice that parental monitoring or supervision has positive impact on the risky sexual behaviour of young adults. Therefore, it is important for STIs preventive campaign to highlight the positive role of mothers' guidance in curbing risky sexual behaviour, and their potential to enhance sexual morality of the young people.

Similarly, open and honest communication between parents and children on matters pertaining to their (the children's) sexuality is obviously vital. Leaving innocent children to their peers can be very dangerous. Evidence abounds of people being misinformed and misled. Correction may be too late in coming because the preventable harm might have been done. Therefore, it is important for parents especially the mother to expose their young wards to the correct and appropriate sexual education that would prevent them from becoming vulnerable to wrong peer influence outside the home. "A stitch in time saves nine," is what the wise saying admonishes.

One additional point that should be stressed is the fact that given that the level of education attained by parents determines whether their children would have an open communication with them on their sexual lives, Nigeria needs a further push on the literacy path. Currently, almost half of her adult population cannot read or write, the implication being that as parents they would hardly be in a position to engage in open and informed discussion with their children, especially on culturally sensitive issues like sex, which is almost a forbidden public topic. Looking at these two self-reinforcing

issues certainly would be the first step towards managing one of the tripartite influences accounting for the spread of STIs in Nigeria.

The second layer of influence is young people's peers. Peers are probably the most influential group on the sexual behaviour of their contemporaries. That was also reinforced by the data collected in this study. The agreement by the informants was significant that peers' overriding influence on young people's risky sexual behaviour could not be discountenanced. Most of the informants stated that friends influenced them into involving in risky sexual behaviour that culminated in their present HIV status. This finding is in line with Jessor (1991) which showed that youths associating with morally upright peers are rarely influenced into involving in risky sexual behaviour. Similar studies conducted by Moodley (2007), Lengwe (2010) and Blum and Mmari (2005) revealed that young people's sexual activity is influenced by their peers, especially if those colleagues were already sexually active. This finding shows the implications of the involvement of young people with friends with loose morals. The lesson for STIs preventive campaign is to emphasize to young people to keep friends that have positive moral and social character. It is a case of the popular saying that "birds of the same feathers flock together," which would be good theme to emphasize in future communication campaigns.

The last of the triple agents of influence is the society or community itself. The Nigerian society has impact on the lives of young people. And this comes in several ways that are both positive and negative. Some informants from the Northern part of Nigeria call

attention to the positive role of the community in frowning against unmarried couples living together. This, they contend, have the effect of curtailing risky sexual behaviour among the youth. This singular example demonstrates why the STIs preventive communication intervention should ensure that campaigns are developed in ways that there will be healthy balance of the negative and positive influence of the society in containing the spread of STIs. While the good values of the society should be promoted and commended for continuation by the people, intensive efforts should be made to discourage the negative social and cultural influences in ways that make people to have behaviour change.

5.3.6 Knowledge and Attitude in STIs Preventive Communication Campaign

This section asks two mutually reinforcing questions. The first is, how deep is the knowledge of the young people in respect of the STIs? Secondly, what attitudes of the young people can be discerned in relation to this knowledge? Data from this study revealed that young people had a good knowledge of HIV/AIDS but their knowledge of other STIs such as syphilis, herpes, gonorrhoea, hepatitis B, etc. was limited. Though the study also established that the majority of the young people were exposed to STIs messages in the various mass media, yet the corresponding depth of their knowledge of that same disease (HIV/AIDS) was shallow. They only knew of the basic things about HIV/AIDS. A small fraction of the informants acknowledged that the last time they were exposed to gonorrhoea advertisements was about ten years ago! This shows that the emergence of HIV/AIDS had almost eliminated media messages on other STIs such as gonorrhoea, herpes, syphilis and hepatitis B, etc. It stands to reason that with the

spreading of other STIs, campaign planners would need to step up the level of information being disseminated on other STIs such as gonorrhoea, syphilis, hepatitis B, and the like to the people.

Back to back with this issue was another development, which was in respect of the young people's knowledge on STIs. Interestingly, the data revealed a serious misconception about STIs on the part of the Nigerian youth. This was adjudged as one of the natural outcomes of the scanty information on STIs by the various mass media. The misconception had perpetuated a number of contradictions. For example, some young people have an average knowledge about STIs while others do not. Also, within those who are STIs negative, there were those who did not believe in the existence of HIV/AIDS. Gross was their misconception as they termed the disease as Europeans' affliction. Still, were others who believed that STIs like gonorrhoea and syphilis could be contracted by using dirty toilets. Here was a demonstration of misconceptions compounded by ignorance. Few who were HIV positive actually confessed that prior to their testing positive, they used to have the impression that HIV does not exist in Nigeria. Misconceptions are wrongs steps to cultivating equally wrong attitude. The way that Temin et al., (1999) and Oladepo and Fayemi, (2011) summed up the findings was succinct: young people in Nigeria have various misconceptions of STIs. These misconceptions have the tendency of fuelling risky sexual behaviour. Therefore, there is a need for STIs campaign planners to focus attention on providing young people with adequate information on STIs with a view to deepening their information capacity.

Of course, such a deepening of capacity to knowledgeably decipher STIs can have a spill-over effect in helping the youth to have correct understanding of and sources available to contract cure for them. It would, definitely, help check the younger generation from running after the shadows as they are currently doing in respect of searching for cure for STIs. Presently, many of the young people, by their own self-admission, preferred to consult the traditional medical practitioners for the treatment of STIs like gonorrhoea and syphilis, instead of consulting the orthodox doctors. Quick medical service and cheap cost were given as the reasons for the patronage of the traditional medical personnel. There was, yet, another reason: the fear of running into or encountering people they know in the hospitals. The natural interpretation that can adduce to is, perhaps, the perception of being stigmatized discouraged the young people from getting proper medical treatment on STIs from orthodox doctors. This finding is in accord with studies conducted by Cherie and Berhane (2012) and Temin et al., (1999) which indicated that stigmatization is a big challenge towards controlling the prevalence of STIs in the society. We therefore have to turn to the mass media to help deconstruct the myths perpetuating stigmatisation in the society.

Particular attention will also be needed to motivate the young people to patronize orthodox doctors and hospitals to secure treatment of the STIs. It may lack scientific attestation but the reality is that the informants believe in the efficacy of prayers as a last resort to finding cure when they contracted STIs. As doctors often say, doctors treat but God heals, meaning that cognisance has to be taken of religion as it still remains a potent

influence on attitude towards STIs, which means that any meaningful preventive communication campaign must be aware of it.

Nevertheless, the improvement in the quality of knowledge of the people about STIs does not provide the desired answer to the question of what would effectively dissuade young people from taking paths that often lead to the diseases. Rather, it would be their cultivation of the right attitude. By the data from the study, good parental background was identified as the potent tool leading to imbibing the right disposition that could effectively check the predisposition of the youth in contracting HIV/AIDS and other STIs. Those not strolling on the banks of risky sexual behaviour attributed the motivation to this factor. Identified as of equal motivation by some male informants was the fact that had little or no financial resources to "entice" women. To yet another group, the restraint was in connection with having the "right partners" for whom they were preserving their virginity. This exercise of self-restraint and good parenting definitely can be used as themes in curbing the spread of STIs.

The good news however about both STIs positive and negative informants in this study, is that they believed condom use could curb STIs. Nevertheless, its voluntary acceptance and use could seriously be undermined by the sentiments surrounding its procurement. More than a handful of the informants who were STIs negative explained that they are usually "shy" to buy contraceptives because it might give the sellers wrong perception about their sexual life. There were cases of other informants as well, the STIs negative, who felt suggesting condom use to their sexual partners might connote a negative

perception of lack of trust and fidelity. Also, reported, were cases of unreliability of condom as a protective method by STIs negative informants who had tried it and found it defective – it burst during sexual intercourse.

On a general note is the fact that a good condom is relatively expensive, thereby making it unaffordable by young people in need of its use. What this evidence suggests is that it is important for young people to be sensitized regarding the value and use of condom in sexual relationship, at least if they must live an active sexual life. That condom is a protective means against STIs, and that its use is not synonymous with betrayal of trust and infidelity as being wrongly connoted. Rather that it is a means to safe, protected and healthy sexual relationship.

5.3.7 Adequacy of message

Going by the study's results, young Nigerians rated STIs' information to which they were exposed to as out-dated and inadequate. Moreover, they believed that there were over saturation of HIV/AIDS messages at the expense of other STIs. The young people were also of the view that media information on STIs apart from being stale were often repetitive, drumming more on what people already know about such as HIV/AIDS being an infectious disease that can be contracted only through sex, and that it is a killer disease as well. The media messages rarely showed currency with regard to what the youth ought to know. Thus, particular areas of youths' information need such as STIs' symptoms, the need to get tested, danger of transmission of mother to child infection, and the many more hardly get mentioned. A resultant effect is that young people are not

easily inclined to go for voluntary testing, especially in connection with HIV/AIDS, because they think that the infection is for other people. Unfortunately, it sometimes gets too late for them to discover their HIV status, and by then they might have become vulnerable to preventable opportunistic infections associated with AIDS' complications. STIs campaign in Nigeria would have to be responsive to these issues if it is to keep pace with the dynamics affecting STIs in Africa's most populous country.

5.4 Media of STIs communication

One of the four objectives of this study was to explore the culturally appropriate media for effective dissemination of STIs preventive messages to young people in Nigeria. Three sub-themes emerged from the discussion that showed the use of the categories of mass media, that is, the traditional media, the new media, and the inter-personal channel of communication. Consequently, the study established the preference of the young people for multiple information sources. But, there was no unanimity as to which of the categories of the media served as the most popular source of obtaining information. Individual has his/her own preference with some depending on the new media, a number on traditional media, and still a few more on the interpersonal communication. In effect, all the three categories of the mass media appeal to the young people.

5.4.1 Limitations of Mass Media

Subjected to general appraisal were the observed limitations of the mass media in relation to STIs preventive communication campaign in Nigeria? The first constraint

identified was illiteracy, which was widespread. More than half of Nigeria's estimated population of 150 million citizens could neither read nor write even in their mother tongue. The other side to the illiteracy being a barrier to achieving effective mass media messages lies in the fact that people might even be exposed to the information being purveyed by the mass media, but they may not understand what the message is about. This finding accords with the study of Ovbiebo (2011) found that some Nigerian rural women remained vulnerable to HIV/AIDS because they were not being communicated with in the language they understood. The second was the country's notorious epileptic power supply. The perennial poor and inadequate power supply makes it difficult if not impossible for some young people to be exposed to mass media messages that are disseminated through the various mass media. This finding was also corroborated by Nwagwu (2007) whose study revealed that poor and inadequate electricity supply is a major factor obstructing the effectiveness of the broadcast media as vehicles of passing across the reproductive health information to young people. Thirdly, majority of messages disseminated on STIs in Nigeria are in English with a sprinkling of a few others in the three major Nigerian ethnic languages – Hausa, Igbo and Yoruba. Lastly, the study also revealed that the tight work schedule of young people restrict their access to mass media messages. Therefore, it is necessary for the campaign planner to disseminate STIs messages through the various mass media that the different segments of the population would be exposed to.

5.4.2 Better Media Strategies

The next follow-up question was to explore which media strategy suits the promotion of the STIs preventive campaign? Informants voted in favour of "integrated marketing

communication" or media mix as the best means of improving the accesibility of young people to STIs information. Specific attention was drawn to media outlets like street campaigns combined with distribution of flyers, T-shirts and condoms. This suggestion was premised on the believe that it could afford busy people with tight work schedule who could not be reached by other media types to be reached with STIs information either in their work places or homes. There were also others who felt that radio remained the best form of communication. The medium has the reach, accessibility and affordability potential. These are the conditions that have given it the huge advantages over others. Similar result was recorded by the study conducted by Bessinger, Katende and Gupta (2004) which indicated that the exposure to behaviour change messages especially through the radio had strong influence on the people.

From the study's findings, the print media has not been effective in the dissemination of STIs messages. One reason was the cost of newspaper, which informants found discouraging. However, according to the male informants, they patronised sports newspapers more than other conventional newspapers. This obvious implication is that young males can be reached easily through the sports newspaper than the conventional publications. Therefore, campaign planners will find this channel useful in reaching this segment of the Nigerian population.

In fact, hardly is any part or home in Nigeria where television is a scarce commodity or luxurious family possession. However, as already stated elsewhere in this study, Nigeria's epileptic electricity supply limits access to the medium. Nevertheless, with the

poor reading culture of Nigerians, which is bound to affect the popularity of the print media even among the literate, and coupled with high illiteracy rate, television remains one of the best media strategies to promote STIs prevention.

Contrary to the notion that owing to modernity and influence of Western culture, the evidence was found that to a reasonable extent, young people still have forms of regard for religious and traditional leaders. More so, for Nigeria where there has been loss of the citizens' confidence in government and its agencies, dragging religious and traditional rulers who still enjoy some form of respect among the people might create the required respectable authorities and figures who could serve as moderating influence on the young people potential to indulge in risky sexual behaviour. As some of the informants maintained, people are less sceptical of religious and traditional leaders compared to government officials, non-governmental organisations (NGOs) and even foreigners and their organisations. The interviewees then emphasised that religious and traditional leaders still have paramount roles to play in the dissemination of STIs preventive communication messages. Lagarde et al., (2000) also found a similar finding which indicated that efforts should be intensified to involve religious leaders at the local level in the bid at curtailing STIs like HIV/AIDS. What all the findings boil down to is that STIs preventive communication campaign would be effective when media mix is chosen as strategy. Campaign planners have to bear this in mind that those who bear the influence on a target group have the best potential to mould their opinion

Happily, in the light of the empirical knowledge of this study, and stemming from the wide range of literature dealing on the subject, it leaves small room for contention that the best strategy to communicate the STIs information to young people is by the use of integrated communication. STIs prevalence has gotten to a point in which young people must be bombarded with information; information coming from different sources and levels, to the point that anywhere they turn to, they will be reminded of the danger. Best media strategies would then mean a rich media mix of traditional, contemporary and new communication channels used creatively and in a manner that sustain information on STIs avoidance.

5.4.3 Sources of Information in STIs Preventive Communication Campaign

One of the highpoints in the discovery of the study was that most of the HIV/AIDS informants indicated the popularity of the inter-personal communication as the chief means through which they had been informed about STIs. Two of the commonest modes of this channel –seminars and symposiums – were identified as being of great value. The HIV/AIDS Support Groups was also mentioned as an additional source of information. Through their regular attendance, they were able to interact with doctors and other health care providers that assisted them in updating the information at their disposal.

Fingers were also pointed in the direction of the school as another important medium through which the campaign against the spread of STIs could be consolidated. Most of the student informants in tertiary institutions confessed that their first exposure to HIV/AIDS information was through the seminars and workshops that they attended

while they were in high school. The informants credited health clubs in their schools for the organisation of the lectures on STIs and other related issues that provided them with the foundational knowledge about STIs.

On their own, however, they have discovered the value and vast potential inherent in the new media like the Facebook, Twitter, Badoo etc. These social media platforms like many others have become important sources through which they avail themselves with information on STIs. As should be expected, the new media tend to be more popular among the undergraduates in the tertiary institutions. As Jones and Biddlecom (2011) and Levine (2011) have discovered in their study that the internet has become a popular vehicle through which the youth derive information. However, the challenge to making optimal use of the sources, according to the young people, was the epileptic nature of internet facility and electricity in Nigeria.

Unbelievably, books still made a difference as avenue of obtaining information on STIs among the Nigerian youth. This is ironical because Nigerians are often criticised as lacking in reading culture. Young informants in this study, though acknowledged the shortcoming even among them, but maintained that they still use books, even if merely to scan through to search for the information they were looking for. As for pamphlets, however, they saw it as a highly valuable source of information. Nevertheless, since the bulk of the communication used English as a language of communication, this made them to have limited appeal to illiterate young people.

The judgement was almost without dissension that radio remained the most popular medium for STIs information dissemination. Many informants described radio as cheap, affordable, and with extensive coverage. Consequently, the medium served as their most frequented source of accessing information. In fact, the bulk of information they had on STIs was derived from radio. However, they judged the limitation of radio as comprising of the preponderance of focus of radio STIs programmes on HIV/AIDS compared to other STIs diseases such as gonorrhoea, syphilis, herpes etc. Television was also mentioned as another source of information. However, the medium suffered from low accessibility because it was a restricted medium because of the epileptic power supply, also some people's tight schedule would not afford them the opportunity to watch television programmes.

5.5 Chapter Summary

This chapter has provided further evidence on the need for cultural sensitivity in STIs preventive communication in Nigeria. The data in the study revealed that religion aspect of culture has the capacity to protect young people from engaging in sexual risk behaviour. The study established that modernization has not diminished some values placed on virginity within the Nigerian society. It was also noted that some cultural practices in Nigeria were promoting, sustaining and fanning the spread of HIV/AIDS because those culpable practices condoned extra-marital activities of men in Nigeria. Furthermore, the data from the study shows that stigmatization remain a major burden in the Nigerian society while the STIs messages portray STIs particularly HIV/AIDS as an infection that affects only the young people. The data from the study indicated that radio

remains the most popular source of information on STIs while PLWHA prefer getting their information through inter-personal communication.

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

6.1 Introduction

This concluding chapter elaborates on the theoretical and methodological contributions the study has made to the understanding of the relevance of cultural sensitivity in STIs preventive communication campaign in Nigeria. The theoretical contributions of the study teased out two models; one model for STIs positive and another for STIs negative young people in Nigeria. It also highlights some practical contributions for policy and programme development, touches on implication for future research, and presents limitations of the study, and offers some recommendations to ameliorate the threat that STIs have become to Nigeria's younger population and also its contributions. Put succinctly, the distinct contribution of the study lies in its empirical nature that significantly permitted an understanding of how culture can be used as a veritable tool in improving the conduct and management of STIs preventive communication campaigns in Nigeria. The study concludes that it is imperative that the design of STIs preventive messages in Nigeria should incorporate the norms, values, beliefs, and other social–cultural factors of the different ethnic groups in Nigeria. Messages should be tailored to respond to this cultural dynamics because people must not be approached as "cultureless" group.

6.2 Theoretical Contributions

Whatever may be alluded to as the contributions of this work to theoretical knowledge, such efforts can only be described as modest. The study, in fact, is a child and beneficiary of rich and excellent previous scholarly, academic and professional thoughts and ideas on the subject. Indeed, many scholarly, academic and professional publications have profoundly articulated Nigeria's young people health behaviour. Few

empirical studies have explored on the cultural implications of the risky sexual behaviour of the young generation. Therefore, this study theoretically contributes to knowledge by exploring how the "cultural perspective'' that influences risky sexual practices of young people can be used to address the prevalence of STIs. Hence, this study based its approach by using the Theory of Reasoned Action and the PEN 3 model.

Paradoxically, it appeared that many of the past research efforts studied individual context, the influence of religion, the influence of ethnicity (Ahmad & Harrison, 2010; Carter *et al.*, 2007; Green *et al.,* 2009; Mah *et al.,* 2008) on STIs. One overlooked gap appears to be how culture is defining the context of sexual behaviour; the broad influences it is casting on sexual relations that include issues like sexual initiation, STIs and predisposing factors that lead to sexual risk-taking behaviour. This study empirically contributes to a better understanding of this hitherto unexplored subject of how cultural practices are influencing the prevalence of STIs among Nigerian youths.

Empirical evidence was found in this study to strengthen the nurturer component of the PEN-3 model which discusses the role played by friends and family in supporting or discouraging changes in the health behaviour of individuals. This study found that the role played by family and friends further re-enforced the gender inequality on sexual issues among men and women in Nigeria thereby contributing to the continued prevalence of STIs in the country. Among other factors, this study also found evidence that the Nigerian cultural norms did not address the extra-marital activities of men but was proactively fighting to curb the infidelity of women. Therefore, the effect has

substantively made women to be vulnerable to contraction of STIs through their spouses. The study also discovered a similar cultural derivative from the existing practices which was the subservient role of women. The study revealed that Nigerian women suffered restriction both in and out of their matrimonial homes. On the positive side, this has helped reduce the prevalence of STIs through faithful married women. However, Nigerian men are allowed to go freely in and out of the home, as they will and desire. The inadvertent negative repercussion of this practice was that it was contributing to the spread of STIs because some of the men use the opportunity to engage in extra-marital sex.

Again, empirical evidence was found in this study to strengthen the role of nurturer component of the PEN 3 model. It was revealed that the Tiv people in Nigeria (people from the North-Central Nigeria) allow their male guests to have sexual intercourse with their wives or female children as a means of entertaining them. In other words, wives and daughters were treated as "possessions" that could serve as objects for sexual gratification. The evidence resulting linked the practice with the spread of the STIs infections in Nigeria. This study further strengthens the nurturer component in PEN 3 model with the issue of early or forced marriage which was also found to be contributing to the spread of STIs. In some cases while reducing the risky sexual behaviour of young girls, forced marriage has had the opposite effect of driving young girls into prostitution in the case of those who found their parents' choice unacceptable or discover their inability to cope with their chosen husbands. However, quite emphatic was the contrasting cultural value of circumcision. The practice of female circumcision emerged

as a core concept in STIs preventive communication campaign in Nigeria. There was an established link between the practice and STIs because of the use of sharp and unsterilized objects and the poor sanitary environment in which the circumcision usually takes place. Nevertheless, some young girls still have cultural attachment to the practice despite the campaign against it. Thus, this study has contributed to validate that cultural perceptions sometimes surpass scientific proclamations. Again, empirical evidence was found in this study to support the nurturer component of PEN 3 model by highlighting the influence of peers on risky sexual behaviour. This study found that peers are significantly influential in determining the risky sexual behaviour of young people.

In addition, this current study has added to existing literatures by strengthening the TRA theory which shows that the subjective norms in some communities in Nigeria have helped to reduce STIs. For instance, virginity is one. It has remained an attribute of the Nigerian culture, celebrated and seen as a mark of virtue in the womanhood.

Furthermore, this study contributes to knowledge by availing us on a deeper and better understanding of the role of enabler component in PEN 3 model as a tool for curbing the prevalence of STIs in Nigeria. Within the perspective of the study, it was shown that the poor economic situation of women made them subservient and dependent on men. Similarly, the financial constraint of young people was an impediment in their usage of condoms, thus leading to their vulnerability to risky sexual behaviour.

Within the cultural configuration of exercising authority capable of restraining individual behaviour, religion was discovered as an aspect of the cultural life of Nigerians with vast potency. The empirical evidence in this study found that the perceptions component of the PEN 3 model to a larger extent provides a better understanding of how the religious belief of individuals underpins their decision making as it regards risky sexual behaviour. The finding improves the cultural sensitivity perspective by offering that the two main religions in Nigeria, Islam and Christianity can improve the health promotion framework. It extends the cultural sensitivity focus by showing that the two religions preach against adultery and fornication as well as other social immoral behaviour. As a result, to a lesser extent, they guide the conduct of the people. Religion can therefore be used to achieve behavioural change among the religiously inclined young people.

Among other factors, this study also found evidence that to a greater extent, family norm have a positive effect on the lives of Nigerians in spite of some few negative influences it has on the prevalence of STIs. While on the negative side, cases exist of families encouraging their wards to involve in risky sexual behaviour, especially for monetary gain. The positive aspect of the family life shows that young people still cling to the family especially the mother as the bastion of support, the indubitable protective factor against involvement in risky sexual behaviour. Therefore, this study also contributes to the understanding that the inclusion of motherly advice in STIs preventive campaign can improve the effectiveness of STIs preventive campaign towards ensuring behavioural change among young people.

This study further contributes to knowledge by strengthening the existential behaviour component of PEN 3 model. The finding of the study enlarged the scope of understanding by showing that language is a strong variable in the conceptualisation of STIs preventive campaign. It is a dynamic that should feature right from the conceptualisation of the message and continually evaluated all through the life-cycle of the campaign to be sure that people can connect cognitively and perceptually with the message of the campaign. The findings underscored the serious implications of language towards achieving effective STIs preventive communication campaign because language disconnects automatically translates into audience disconnect.

In addition, this current study has added to existing literature in the aspect of stigmatization against PLWHA. The study revealed that the negative attitude that PLWHA experienced within their society, media and family serve as a disincentives towards the disclosure of status or treatment seeking behaviour.

Again, empirical evidence was found in this study to establish that there is a need for STIs preventive communication campaigns to emphasize that HIV/AIDS particularly is not a youth disease/killer disease and also demystify the various myths and misconceptions that individual have on STIs. This study found that most of the PLWHA knew their status when they went for ante-natal check-up. Among other factors, this study also found evidence that the STIs preventive campaign that is disseminated to the public is stale and lack creativity of concept.

Again, empirical evidence was found in this study to support the neighbourhood component of the PEN 3 model which posits that community should decide the means through which they receive their information if effectiveness is to be attained. The findings of the study corroborate the evidence judging the indications emanating from different sources. Most of the HIV/AIDS positive individuals, for example, identified inter-personal communication such as seminars, talking with health practitioners, workshops and support groups in clinics as best avenues for them to have improved knowledge of HIV/AIDS. It serves no useful end and neither is it cost-effective to put emphasis on the use of other media channels as primary agents of reaching this group of people. On the other hand, for the STIs negative individuals who preferred the internet, radio, schools seminars and other integrated marketing communication channels, to reach them, it would amount to waste of resources to deploy other means. The key however is that message conceptualisation and channels used need to have specific audience in mind. The audience cannot be treated as a single mass of message receptors if communication effectiveness is to be achieved. Another complementary factor that would have to be taken into consideration in this area is that campaign planners must determine the limitations of the various mass media (such as electricity failure, illiteracy, cost and unaffordability) prior to making a media choice. These factors ultimately decide the effectiveness of cultural sensitive STIs preventive communication.

The peak of the theoretical contributions of this study is the teasing out of two models which are cultural sensitive model for STIs positive young people and cultural sensitive model for STIs negative young people. This will be discussed in the next section.

6.2.1 Cultural Sensitive Models

A major development from this effort is the production of two main cultural sensitive models, one focusing on the STIs negative young people, and the other, about their STIs positive counterparts. These models help to answer research question four whose aim was to examine how culturally based health communication can affect STIs preventive communication. These models show how different STIs messages ought to be designed for these two categories of people in order for the STIs communication campaign to be efficient and effective.

Under the cultural sensitive model for the STIs negative young people, the elements of culture deserving attention, the type of message content that needs to be emphasized, and the message channels that should be adapted in the dissemination of STIs information for this category of people, were all emphasised. Likewise, the same – that is, identifying the critical variables – crucial to the development of cultural sensitive communication for STIs positive young people are highlighted with a view to ensuring the effectiveness of any contemplated campaign.

6.2.1.1 Cultural Sensitive Model for STIs Negative Young People

Generally, from the findings of the study, the elements of culture, which best contribute to effective communication campaign of STIs, with negative young people in Nigeria in mind, are: religion, virginity, faithfulness in marriage, female circumcision and polygamy. Some aspects of the culture contribute negatively to the prevalence of STIs among Nigerian youths, while a number of others contribute positively to it. Religion and virginity, for example, are regarded by the youths as good themes to explore toward promoting sexual abstinence that has high potential of insuring against risky sexual behaviour. Also, faithfulness in marriage was regarded as a positive cultural value with the potential of reducing the prevalence of STIs among young married couples. On the other hand, however, is polygamy, which is construed as a negative aspect of the people's culture, and has continuously contributed to increase in prevalence of STIs. The negative values of polygamy might, as a result, be a good theme to explore to dissuade the young negative STIs population from polygamy, which will naturally expose them to multiple sexual partners and the potential risk of contracting STIs in the future. On the contrary, polygamy can also be used in the positive light if the media convince people who are already in a polygamous marriage to remain faithful to their partner(s). The campaign should call attention to the fact that faithfulness in a polygamous home can still result in the reduction of the prevalence of STIs. This domain from the STIs positive model is derived from the nurturer component of relationship and expectation domain. While polygamy is derived from th negative component of the cultural empowerment domain of the PEN-3 model.

This leads to the media content of the STIs positive model. For the STIs negative young people, the “cultural identity marker”, which stereotyped STIs as a youth disease, was considered unwholesome. Overall, they were not comfortable with the image and imagery of the youth depicted in the media campaign messages. The messages painted in the minds of the young people misconceptions and fed myths that should have been clarified by the STIs preventive messages disseminated to the various publics. This is derived from the perception component of the PEN-3 model.

As an instance, majority of the young people felt the message did not stress the importance of knowing the STIs status of expectant mothers. Also, the lack of creativity or the inadequate use of it, surrounding the messages often disseminated, discouraged the attention the young people should have paid to them. This became prominently noticeable in the use of contraceptives or other means of protection by the sexually active younger population. Those who preferred to use protection had another problem: the hurdle of “enabler factors”, which make their procurement almost impossible. This is derived from the enabler component of the relationship and expectations domain of PEN-3 model.

However, the irony, found by this study, is that language still has an essential role in message design. This singular phenomenon has a potent role as it can make or mar the effectiveness of STIs message. The study shows that if the message content and channels are gotten right but the language usage is not appropriate, it will still lead to ineffective dissemination of information. This shows that language constitute an

important phenomenon that must be put into significant consideration Thus, the tripartite combination of message, channel and language constitute an important phenomenon that must be put into significant consideration in achieving effective STIs message dissemination. This is derived from the existential component from the cultural empowerment domain in the PEN-3 model.

On the side of media usage, that is, which of the channels of communication has the greatest potential of reaching a particular community of STIs vulnerable youths, it was discovered that STIs negative young people prefer information to be disseminated to them through the channels they can easily have access to. Unexpectedly, many of them identify the "new media" such as internet and the social media, while the traditional ones like the school seminars and radio also constitute avenues that they relate with. The young people also suggested that the utilisation of traditional and religious leaders in the dissemination of STIs messages would go a long way in ensuring the desired behavioural change. This is derved from the neighbourhood component of the cultural identity domain of the PEN-3 model.

The general import of this discovery is that the failure to follow a strategic process that consciously attends to the culture, values and norms of the people in message design, packaging and dissemination will result in unfavourable reception or even rejection of such campaigns. Exceptions cannot be made of the STIs campaign and that is why it raises the issue of ensuring cultural sensitivity in the way behaviour change communication targeting the young people in Nigeria is packaged.

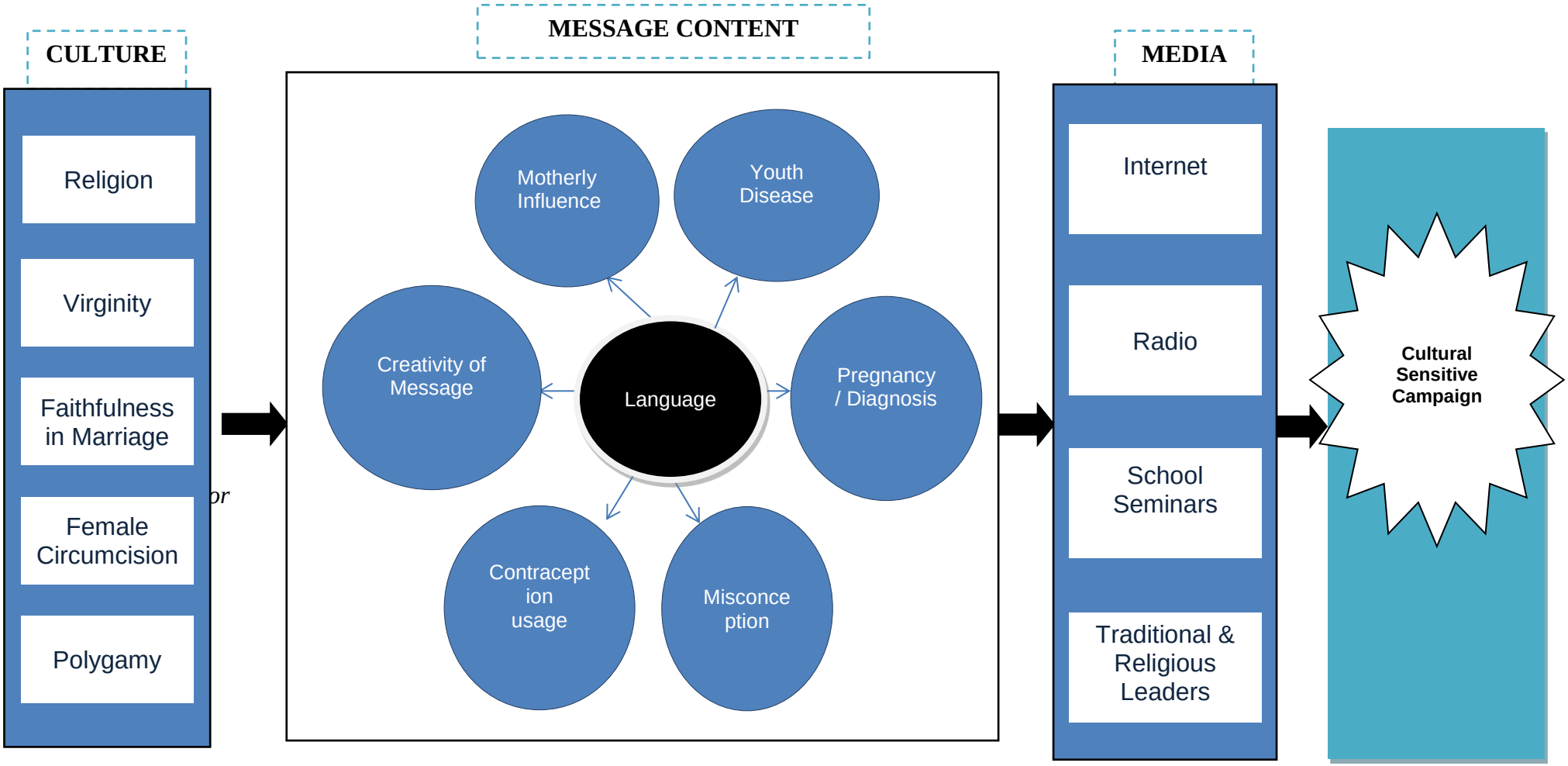

Figure 6.1. Culture Sensitive Model for STI Negative Young People in Nigeria

6.2.1.2 Cultural Sensitive Model for STIs Positive Young People

Virginity, faithfulness in marriage and female circumcision constitute the elements of culture which best contribute to effective communication campaign for STIs positive young people in Nigeria. The informants explained that the role of nurturers and the need to satisfy a significant others as the factors which influence virginity, faithfulness in marriage and female circumcision. Nurturers is one of the componets in PEN-3 model while opinion of others is derived from TRA.

On the message content realm, the young people explained that the portrayal of STIs particularly, HIV as a killer disease was what contributed to the negative perception that people have about them. This negative perception by the people made the people living with STIs and PLWHA not to disclose their status to their friends and family because of the fear of stigmatization. The findings of the study also indicated that if there is a need for any meaningful impact of STIs preventive messages, then there is a need for the involvement of people living with STIs in the conceptualisation of the STIs messages. The involvement of these groups of people will help in synthesizing the most cogent information which will strictly address the purpose of the message that is disseminated. The informant also indicated that there is a need for STIs messages that is disseminated to be current and up-dated. However, the backbone of the STIs messages remains that there is a need for messages to be disseminated in the local dialects of the recipient of the messages. This remains important if the messages disseminated must remain effective and successful. The model shows the language revolving round the other concentric circles in the message content block. This shows that that language is the

unifying force that holds other circles in the message block content. This domain reflects the relationship and expectations domain in PEN-3 model while the language attribute in the message domain is derived from the existential component of PEN-3 model.

On the final analysis, the findings of the model indicated that the STIs positive young people in Nigeria prefer interpersonal communication (seminar, communication with medical practitioners and support group meetings) and radio. The reason for this preference is because they do not like the information that is disseminated thorough other traditional media and internet about them. The preference for radio might be connected to the fact that radio offers better and personal information and it is also portable and convenient for them to carry about. This domain is derived from the neighbourhood component of PEN-3 model.

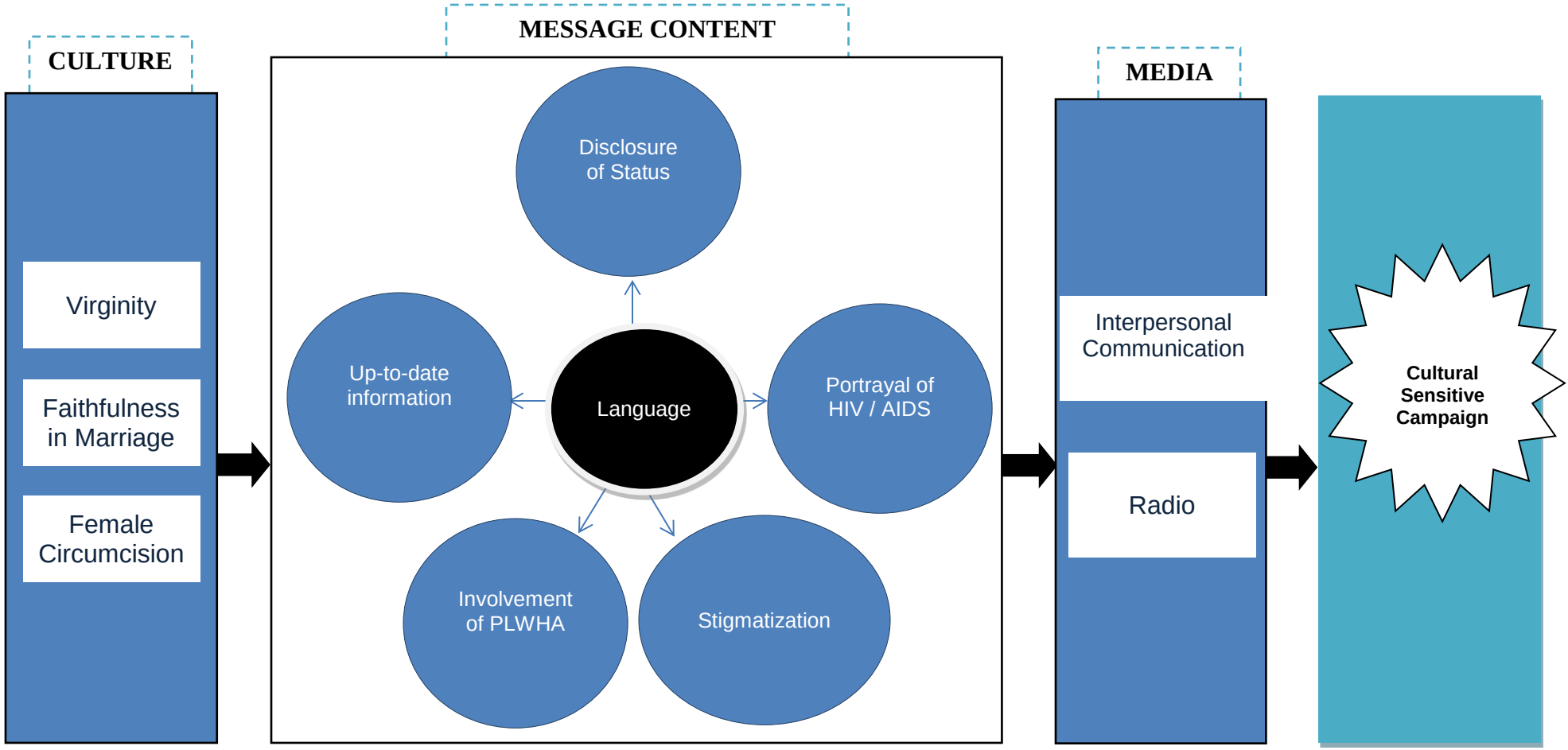

Figure 6.2. Culture Sensitive Model for STI Positive Young People in Nigeria

6.3 Methodological Contributions

This current methodological approach was radically different from most previous studies because substantial studies used the quantitative method. This study provides a comprehensive evaluation of cultural sensitivity in STIs preventive communication campaign in Nigeria. This study embarked on pure qualitative method in order to bridge the gap of having an in-depth and rich understanding of how culture can be used to improve STIs preventive communication campaign. This methodological approach further contributed to how qualitative instruments can be used in exploring highly social and cultural subjects by embarking on triangulation method through the usage of STIs positive and negative young people. The qualitative study provided an enhanced and in-depth understanding of cultural sensitivity of STIs preventive campaign through tapping the perspectives of both STIs positive and negative on the issue.

The study also derived its methodological contributions through the unit of analysis of this study which are the STIs positive and negative young people within the age range of 15 -26.

6.4 Practical Contributions

Several issues have been thrown up by this study. Theory and model have been tested. Opinions have been expressed just as facts have been subjected to analytical inferences. The issues were as myriad as they were diversified in scope, perspective and dimension. Important areas calling for attention can however be distilled from the basketful ideas that are portending the way forward. On the general perspective, the findings of this study indicate that TRA and PEN 3 can be used to address the problems facing STIs

both in developing and developed countries. An addendum to this is that the study will be useful for policy makers and the public at large on how to curb the prevalence of STIs in Nigeria by paying close attention to areas of Nigeria that are either enhancing or discouraging her young people's disposition to risky sexual behaviour. What this implies is that STIs would have to be taken seriously, first by the government and the people. It is in this light that the following recommendations are made.

i. There is need for a broad based and relentless awareness campaigns. The campaigns would need to be segmented and targeted at different segments of the public like PLWHA, STIs negative young people, literate and illiterate people, young males and females, traditional and religious leaders, medical and health workers and other various professionals, to mention a few.

ii. Also, future STIs preventive communication campaigns in Nigeria would have to make a radical departure from the past. They would need to be anchored on the cultural norms and beliefs of the people and embodied as communities. High creativity is required in terms of use of the indigenous languages such as integrating local proverbs and idioms that can add to the effectiveness of the messages.

iii. The designers of STIs preventive communication campaigns should as a matter of urgency cultivate the habit of being sensitive to the influence of culture on STIs message acceptance by the people. It is worthwhile to make the process to be guided by the needs assessment of the people (Madelief, Schaalma,

Bartholomew & Van Den Boerne, 2008). Needs assessment involves conceivers and designers of the campaign meeting the target communities to assess their significance needs and learn about their experiences and making use of the knowledge derived as the basis for designing their intended campaign.

iv. Beyond dispute, the paradigm must shift in terms of approach being used to execute STIs preventive communication. What is strongly recommended is the participatory method instead of the top-down model that had characterized the previous attempts. The top-down approach had not been sensitive to the culture and norms yet cultural sensitivity had shown that it could only be ignored at the peril of the interventions and its implementers. The integration of positive cultural practices, norms and taboos should therefore feature in the campaign intended to stop the spread of STIs.

v. It is also important to involve traditional, religious and STIs positive people in campaign conceptualization, planning, design and implementation if behavioural change is to be achieved in the country as a whole.

vi. There is also a need to create more awareness regarding the risks involved in cultural practices such as wife inheritance and the use of wives and female children to entertain guests, which are pathways to contraction and spread of STIs. Community opinion leaders and traditional rulers of areas where these

practices are still being practised should be mobilised, educated and enlightened about the dangers inherent in these cultural practices.

vii. Similarly, female circumcision would need to be strongly dissuaded. Government should work in partnership with communities to devise an alternative to female circumcision that will give same social value and respect to people who believe so much in the cultural practice.

viii. It is equally needed that government take every step to put an end to forced or early marriage of young girls. The fact that government ignores the inappropriateness of early marriage has continued to increase the prevalence of the practice thereby exposing young girls to STIs.

ix. Traditional doctors play a significant role in the treatment of STIs among the young people. While it is difficult to bar young people from seeking treatment from them; there is a need for the traditional doctors to be trained in order to enhance the treatment and STIs information that they provide for those who consult them. On the other hand, it is also essential to sensitize young people on the need to use the orthodox treatment method, visit the hospitals, when infected by STIs instead of going to roadside medicine shop.

x. Designers of STIs preventive communication campaign should, as a matter of urgency, create awareness on the importance and need for pregnant women to know their STIs status during their ante-natal care.

xi. In the light of the fact the use of condom remains the sole decision or prerogative of the male, it is important for a male-oriented campaign to be mounted to persuade men to accept condoms as a means of protection.

xii. Women have to be economically empowered so that they can provide for themselves as well as have bargaining power in the home and in the larger society. This will guarantee them a degree of independence and autonomy to take crucial decisions concerning their lives, including their reproductive health.

xiii. There is a need for the health services to be within reach of the people. Therefore, there is a need for mobile medical vans that can make health services accessible, particularly to remote and inaccessible areas of the country.

xiv. STIs campaign planners need to re-direct the predominant focus of their attention on HIV/AIDS to other STIs. This is the reason why young people have little or no knowledge of other STIs that are very detrimental to their reproductive health. This has to be addressed to give them a balanced view of the risks associated with sex.

xv. It is high time that government took decisive action against parents influencing or exposing their children to risky sexual behaviour because of family financial constraints. A serious public awareness, enlightenment and mobilization is required so that all and sundry can know about the negative consequences involved.

xvi. There is a need for campaign planners to design STIs messages in the different dialects in Nigeria. The use of English language and the three main languages for STIs message design has reduced the effectiveness of the STIs messages. Since young people cherish their indigenous language, information passed across in their mother tongue would be positively received.

xvii. Campaign planners also need to correct the distorted image of STIs by enlightening the people that not only young people are susceptible to HIV/AIDS and other STIs in the society. It is important to emphasise that elderly people and infants are equally at high risk of contracting STIs.

xviii. In view of the popularity of radio as the best form of communication of receiving information on STIs, the government should provide appropriate support for the introduction of community radio as well as strengthening the capacity of existing ones to perform more enlightening and educational public service roles. The indigenous form of communication should also be encouraged.

xix. Religion has been seen as a key element of culture that can be used maximally to curb the prevalence of risky sexual behaviour often leading to STIs. Since religiously inclined young people regard involvement in risky sexual behaviour as a sin, this is a good theme to explore in conjunction with other tenets in prevention campaigns.

xx. The bottom-line of all these recommendations rests on the Nigerian government. The government will have to evolve the right policies and programmes backed up by the political will to see STIs scourge not just as health problem but as a major development challenge with serious implications for the future and progress of the country and its people.

6.5 Suggestions for Future Research

Obviously, there are areas of the study that can be built on either because they have not extensively or conclusively explored, or because they have stimulated new thoughts of widening the scope in another direction. Of course, this study is very unpretentious in terms of scope and dimensions. To point one quick area that needs fresh insights is to direct attention on focusing on mixed methods with a view to arriving at a rich empirical conclusion. Another area for future research is to conduct a study among young men and women with low education qualifications. This, certainly, will fill the knowledge gap on experience and perception on cultural sensitivity in STIs preventive campaign in Nigeria which has been observed in this study.

The present research was conducted in the urban part of Nigeria; therefore, it would be interesting to know the results that would evolve from the rural and remote areas of the country. In all likelihood, the results emerging from such studies will either provide additional information to this study, or serve as a comparative view on the subject. In the final analysis, future studies should extend the research frontier to other people who are beyond the age range of 26 years old that were used as a unit of analysis in this research. This will enable the study to get different perspectives from people from another age bracket. The different perspectives that would be garnered from such research will guide STIs campaign planners to implement better campaign strategies which will be strategically targeted towards people who are vulnerable in the age bracket beyond 26 years.

6.6 Limitation of the Study

This study employed the qualitative research method using both STIs positive and negative individuals through the utilization of in-depth interviews. The findings of this study can only be taken as exploratory and not conclusive of the general Nigerian situation. In the first instance, the sampling population was small, and secondly drawn from a few different ethnic groups of people who are residents in the three states used. This does not make broadly representative of the vast Nigerian population with over 250 ethnic groups. Compounding the sampling size and distribution problem was another limitation, which concerned the researcher's inability to have access to some potential informants who are STIs positive in University of Ilorin Teaching Hospital (UITH) Ilorin due to some bureaucratic hurdles created by the hospital management.

Despite being an in-depth interview, this has not eliminated the probability of informants being selective with the type of information they willingly divulged. Probably, the informants might not have given away information to the fullest extent possible. There could have been some form of self-censorship in order to project a good image of themselves and representation of their culture. Self-censorship might also have intruded in the way informants provided answers to some questions that they felt were too personal. They might have also deliberately omitted details, or partially revealed their experiences. Since there was no way of cross-checking the accuracy of the information, the responses could only be taken at face value which naturally imposed the limitation of its own.

Another limitation of this study is relation to the age bracket of the informants. They were young people between the ages of 15 and 26years. Therefore, their age, maturity, exposure and experiences could have influenced their perspectives regarding the influence of culture on STIs, the media and message strategies on STIs as well as other related issues. The resultant findings, probably, was limited too based on the selectivity of the people who participated in the study. However, attempt was made to keep the findings in context as the demanded by the cardinal principle of qualitative analysis.

6.7 Conclusion

In concluding this study it would only be worthwhile to recapitulate some of the cogent or salient issues. It starts by asserting that the data that have emerged from this study

indicated that there were positive and negative cultural practices that had the tendency to reduce or increase STIs prevalence. Therefore, it is imperative that contemplated communication intervention programmes in Nigeria should put into consideration the norms, values, beliefs, and other social–cultural factors unique of the different communities. Different ethnic groups in Nigeria possess different cultural norms suitable for incorporation in the design of preventive messages. Messages should be tailored to respond to this cultural dynamics because people must not be approached as "cultureless" group. Culture is a strong element defining the identity of people; its dynamism is strong that it cannot be neglected in effecting effective behaviour change.

The young people from this study advocated the need for segmentation in STIs preventive campaign communication because Nigerian culture provided different roles for the genders in the Nigerian society. STIs preventive messages, consequently, need to be sensitive to gender based cultural issues in their campaign outreach. On the issue of language, the young people similarly opined that local language gave them a sense of belonging and gave them easy identification with information given in their mother tongue. Therefore, they clamour that for STIs messages to be effective there is a need to use the different dialects in Nigeria to re-enforce the existing campaign in English and the three main Nigerian languages which will make STIs messages more effective.

Another lesson from this study is the strengthening of the position of PEN 3 model that posits that culturally sensitive communication interventions are crucial, and that communities should spearhead behaviour interventions, both as agents and beneficiaries,

in order to make the intervention gain acceptance in the community. Logically, planners and designers of communication intervention programmes have to learn to work with target communities before, during, and after the intended intervention programme. As a prior step, they have to assess the priority needs of the communities, share experiences with them, and use the facts gathered as the basis for designing their intervention programmes. Loudly, this study is shouting the caveat: when prevention intervention programmes and policies are designed for young people, let it be researched and evidence based. STIs preventive campaign planners should not ignore the fact that not respecting the cultural context of their target audience would only lead to waste efforts.

To a reasonable degree, this study has demonstrated the possibility of exploiting evidence-based approach that researchers, policy makers, NGOs and government agencies can adapt and adopt in designing culturally sensitive STIs preventive campaigns in different parts of Nigeria. We have seen how commitment to achieving objective understanding of an issue can lead to learning about many factors influencing it, which have to be planned for towards finding a realistic solution. An example from this study is the fact that indicating the need for messages that can improve the knowledge of young people about other STIs apart from HIV/AIDS. This vital knowledge would have been impossible if, as this study had done, the researcher had not gone to the field to get information first hand from STIs positive and negative young people from different ethnic groups in Nigeria.

What this suggests is that finding answers, or responding, in pragmatic ways to all the myriad issues that the study had afforded to be learned about STIs will serve the best interest of Nigeria in the attempt at containing the rising spectres of risky sexual behaviours among her youths. The future of the country will thereby become more secured.

6.8 Chapter Summary

This chapter provided established the theoretical, methodological and practical contributions of this work to knowledge. The study also produced two main models that can be used to communicate effectively to young people on STIs preventive communication. The first model is for STIs negative young people while the second model is designed for STIs positive young people. The two models established that there is a need for different communication campaigns for the different segment of the population.

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