Secrecy & Disclosure

How women with sexually transmitted infections manage their steady relationships
An exploratory study in Suriname

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After 18 hours of non-stop writing I am filled with happiness and pride to finally start with the preface of my thesis. This thesis is the end product of the international course ‘Amsterdam Master’s in Medical Anthropology’ over the year 2006-2007. It marks for me the closing of a wonderful year in the Netherlands and the beginning of a new, hopefully, very fulfilling chapter in my life.

When I started the AMMA course in the beginning of September 2006, the topic I have chosen was in the back of my mind. I knew I wanted to ‘do something’ with sexually transmitted infections, but what exactly mentally matured in a later stage. I have chosen to write about a sensitive, but very important aspect in the context of sexual and reproductive health: “women with symptomatic sexually transmitted infections managing their steady relationships”. The topic embraces aspects of stigma, issues of status disclosure and partner notification. And it also deals with secrecy and lying as management strategies.

I had looked forward to the data collection in the field, since I was wondering how people would react on my questions. I feared many rejections, but besides some minor problems, everything went fine. Different it was in writing this thesis. Disaster happened. In the last week of finishing my thesis, a computer virus infected and destroyed a great deal of my data. I was shocked and mad at myself, but later on I was very much amused when my supervisor Sjaak remarked: “it sounds like your stories of STIs in Suriname.”

My immense gratitude goes to several organisations and people. First, I would like to thank the University of Amsterdam and the AMMA committee for selecting and accepting me as a student. My cordial gratitude goes out to NUFFIC for granting me this great fellowship and the Dutch Embassy in Suriname for their excellent guidance.

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Thank you,

Sahienshadebie Ramdas
Abstract

Sexually transmitted infections (STIs) are a complex public health concern. On one side, the spread of STIs can be prevented within steady relationships if sexual partners disclose their status. On the other side, and understandably, STIs are often surrounded with secrecy and lies. This research is an attempt to understand this dilemma. The main research question is: “How do women manage their relationships when they have a symptomatic sexually transmitted infection; do they disclose their status to their steady or other sex partner(s) or do they keep it a secret and why?”. STIs, other than HIV are the focus of this study, since they are important co-factors in the acquisition or transmission of HIV. In the first chapter a short introduction is given about Suriname and the country’s health system and services. The methodology of the research is presented as well and a brief elaboration on theoretical concepts. This study is a small-scale exploratory research. Fieldwork was carried out at the Dermatological Service in Suriname. Multiple in-depth interviews were conducted with nine Surinamese women who were in steady relationships and infected with a symptomatic STI. Six were STI patients and three were recruited outside the bio-medical circuit. Several key-informants were interviewed as well. The main theoretical concepts used are explanatory models of illness and disease, stigma and secrecy and impression management.

Chapter two presents nine case studies of women with STIs which constitute the core of the research findings. Each story is different and as the context changes, the scenarios change. The last chapter is on the analysis of the data. Based on my research findings, I conclude that these women managed their relationships and sexual lives by applying different strategies on different levels within their specific socio-personal setting, economic and cultural context. These strategies were closely connected to aspects of stigma related to STIs and sexual behaviour, issues of secrecy and lying, status disclosure, partner notification and women’s causational explanation for their health condition. My research further showed that most of the women in this study disclosed their STI status in a ‘diplomatic’ way, to their steady partner and/or to their other sex partner. This ‘diplomatic’ disclosure could vary in degrees of openness depending on the relational context of the women. Complete secrecy was kept only in one case. The moral experience of stigma was a cross-cutting issue. Mental efforts in terms of thoughts, calculations and possible explanations of the women with STIs about their condition have been powerful forces in facilitating the way women managed their sexual lives and relationships.
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Introduction: Sexually transmitted infections as focus of the study

This study discusses an intimate area of people's life: having an infection or a disease in the most private parts of the body. It is about getting to know a person with a sexually transmitted infection and trying to grasp the dynamics of their feelings, thoughts, explanations, actions and attitudes towards it in a way that make sense to them in their own daily reality of life. In particular I have explored a small group of women experiencing symptomatic sexually transmitted infections (STIs), other than HIV, within the context of steady relationships. I have tried to understand how they went about disclosing their status to their steady partner(s) and how they tried to manage their sexual life in the given context.

My research is connected to the field of STI/HIV/AIDS prevention. Status disclosure to sexual partners when having a sexually transmitted infection (STI) is of utmost importance to prevent further spread. Therefore, openness and communication about STIs are stressed and stimulated by international and national health authorities. A necessity indeed, since STIs are a global public health concern. According to the World Health Organization (WHO), every day, nearly a million people acquire a sexually (STI), including the human immunodeficiency virus (HIV) leading to the killer Acquired Immunodeficiency Syndrome (AIDS). According to the draft global strategy report on prevention and control of STIs, 340 million new cases of curable STIs are estimated to be occurring every year worldwide in men and women within the age group 15-49 years (WHO 2006: 12).

South and South-East Asia are the most affected regions, followed by sub-Saharan Africa and the Latin American and Caribbean countries. Millions of viral STIs are also reported to occur annually. It is stated that STIs constitute a huge health and economic burden, in particular for developing countries, where 17% of economic losses are estimated to be caused by ill-health due to STIs (ibid). Except for this, STIs, other than HIV, are also reported to impose a huge burden of morbidity and mortality having negative impact on national and individual economies especially on sexual and reproductive health and child health (ibid: 15).

HIV in itself is an STI, because the predominant mode of transmission is sexual. But numerous epidemiological and biological studies done over the years emphasize the facilitating role of other types of STIs as important co-factors in the acquisition or transmission of HIV (Workowski et al. 2002; WHO 2006: 9). Thus, people having another type of STI stand at greater risks to be infected with HIV more easily. In Suriname, annual new cases of HIV+ accumulate at very high speed since 1996 and currently the ‘adult HIV
prevalence rate is estimated at 1.9%, while the total number of persons with HIV in Suriname is estimated at 8000’ (Terborg et al. 2006: 60). Having another type of STI could have been facilitating this further spread.

National data on other types of STIs are lacking, since systematic and comprehensive data collection and analysis in this area, as in many other developing countries (Mayaud & Mabey 2004:3), are a major problem. An important source of STI data however, is the Dermatological Service of the Ministry of Health. Estimates are that about 20% of all STIs are treated by the STI unit of the Dermatological Service (Ministerie van Volksgezondheid 2005: 23). The data provided by the department shows STI trends among the group of STI patients visiting the clinic. Of all STI diagnoses for the male patients (866) in the periods 2004-2006, Gonorrhoea accounted for 70%, followed by Condylomata Acuminata with 7% and Genital Herpes with 6%. Of all STI diagnoses for the female patients (718), Gonorrhoea accounted, though less than within the male population, also for the majority: 26%. Gardnorea Vaginalis accounted for 18%, followed by Candidiasis with 18%, Trichomonas Vaginalis with 11%, Condylomata Acuminata with 11% and Herpes with 4%. Most STIs occurred within the age group of 15-49 years for both males and females.

The data provided above only stresses the severity of the situation regarding STI infections and the importance of open communication. But when viewing the socio-cultural, emotional and physical context in which STIs are imbedded, it becomes evident that being open and honest about one’s STI status is often more difficult than expected. STIs have a highly stigmatizing character (Inhorn 1986: 42). Even though bodily deformities due to symptomatic STIs can be hidden most of the time for others, having an STI and disclosing one’s status to others can be extremely difficult and blocked due to overwhelming feelings of fear for rejection, guilt and shame (Inhorn 1986: 62; Eng & Butler 1997: 1; Nack 2000: 105; Lichtenstein & Schwebke 2005: 385; Mulholland & Van Versch 2007: 25).

In my research I wanted to explore further on the aspects of status disclosure and management of sexual life within steady relationships. On one side the spread of STIs can be prevented within steady relationships if sexual partners disclose their status. On the other side, STIs are often surrounded with secrecy and lies. My research, therefore, is an attempt to explore this dilemma between secrecy and prevention. My main research question is: “How do women manage their relationships when they have a symptomatic sexually transmitted infection; do they disclose their status to their steady or other sex partner(s) or do they keep it a secret and why?” In the following sub questions, whenever I mention ‘women’ with STIs, it is within the framework of marital or steady relationships. Defining
steady relationships is often difficult, because such definitions are always context dependent and may vary cross-culturally. Therefore I have worked with the women’s own definition of steady relationships. I have specifically focused on STIs, other than HIV. In this document, whenever I use the phrase ‘women with STIs’, I mean ‘STIs other than HIV’, except when more clarity is needed.

The sub questions are:

1. Which explanations were given by the women for their STIs and why?
2. If women decided to visit the clinic for treatment of an STI, how was their health seeking behaviour prior to that and what made them visit the clinic?
3. How did the women with STIs deal with status disclosure and partner notification and in which way did stigma affect their action?
4. How did doctors respond to requests of STI patients regarding status disclosure and partner notification?
5. What was the role of secrecy in the women’s life and how did that correspond to the management of their partners’ impression of them?
6. In what way did the women with STIs think about being at risk for attracting HIV and did they use condom use in their sexual relationships?

One issue that came up in several researches and discussions is that people often did not know that they were infected with an STI and that they had infected their steady sex partner with an STI (Inhorn 1986: 60; Youm & Laumann 2002: 3). The foremost reason for this is the asymptomatic character of many STIs (Mayaud & Mabey 2004: 8; World Health Organization 2006: 32). For my research this has not been a problem, because I focused on women, married or in other steady relationships, with existing symptoms.

There are two major reasons why I have been interested and motivated in doing this study from the emic perspective of women with sexually transmitted infections. The first and direct reason is the fact that I wanted to anticipate on the existing gap in knowledge and understanding about the sexual behaviour of people with STIs, since there are very few studies done about people with STIs in Suriname (Ministerie van Volksgezondheid 2005: 23). I have been confronted with this as well in my own work at a community health development institute, where I was engaged in collecting and analyzing data on several sexual and reproductive health issues. It became evident that more in-depth research was needed about understanding people’s sexual behaviour with regard to STI/HIV/AIDS prevention. This
stimulated my interest in doing this study, which I believe is both useful and necessary for my community.

In addition, several important national and international health policy documents and studies express the growing need for more research about people with STIs and understanding their sexual behaviour in personal and socio-cultural contexts (United Nations Fund for Population Activities 2004: 1; Ministerie van Volksgezondheid 2005: 26; Terborg 2006: 73; World Health Organization 2006: 29; Mulholland & Van Wersch: 1). This call comes from the increasing recognition that tackling infectious diseases, in this case HIV and other STIs, from bio-medical perspectives only, is not enough to control and prevent further infections. This is because human behaviour, especially sexual behaviour is far more complex and diverse (Helman 2002: 111). Therefore, to stimulate behavioural change needed to improve peoples’ health in general and sexual and reproductive health in particular, it is necessary to understand how and why people behave the way they do.

The second and more hidden reason for doing this research is my personal experience with some people known to me who have been confronted with STIs in their lives. In the moments spent with them I have shared their doubts and anxieties, helped them to think about possibilities of how to solve the problem and experienced how difficult it can be to deal with STIs. I have also seen how they were emotionally tortured for having an STI and how they fought with the fear of having HIV. In previous research that I conducted about adultery in Suriname (Ramdas 2005), I also learned about some people who had multiple sex partners, had unprotected sex, got infected with an STI and then managed to somehow deal with it without their steady sex partner ever knowing about it. From these experiences, I got the motivation to do research about people with STIs in marital or steady relationships whenever an opportunity arose. This study provided that opportunity.

 disclosing one’s STI status to sexual partners is crucial to avoid STIs rapidly spreading. My study is an effort to contribute to better insights in the phenomenological and socio-personal aspects shaping people’s sexual behaviour and their decision to disclose their status to their sex partners which may be of important value to prevent and control further spread of STIs and HIV. The knowledge provided through this study might be crucial for health policy makers and other health professionals, especially those involved in design and implementation of STI/HIV/AIDS prevention programs. This research has a very exploratory character; therefore I aim as well to stimulate further future behavioural research about people with STIs.
In chapter one, I briefly present Suriname’s socio-demographic context and continue with the methodology of the research. Relevant theoretical concepts and other methodological issues are also part of this chapter. In chapter two the case studies are presented; nine different stories of nine different women are highlighted. In chapter three, the contextual analysis is made with emphasis on the use of the theoretical concepts in relation to the empirical results. Parts of both the case studies and interviews with key informants knowledgeable about people with STIs are, wherever necessary, used. Conclusions are part of the final section.
Chapter 1
Background Suriname and research methodology

This chapter is meant to provide some background information about Suriname, the country where the research is conducted. In the sections following after the methodology of the research is presented as well as a brief elaboration on the theoretical concepts. The goal is to provide an in-depth understanding of the methodological and theoretical framework within which this study is done.

1.1 Background Suriname

Suriname has a relatively small population of 492,829 people consisting of several ethnic groups. The four major ones are the Hindustani’s with 27%, followed by the Creoles with 17.7%, the Maroons 14.7% and the Javanese accounting for 14.6%. Unemployment rate among males and females are estimated at respectively 4.5% and 5.0%. Suriname is considered a relatively underdeveloped country; estimates are that 70% of the population lives below the poverty line (Terborg et al. 2006: x-8).

1.2 Suriname’s health system and services

Suriname’s health system is formally founded on the bio-medical health system. The core institutions are the Central Office of the Ministry of Health, the Bureau of Public Health and the Inspectorate. The central office and the Inspectorate function at the level of planning, monitoring and control of global and national health programs. The Bureau of Public Health is the main organization for health care and includes a health education department, an epidemiology and biostatistics department, and several programs for family health and disease control. This office provides information on disease distribution through its epidemiology unit, which operates a surveillance system on communicable diseases in cooperation with the Regional Health Service. The Ministry of Health assigned the Medical Mission, a private, non-profit organization, with the responsibility for all medical care in the Interior (Terborg et al. 2006: 141). There are also several non-governmental organisations supporting community health development and an informal traditional healthcare system also exists.

Another organization with disease control activities and health promotion is the ‘Dermatologische Dienst’ (Dermatological Services) of the Ministry of Health. The control of STDs and HIV/AIDS are one of their important goals. Services are provided through a central
polyclinic in Paramaribo and two other districts. Every year, the Dermatological Service handles 24,000 patient visits and performs 46,000 laboratory tests. Approximately 20% of visits are due to sexually transmitted diseases (Ministerie van Volksgezondheid 2005: 23).

1.3 Study type
The nature of my research is problem oriented. Sexually transmitted infections and HIV/AIDS are prioritized sexual and reproductive health problems in Suriname. This study is a small-scale exploratory study with a descriptive character.

1.4 Defining the study population
My initial goal was to study both men and women with sexually transmitted infections. During the six weeks of fieldwork in Suriname I spoke to both men and women, but to women in majority. After returning back to the Netherlands and after discussing my field research with my supervisor, it became clear to me that I had extensive material on the stories of women. My supervisor suggested focusing on women only. Drawing forth on his suggestion, I shifted my orientation on women as my study population. These are women, living in Suriname, who are in a marital relationship or other steady relationship, and who are infected with symptomatic STIs. I deliberately defined my study population in this way, because in my study I have focused both on women with STIs who seek bio-medical health care and women who do not. In my study population I did not include commercial sex workers, because their social working and living conditions are quite different than those who do not work in that sector.

In total I spoke with nine female informants. These women I spoke were mainly STI patients of the STI clinic at the Dermatological Service in Suriname. Only three were persons outside the bio-medical setting. I spoke to women with several ethnic backgrounds: three Hindustani women, two Creole women, two women from the Maroon society and two women with mixed ethnic backgrounds: one was a mix between Hindustani and Javanese, the other had several mixtures but had strong features of a Javanese mix Creole. All of the nine women were in steady relationships. Their age ranged between 20 - 45 years.

1.5 Fieldwork at the Dermatological Service: quite an experience
With a topic as sensitive as mine I thought it would be very difficult to find informants. Especially with the limited time of six weeks in the field. Anticipating on that I had already contacted the head of the Dermatological Service of the Ministry of Health in Suriname, Drs.
Leslie Sabajo. After some emailing back and forth about my research, doctor Sabajo gave his permission to conduct the research at his institution. I would be supervised there by Drs. Ricardo Hu, a dermatologist, who I also had contacted beforehand because of family ties. He is my sisters’ husband. Formal permission of the Medical Ethical Commission in Suriname was further needed to conduct my study. Doctor Sabajo guided me through the process.

On the 21st of May 2007, I started the acquaintance process at the Dermatological Service. The staff was very friendly and helpful and I was appointed my own room for the interviews. The few days I used to observe the daily life at the clinic. Everyday patients were coming. The clinic looked very busy and sometimes there even was a chaotic sphere: nurses calling from one to the other side, people walking, asking whether the doctor was already present or not and medical students walking around making notes. The doctor’s offices, especially the treatment rooms were not very spatial and at times medical students, the nurse and the patients were crowded together at the same moment. For me it was really getting used to it, since I had never experienced working at a clinic before. I always was aware of the fact that patients sitting in the waiting room were looking at me, whenever I came out of my room. Probably wondering whether I was a new doctor or a medical student, since previously another medical doctor had occupied the room.

My fieldwork at the Dermatological Service was basically interviewing STI patients in the privacy of ‘my’ consultation room. Dr. Hu, who held his consultations, in just three rooms before mine, stayed in touch with me through the telephone. Whenever he had an STI patient willing to participate in my research he phoned me to ask whether I was free at the moment to do an interview. He then would send the patient to me. Or I would go to his room where he introduced me to the patient. After the introduction, the patient would walk with me to my room. Dr. Hu had also asked me to wear a white coat, which he very kindly lent me. With a white coat on, he rationalised, people would be more open to talk with me. I did put the white coat on at the clinic, but I always felt awkward. I was not a medical doctor. Therefore, in the privacy of my own room, I often took off the white coat. When STI patients came to see me, I stressed the fact that I was not a medical doctor but a researcher, a student. And made sure they understood it. My fieldwork at the Dermatological Service ended on the 29th of June 2007.

1.6 Finding informants
Due to the sensitive nature of my study topic, my research questions, study population and the limited research time, I used convenience sampling and snowball sampling to get the
informants. At the Dermatological Service, STI patients who happened to be there for a consult, who corresponded to the study profile and who agreed to participate in my research were selected. In all the cases, the medical doctor acted as a gatekeeper. The selected STI patients were informed by the medical doctor about my research and after free and informed consent, they were sent to me. I was not present during that interaction process. But the sampling prerequisites and conditions were discussed thoroughly with the medical doctor.

In the first meeting with the women, I informed them thoroughly about the research as well. They were free in deciding whether to sign a letter of consent or not and whether the conversation should be recorded or not. Many of them did not mind the conversation to be recorded; a letter of consent was signed by five informants. To select people with STI outside the bio-medical circuit was a bit problematic, but I managed to get three female informants. Two women I could contact through others using the snowball sampling method. And one informant actually contacted me by coincidence. In the local newspaper there had been an article written about my field research and the informant had read it. At a party she came up to me and asked me whether she could participate in my research.

According to estimations of the nurse working for Dr. Hu, about 40 patients had come for a medical consult within the six weeks of my stay. 27 of them were STI patients who had come there for the first time. Due to the fact that I was in conversation with my informants at the time that other STI patients came to the clinic, I was not able to count exactly how many STI patients meeting the selection criteria had been visiting the clinic and how many of them refused to take part. I received in total twelve STI patients, both male and female STI patients who met the selection criteria. From the twelve, eight were female and four were males. From the four males, I was able to have an in-depth interview with only two of them. The other two agreed to participate, but did not have time at that moment and told me, after phone contact, that they could not take part on the research due to busy work schedule. But maybe my own gender identity as a young Hindustani woman could have led to their ‘inability’ to participate further in the research.

From the eight females, one agreed to participate with the research, but during the interview she still felt uncomfortable talking about it and withdrew. Another female agreed to participate, but the quality of the interview was not good and the conversation with her stayed on a superficial level. With the rest of the six female informants, I had more than one in-depth interview. The sample size that I intended to use before doing the field research was between ten and forty. The actual sample size that I finally ended up was nine. Six females from the Dermatological Service and three from outside the clinic.
Apart from people with STIs, I have been able to have interviews with twelve key informants in the field of STI/HIV/AIDS: two social workers at the clinic, a counsellor at the VCT site of the Dermatological Service, three medical doctors, the head of the laboratory department of the clinic, the head of the National Health Information System (who is a medical doctor as well), the director of a community health institute ProHealth, the director and one nurse of the national family planning institute, the LOBI foundation and another key person who had worked as a nurse in a hospital. I also managed to speak to some women selling traditional medicine and others selling medicine in a drugstore under the market place. I visited a pharmacy and spoke to the pharmacist as well.

1.7 Key components data collection and analysis

The main challenge in this study was coming in contact with people who suffered from symptomatic sexually transmitted infections- and grasping their story from an emic perspective--: their experience with STI, explanations, feelings and underlying perceptions and ideas on how to manage having sex with their steady partner(s) with an STI and if, how and when to disclose their status. Because of this interest, the methods used in my research are very qualitative. The central data collection method used is the in-depth interview with a high degree of flexibility: the interviews were semi-structured and flexibility was built in timing and sequence of the questions. In fact, the interviews became, when talking to the informants in further meetings, more like conversations.

The conversations with the informants were in different languages. In most cases Dutch was spoken. With one informant 'Sranan Tongo' was used, another language spoken mostly by the Creole community but understood and also spoken by other communities in Suriname. With two informants 'Sarnami' was spoken which is commonly used within the Hindustani community. Since I myself am a Surinamese, the advantage is that I speak Dutch, 'Sranan Tongo' and 'Sarnami' fluently. Dutch is the formal national language and Sarnami is my mother language. Understanding the conversation and translating it to English was therefore not a problem. But all languages have particular words or way of saying that cannot be translated into English without changing nuances of its meaning. During the analysis of the data I was fully aware of that. In cases where translating words or sentences would change the meaning, I explained, but did not translate. In cases where the meaning was not lost by translation, I carefully translated.

Apart from the personal conversations with the informants, I have also used other sources of information. To get more insights in perceptions, opinions and explanations about
people with STIs from a wider social point of view, I had also semi-structured interviews with key figures. These key figures were knowledgeable in different aspects related to STIs and the sexual behaviour of people with STIs.

Other data collection methods used are literature study, secondary analysis of statistical material collected from the Dermatological Service, using other available information such as information folders on STIs, health reports and newspaper articles. I also did some observation of the interaction between doctor and STI patient to get an idea, if and how, issues of status disclosure and management of the patients’ sexual life were discussed between the medical doctor and the patient. But I had only few chances to do so.

The style of analysis used in this study is based on the character and aim of the research. Since this is an exploratory research with the intention to address and understand behavioural aspects of people with STIs, I used the thematic content analysis. The analysis is done manually; coding schemes are developed to understand issues at a broader socio-theoretical level. Quotations are used to exemplify certain situations. Narratives are written extensively to describe the sometimes very complex relationships between steady partner(s) and other sex partners. Thick descriptions of accounts for sexual behaviour and thoughts about status disclosure and management of sexual lives are used and linked up with the theory.

1.8 Validity and reliability
When doing research, every researcher is faced with issues of validity and reliability. The terms have different meanings in quantitative and qualitative research. In my qualitative and exploratory research I defined validity in terms of the informants understanding my questions and answering them. In other words: are we talking about the same thing? So the question is not only: did they understand my question but also did I understand their answer? To ensure the validity of the data as much as possible every time I had an interview, I cross-checked the information constantly with the informant themselves by repeating the questions in a later stage in a slightly different manner. Or by repeating the answers they gave in a direct or comprehensive way.

When they spoke a different language and would mention specific terms or phrases, I asked them what exactly they meant. To give an example: one of the maroon women told me in her language, she did not feel fine in her “mi oema sma prest”. Literally the words meant “the part or place of my womanhood’. I knew she meant ‘her vagina’, since I know the language and the way people express themselves, but to make sure I understood correctly, I asked her “do you mean you don’t feel fine here?”, showing the genital area of my own body.
She confirmed. Having knowledge of the different languages spoken in Suriname was in this regard very useful.

Multiple interview sessions with both STI patients at the clinic and with the female informants outside were conducted in order to ensure a higher degree of validity. I also always asked the informants, especially at the clinic, whether they had the time to talk to me. If not, another appointment was made. In this way I tried to prevent a situation in which the informant would provide hasty and insufficient information leading to increased chances for invalid information. Being able to comfortably and openly express emotions, thoughts and opinions was at the core of the process.

In quantitative research reliability often refers to ‘repeatability’ of interpretations in terms of similar study results when similar studies are done (Green & Thorogood 2004: 194). Since my research is a small-scale, qualitative research, each informant and the stories they gave are unique; ‘repeatability’ therefore is not a suitable and useful definition of reliability. The more important issue for me was ensuring reliability in terms of ‘truthfulness’ of the informants’ information. How could I know the informants were not hiding certain things from me or just ‘lying’ to me? As pointed out previously, the topic I did research on was very sensitive. Informants could therefore have easily given me ‘false’ information for whatever reason. But I believe my research still has a high degree of reliability.

Before starting the interview I often patiently explained the informants how important their information is for the research and ensured them of a non-judgemental approach from my side. In this way I could avoid socially desirable answers and if necessary and appropriate I probed and asked confronting questions to dig further into the informants’ ‘true’ feelings and thoughts.

I also constantly adjusted the interaction between the informants and myself to situations occurring before, during or after the interview. When an informant started to cry for example, I put everything aside and showed emotional understanding for the person. Most of the times I moved over to the informant and held her hands in mine, letting the emotions run through her by keeping silent or telling her I could understand that it is a difficult situation for her. Also having more than one interview session and the process of getting to know the person and them getting to know me was important to get reliable answers. I further believe my informants did not have reasons to lie to me, since I was an outsider to them. Some of them even showed me, by hugging me after the end of the conversation how much they appreciated talking to me about their situation. They told me they felt relieved finally being able to share their ‘true’ stories with someone without the fear of being judged.
1.9 Ethical considerations

Considering ethical issues is crucial for every research. Neglecting ethical issues may have serious consequences for the start, continuation and success of the research. Especially for the kind of sensitive research that I have done, I want to discuss some issues which I think are very important. How ethical was it, for example, to conduct this research? I believe my research was within the ethical boundaries. Even though I talked with people about very intimate and private aspects of their lives, I have done this only after informed consent and voluntary participation. In fact, double informed consent is obtained before starting the interviews; first by the medical doctor and after, by me. Informants were fully informed about the purposes of the study and my intention of using the information they provided in my study. They had the right and space to withdraw at any moment before, during or even after the interviews if they felt uncomfortable.

Due to practical reasons, I would not be able to involve the informants in the analysis of the data. I discussed this with them and ensured that I would respectfully present the information they provided and that anonymity would be guaranteed. A necessity, because I noticed, afterwards, how important anonymity and confidentiality for the informants were in the field, especially for those outside the bio-medical circuit. I had to really ensure them that the conversations between them and me were totally confidential, anonymous and private. I could understand, because their information could bring them in a very difficult situation if recognized by others. In the collection and analysis of the data therefore, I have changed their names and names of places with fictional ones. Only where permission was given, interviews were recorded through audio-tape.

Furthermore, was it ethical to approach STI patients of a clinic? Medical doctors do have the moral and legal obligation to guarantee the confidentiality and privacy of their patients. In my research, I fully respected this obligation. Formal approval was obtained from the Medical Ethical Commission to conduct this research. Also formal permission was given by the medical doctor Drs. R. Hu, whose patients were approached, and the head of the Dermatological Service in Paramaribo Drs. L. Sabajo, to conduct this study at the STI clinic. As explained in the problem statement, my research is very relevant in the context of sexual and reproductive health, including the AIDS epidemic. The major goal of this research was to obtain my masters degree in Medical Anthropology; still, I considered that only as a facilitating element in my research. The more important reason was to contribute to the improvement of the sexual and reproductive health within my community. I hope that my
findings are useful for health professionals working on health intervention programs aimed at behavioural change and that the community in fact, will be primarily gaining the benefits from this study.

1.10 Theoretical concepts
In my study I have used several theoretical concepts related to behaviour when suffering from a disease. In the following sub-sections I will briefly highlight these concepts on the basis of which I analysed my research findings. Further elaboration on these concepts as analytical tools will be given in chapter three.

1.10.1 Explanatory Model
Health and illness are experienced, interpreted, treated and explained differently by different individuals on the basis of their socio-cultural background. Kleinman (1980) provides a useful framework to look at this process he termed “Explanatory Models” (EM). Both practitioners and patients have their own EM about diseases which they use to explain sickness and to provide or seek for treatment. EMs are also used to understand social and personal meaning and perceptions given to the experience of sickness (Helman 2000: 85). EMs provide in particular explanations on several aspects of illness. In my research I have highlighted the social dimension of explanations given by the women on the aetiology of the infections.

1.10.2 Secrecy and stigma
An important aspect I explored in my study is the aspect of secrecy and lying in the individuals’ lives. If women are infected with an STI while having a steady relationship, how, why and in which cases do they their status a secret? Why the need, what’s the gain, what’s the loss? Is there secrecy towards everyone? In ‘Secrets: On the ethics of concealment and revelation,’ Bok (1984), explores key moral questions about secrecy and the justification of it. She also describes several settings in which secrets can be found. In a more recent article, Van der Geest (1994) elaborates on the concept of secrecy and refers to secrecy as a strategic tool used by people in some situations to further their own interest. Secrecy is linked to the concept of stigma. Goffman (1963) approaches stigma from a reductionistic perspective and defines stigma as “an attribute that is deeply discrediting” (1963: 13) with the power to reduce individuals from being ‘normal’ to ‘deviant’ due to the negative connotations attached to the concept of stigma. But when stigmatizing attributes are not visible for or known to others, the
issue for the individual then becomes how to control or manage information about his situation. Lying and intentional concealment become a strategy.

1.10.3 Impression Management
Another important theoretical concept used in my research is the concept of impression management as developed by Goffman (1959), who describes and imagines social life in terms of a theatrical performance on a stage. This stage is similar to the world people are living in and in which they perform changing roles. Goffman uses a double dichotomy: first by dividing individuals as ‘actors’ and ‘audience’. Second, by creating two spaces within the individuals themselves: ‘backstage’ and ‘front-stage’. With backstage he refers to the socio-private setting in which individuals can express themselves mentally, physically and morally the way they are towards themselves. It is also a setting in which individuals can reflect on their position and prepare themselves again as an actor to perform for an audience. Individuals on the front-stage are oriented more publicly; front-stage concerns the image of themselves, the way individuals want others to see them. The central idea is of controlling the impressions to be given off by one in order to control the way others relate to the one.
Chapter 2
Case studies: changing context, changing scenarios

At the core of my research findings are my case studies. The stories of nine Surinamese women with STIs stand central in this chapter. I have summarized and presented the nine cases with the intention to give more insights in the socio-personal life and background of these women, especially their sexual life and the way they coped with their STI. Each case begins with a short introduction accentuating in various degrees the meetings with the informants, my first impressions of them, the quality of the conversations and, or some particular issues about them. I then described the actual case. I have tried to present the cases in a similar way the cases were presented to me. Several aspects are more or less highlighted, varying and changing constantly, in a way following the key issues as they were for the informants.

2.1 Having multiple steady partners and STIs: Mina’s struggle

The first time I met Mina, it was in my room at the Dermatological Service. After informing her about the research she signed a letter of consent. I conversed with her three times. For hours. With each conversation she became more open about her motives and her thoughts. Information she did not gave the first time, she gave in the second and last time. She was so full of emotions and vivid. What struck me was that Mina was extremely outspoken and honest to herself. She did not hesitate to call herself materialistic or lazy, because she enjoyed money spend on her. And she was so filled with dreams and of becoming someone in the society. One time I also phoned her, just to check on her how she was doing. Again I had a very personal conversation with her. Mina told me that she was happy the Dermatological Service had someone like me to talk to. She knew I was not a medical doctor and she knew I was there for my fieldwork. But she told me it was nice and therapeutic to talk so openly about her life. I felt deep appreciation for her trust.

Mina was a young Creole lady of twenty-two years. She had a high-school degree and was working in a governmental organisation until March this year (2007). At the time of the interview, she was unemployed. But she also wanted to study further and had decided to stay home until then.
She had two steady partners. One was a young Creole man, Jan, with whom she had a relationship for seven years. Jan was living in Albina, three hours away from Paramaribo. The other partner was quite an older man, Piet, 59 year old with a mixed ethnic background (Creole-Chinese) with whom she had a steady sexual relationship of three years now.

Mina grew up in a district, two hours away from Paramaribo. When she was 15 year old, she had already an affair with Jan and moved out of her parents’ house. She lived with Jan for a while, but problems started. He could not work and support her financially, because he went two times to prison for dealing in drugs. She also experienced severe troubles with her family-in-laws; they viewed her as inferior. Mina could not endure the situation anymore and left for the city to live with her uncle and aunty. The stay became problematic again and when Piet, who she got to know in that period, offered her a room in his house, Mina did not hesitate. Piet was a very educated, rich man who provided her with more than enough money, and stimulated her also to carry on with her studies. After a while Piet told Mina he rented her another apartment. She stayed now in that apartment together with Piet from Monday to Friday. In the weekends she usually went back to be with Jan.

Mina did not consider Piet to be her steady partner in the way she considered Jan. But she knew that Piet could take care of her in a way Jan still could not. Piet knew about Jan. In the beginning he tolerated her to have the relationship with Jan. But later on in the relationship he did not want her to continue with it, because he was taking very well care of her. In order not to loose Piet and the luxury with him, Mina told Piet she was not with Jan anymore. Jan just called to talk to her and that’s all. To Jan she lied and told that Piet is her uncle. But because her ‘uncle’ was very strict, Jan was not allowed to visit her. Mina kept her life with Piet secret for her parents as well. They did not know anything about Piet. They thought she was living somewhere else due to the problems she had with Jan’s situation and family and were unaware of her steady sexual relationship with another man.

Mina’s life became more complicated when one day she discovered a soar on the borders of her vagina. At first she thought the soar was caused by shaving or by a cut with the razor. She also thought of the possibility of scratching herself with her nails or maybe rubbing too rough on her genitals with her bath towel and did not pay that much attention to it. But three days after she experienced heavy discharge. The discharge was liquid and did not smell. She also discovered another pimple inside the vagina opposite to the soar. She felt totally shocked and broken, because she realised that this could not be the result of a cut by the razor of a shaver: “It’s not a razor. And just like what I say, if you know with whom you’re busy, then you can’t sit and hold a razor accountable. Then you’re going to look further.”
immediately experienced her body temperature rising and got a head-ache. She kept thinking about what it could be and she even thought that it could be something supernatural. Maybe caused by voodoo. If after bio-medical treatment, the symptoms would not go, then it had to be black magic. Mina got fever in the night. The following morning, the soar had increased in size. Mina decided to see the doctor.

At first she was only diagnosed with Trichomonas Vaginalis and Gardnorea Vaginitis. The HIV results were negative, to tremendous relief and happiness of Mina. But the medical doctor had overlooked the fact that she had come to see him because of her soars. Mina had been very active herself in searching for information about her symptoms. She had consulted the library of the Lobi foundation, a family planning institute, on the clinical picture of STIs. And the soars that she had matched the clinical picture of Herpes Vaginalis. Mina was right. In one of the follow-up consultations with the doctor, he confirmed that she did have Herpes as well. “He overlooked it because”, as she repeated the doctor’s explanation, “Herpes is caused by a virus and could not be treated by medication, only the symptoms could.” Mina understood that the doctor is also human, that he could forget some things sometimes and that the practice is so busy. But she wished he had not in her case, because now she had another virus which probably would be in her body for the rest of her life. She also wished that she could spend more time with the doctor, because there was so much she wanted to know about the STIs, their clinical picture and about the impact of the STIs on her future sex life. Mina got an ointment to treat the soars and a cure for the Trichomonas and the Gardnorea. She told the doctor the truth about her sexual partners and asked him if he could prescribe medication for both of them. The doctor understood the situation and provided the necessary receipts.

Mina was filled with unexplained issues, anger, doubts and guilt. She found herself asking a lot of questions: “How could I handle the situation the best? How could I disclose my status without getting caught? Who infected her and when?” She also kept playing and replaying several scenarios with both men in mind. In the years that she had been living with Piet, Mina found out that Piet’s sexual life and activities were enormously complicated. Piet had several women with whom he had sexual affairs. Almost all these women did not have other partners, were relatively young and black. With all the women he had one child and after the birth of a child he had build houses for them. She realised the enormous risk she had taken by having unprotected sex with Piet and strongly suspected Piet: “the last time I had sex with Piet was on the day I discovered the soar. After that, Piet did not ask for sex. Why did he not?” Mina also felt terribly guilty. What if she had infected Piet, because she was still having
sex with Jan? However, Mina refused to feel so guilty because she was aware that feeling guilty can create chances for others to blame. And she wanted to avoid that.

But she thought about Jan as well. The last time she had sex with him was in the week before she discovered the soar. She did not have absolute trust in Jan, but she also did not suspect him that much because in her perception, Jan was more reliable: “He often stayed home and I never had any problems before with him regarding other women calling him or sending messages by phone.” Jan had also threatened many times to commit suicide if she left him. That was a mental burden for her, but at least she knew Jan truly loved her. Jan’s family even mentioned that probably Mina had done some black magic for Jan, since Jan only wanted her. She did not do any such thing, so she reasoned it must be true love from Jan’s side. Whatever the case, she felt very guilty about the situation. She knew she was cheating on Jan.

Mina had calculated the best way to handle the situation. The day she went to the Dermatological Service, she already phoned Jan to find out whether he had experienced some pain or similar symptoms in his genital area. Calling Jan was a deliberate act. Jan’s character was more simplistic, he would ask questions but not very persistently. And though he could think through, he was not very highly educated. Jan could be fooled more easily. By calling him, she acted to be innocent, not knowing from where she got the symptoms. At the same time she was cross-checking on Jan. Although she trusted him more than Piet, she was very cautious that he could be lying to her as well. As she explained: “the same way that Jan believed her that I was true to him, while I was not, I could be believing that he was true to her, while he was not.”

Mina deliberately did not call Piet the day she went to the doctor. Piet’s character was very tough. He was well-experienced, knew when someone was lying, asked a lot of questions and is often difficult to convince. Fooling him would be an enormous task. She decided to confront Piet after she had the results. She found herself to be in a very difficult position. But she disclosed her status to both partners, because she thought good health was very important for all of them.

With Jan she was very patient, explaining him that she had a bacterial infection. She deliberately did not mention any names of STIs. Jan was a bit hesitant to believe and asked a lot of questions about the symptoms and how she got it. Mina persisted she did not know from where and convinced Jan that he had to take the medication as well. She told him she could have infected him as well and that it was necessary for him to take the cure exactly as prescribed. She explained to him all the details. Though hesitant, Jan cooperated. Mina was
relieved, but the one thing that disturbed her was that after closer inspection, she discovered very small pimples in Jan’s genital area. Jan was not aware of it and told her he probably got it from her. Mina gave him the ointment to treat it. For her this was a sign that maybe Jan, after all, did cheat on her. But she would never know it and she chose to let the matters as they were. As she remarked: “I was not a saint myself. I know very well what I have been doing.”

With Piet it was a different story. Mina had very explosive discussions with Piet about her condition. She openly told him she had an STI and accused him strongly of being responsible for it. Previously, she had found lots of condoms in Piet’s bag. She used this finding to attack him and asked him tauntingly what he was doing with all the condoms since she was not the one he was using them with. She had also, many times already, confronted Piet about his lies, deceptions and promiscuous behaviour and used that to blame Piet completely for creating enormous risks for her life. Piet denied everything. Mina was extremely surprised with his Piet’s behaviour, because unlike her thoughts, Piet stayed calm and did not question anything at all. She had deliberately not told Piet about the details of the cure as she had done with Jan. Just to check his reaction: “I threw the medication in front of him and ordered him to use it. I deliberately told him nothing about how to use the medication. I was surprised! He did not even ask how? He probably knew how to use it, because he had used it before!” For herself she was almost fully convinced that Piet was the responsible one for her condition. Ironically, Piet did not have any signs of pimples or soars in his genital area. But Mina was too furious about his sexual affairs with other women and still suspected him to be the one. For her, Piet was guilty and probably glad that she came up with a solution and that he himself did not have to go to the doctor.

As far as she knew, Piet had taken the cure for sure; Jan too. With Mina it was going better as well. The discharge had decreased dramatically and the soar was drying out. But she was still battling with herself what to do about the relationship with both men. She knew she did not want to stay with Piet because of health hazards. But she realised it was a process and that she could not step immediately out of the relationship. She needed a job and a place for herself. It would take some time. With Jan she maybe could build up a life, but he had to become financially independent first. One step at a time.

2.2: A sexual side affair: Reshma’s secret
I met Reshma on a party. She had read about my research in the daily newspaper ‘De Ware Tijd’ and asked me if she could tell me a secret. A very spontaneous lady, who was very open
in telling me her story, but who refused to sign a letter of consent. She also refused to talk with my tape-recorder on. She told me she had a secret to tell. That secret should have to stay a secret. I was allowed to make notes but most important of all, I had to listen to her and understand her story. I met Reshma several times during my stay in Suriname and we spoke about the most intimate details of her sexual life. The conversations with her lasted for two, sometimes three hours. Sitting peacefully under the Jules Wijdenbosch Bridge, across the Suriname River, I had the unique opportunity to have a deep glance in Reshma's very well managed sexual life. Sometimes I asked myself if she staged all of her story to me. It could very well be; she was able to deceive so many others in her life. But why all the effort then? Intuitively I felt she finally had someone to disclose.

Reshma was a 27 year old Hindustani woman. She came from a family with two sisters and one brother; she being the youngest. Her parents were traditional Hindustanis, but she was raised in a rather free cultural environment. Independency and self-consciousness was stimulated by her family, as well as appreciation for education. Reshma had a high-school degree and worked as a civil servant at a government institution. Her parents never forced her to marry and always let it to herself to decide with who she wanted to spend her life with. Reshma did never marry, but she had a few boyfriends before starting a steady relationship; boyfriends her parents never knew about. Only one of her sisters knew all about these relationships; Reshma always had a very intimate bond with that sister: "I can talk about anything with her, she is wonderful. She understands me completely and is not judgemental about my life."

Currently, Reshma had been in a steady relationship with a man for two and a half year. Her partner, Winston, was a non-Hindustani, who was 20 years older than her. She was living together with him and her family had accepted them as a couple. She told to be happy with him, since he loved her, but for her the age gap was quite disturbing: "Many times I look at him and I feel very uncomfortable because his old age is already visible in his face and the rest of his body, especially around his waste." She was also not content with her sex life with him since he got tired very quick and it's Reshma who had to please him by either having oral sex with him or taking such a sexual position that she is in top of him. Despite the age gap and the unsatisfying sex life, Reshma still believed in her relationship: "Winston takes good care of me financially and also emotionally he is very loving towards me. He treats me like a real woman always telling me he loves me." She did not know whether she would stay in the relationship or not, but until now she did not hope anything to go wrong in her life with him.
In the two years that she was with him, nothing did go wrong, but in the last six months Reshma got into a very problematic situation.

Six months ago she met another man, thirty year old David, at a party given by her friends. Winston did not accompany her that night and Reshma spend a lot of time talking to David. He had a very charming personality, young and good-looking with a nicely trained body. She felt very sexually attracted to him and inquired whether he had a girlfriend. David had just, a few weeks ago, broken up with his girlfriend, a Creole lady, and was single at the moment. David was giving Reshma a lot of attention, telling her how beautiful she was and how much he liked her. At a certain moment in time, David asked her whether she’d like to accompany him to his house. Since Reshma already said to Winston that she would spend the night at her friends place, she agreed and told her friend Nita that she’d get a lift from David. And in case Winston called, Nita just had to tell him that she had been sleeping in her house. Nita, who was also a very close friend of Reshma, knew about Reshma’s frustrations with Winston and as an adult she understood what the situation was. She told Reshma not to worry. That night, Reshma had sex with David. She did not feel guilty, because she finally experienced great sex after quite some time. And to be responsible, she used a condom with him.

After that encounter, Reshma went on with her life with Winston. As a matter of fact, she mentioned to be able to cope better with her sexual life now with Winston: “I could close my eyes and imagine it was David. I could endure being on top of him and faking that I came, because my sexual needs were fulfilled by someone else” The affaire that started that particular night with David continued. Reshma never told David that she had a steady relationship with someone. She only told him that she was in for a sexual affair with him, but that she was very busy and that they could only meet when she made the contact. David agreed; for the sex it was fine. In the weeks that followed after that particular night, they had sexual intercourse several times. One night the condom broke. Reshma panicked, but David told her not to since he was tested on HIV and he claimed never to have had an STI. On the question whether he had unprotected sex with his former girlfriend, he replied positively. She panicked again, but David told her not to worry, since he never experienced any STI. Reshma believed him half-half and stayed worried. But since that night, she started to have unprotected sex with him: “I don’t know, I started thinking and connecting my thoughts. David was a well-educated man and he did have a responsible job where he was used to get tested on HIV frequently. How big would be the chances of him having HIV or another STI? I thought then he was probably okay".
But three days after the second time she had unprotected sex with him, Reshma started to sense a bad smell from her vagina. She also had some more vaginal discharge than normally. She worried about it and wondered what it could be. But she didn’t mention it to David and still had sex with him, unprotected: “Before having sex with him, I went to the bathroom and washed my vagina. But both David and I noticed the smell. I still remember his face and how he tried not to inhale too much of the air. But he neither I said anything about it. Fine, not saying anything was also good.” Two to three weeks after the first time she noticed the smell, Reshma stopped seeing David: “I told him I was too busy. But I knew that he had given me some kind of STI. I was mad at myself and I couldn’t say anything, because in a way, I know I had brought it on to myself.”

Parallel to her affair with David, Reshma kept having regular unprotected sex (as usual) with her steady partner Winston. Even after noticing the smell. In the beginning Reshma tried to ignore it by washing her vagina more often and for longer periods with warm water before having sex with Winston. But the smell became worse and also she started to have more discharge. She knew she couldn’t hide the situation and decided to talk openly about it with Winston: “I told him I noticed some bad smell and discharge and asked him if he had noticed it as well. Winston said yes, but he told me not to worry about it, because he thought sometimes women does have more discharge than usual and that the smell probably would go away by itself. I know he had noticed the smell, but not very strongly.” Reshma started telling him that all of a sudden she had all these symptoms and that she didn’t know how she got it. She asked him whether he noticed something on his genitals. Winston hadn’t noticed anything at all by himself. She asked him whether he had sex with someone else. Winston reacted very strongly on this accusation by telling her loud and clear that she was the only woman in his life since the day he met her. He asked her in reverse if she had been seeing someone else. Reshma reacted very hurt and passionate: “if you saw me acting! I told him that he was the only man for me and that I had never had sex with anyone else. How could you accuse me of something like that? Didn’t you know I love you very much?” Winston believed her without any doubts and told her, that whatever it was, she would get treated for it. She had to go to the doctor.

Reshma went to the Dermatological Service, since she knew that the institution did a lot of research on STIs. With fear in her heart, she told the doctor the symptoms and when he asked her about sex partners, she told him that she had only one steady partner. Since she was not seeing David anymore, she did not care about his health. And since he probably was the one putting her in this situation, he deserved to find it out himself. She told the doctor that
maybe her steady partner had been walking out on her, but in any case, she was not the one having other sexual affairs. The doctor needed to run some tests on her discharge and if she could wait for half an hour, she would get the results. Waiting for the results, Reshma was already planning how she would manage this: "I knew I had Winston eating out of my hands, but if I had an STI, he would probably have to be treated too and that could maybe be a problem. Winston is not that stupid." Finally the doctor called her. The results were in: Gardnorella and Trichomonas. The doctor told her, that Gardnorella was not really considered an STI. Though it could be transmitted sexually, it could also be caused by other factors such as stress and hormonal change in her vagina. But Trichomonas was an STI. Reshma felt terrible, but she asked if it was too bad. The doctor told her not to worry. Reshma: "Both infections could be treated well, but I and my partner would have to take a cure even if Winston did not have any symptoms. Otherwise he would keep infecting me and I him. I also told the doctor that Winston had a very busy job and that he would not be able to come soon. And I asked him if I could take his part of the medication as well." The doctor agreed.

Back at home, Reshma told Winston that the doctor told her it was nothing to worry about. It was just caused by hormonal changes in her vagina because of a lot of stress. And indeed, the workload at her office was very much and she also had some discussions with her colleagues that she did not like. No wonder its effect on her. But yes, she could pass it on to him, so Winston had to take the medication as well. He reacted surprised after hearing this and told her that he did not have any symptoms: "Why would I have to take the medication?" Reshma explained it again to him: "I told him to either use the medication or only have sex with me with condom, since I was not planning to be re-infected by him time and time again. It was not my fault that I had got the infection. My body reacted in that way and he would have to understand it!" She knew Winston did not like to use the condom, because his penis could not stay erect with condom on and he also knew that as well. Winston told her he loved her, believed her and cared about her health. Despite his conviction that he did not have anything, he agreed not to take any chances. Both held on to the cure. Reshma was still in a steady relationship with Winston. Sexual affairs with others were past tense. At least that's how she felt for now.

2.3 Unhappy relationships: Marijke's fear
I got in contact with Marijke through key-informants. I met her the first time at the place Marijke was working, after working hours. I immediately sensed fear in her. She agreed on telling me about her situation and even agreed that I would record the conversation. But after
a few seconds talking, Marijke's voice started trembling. She became extremely nervous and
could not speak. I turned off the tape recorder, took her hand in mine and comforted her. I
also decided not to use the tape recorder even if she had given permission. It was a good
decision. I met Marijke five times and spent many hours talking with her. During the
conversations she cried often and sometimes I did as well, I felt powerless, because apart from
listening and writing about her story, I could not do anything else. I only hoped she could let
go of her fear. Maybe then, life would be better for her.

Marijke was a 35-year old woman from a mixed ethnic background. Her mother was
Hindustani and her father Javanese. She herself had more facial characteristics of a Javanese
and in real life she was more Javanese oriented then towards the Hindustani community.
Marijke was the eldest of one more sister and a brother. She was raised in the rural area of
district Commewijne and learned to appreciate the hard work her parents did on the land.
Marijke was working as a financial assistant in a non-governmental institution. She still lived
with her parents and enjoyed life with them. She had a piece of land of her own on which
mango's are growing. She often sold these mangos to other people in the fruit-processing
industry.

For an outsider, Marijke's life seemed one without complications. But for herself,
Marijke found her life to be a complete mess. When she was seventeen years old, she used to
date a Javanese young man who she liked but with whom she never felt really comfortable.
After some years they separated. After him, Marijke had several boyfriends, but nothing very
seriously. Then, in 1998, she left for Curacao on a vacation, to visit a niece, Sara, of hers.
Marijke stayed during that vacation, which lasted two months, at Sara's house. Sara was
married to a Caucasian male from Curacao, Jim, but her marriage was not that smooth as she
wanted to show to the outside world. Marijke noticed that, because Jim told her so. When
Sara went to office to work, Jim spent more and more time with Marijke: "I was flattered with
his attention, but I was so scared that my niece would notice something. But she never did."
Jim told her how unhappy he was and she fell more and more in love with him until one day
they had sexual intercourse. Marijke had never felt so wonderful before and she loved Jim.
She always wanted to have a man like him, but she had to leave. She said goodbye to Jim and
Sara and came back to Suriname. One day she got a furious, mean call from Sara. Jim had
confessed and Sara had called the whole family to tell about the shameless behaviour of her
niece. Marijke was tremendously traumatized and saw herself as an evil person. She felt very
inferior and started hating the family, especially from her fathers' side. She promised herself
not to have a relationship anymore and decided to go on with her life. After all, Jim was the
one with a ring around his finger, not she. If there was anyone to blame, it was him. But she kept feeling guilty.

Marijke went on with her life, but it was not a happy one: "I always felt I was so stupid and ugly. I did not like my body and all the fat hanging around my waste. I also felt so guilty and I couldn't get rid off it." She did not have many friends, but some six years ago, she got a new colleague, Astrid. Astrid was a young Creole woman, who liked to go out very much. Slowly a deep friendship evolved between both. Marijke, who had been in her shell for such a long time, started enjoying herself and on recommendation of her friend, she started working out at a small gym. Astrid liked the gym as well, but did not have enough time to join her and stimulated her to keep going to the gym. Marijke did so and quickly lost several pounds. She became more confident and finally started enjoying her life again. Soon she became one of the best in her group, what gave the social status she always wanted to have. And on top of that she knew, she had the attention of her teacher John. John was a forty year old, Creole man. He was not that educated, but he was a good instructor. During daytime he drove taxi and during the evening he worked at the gym. Many women in the group wanted to get John's attention, not because he had money, but because he often got offers to do advertisement to promote some sport products and he then picked out one of his best students to do it together with him. Marijke wanted to have that special position and deliberately steered towards a sexual relationship with John. John wanted to have a relationship with her as well, but he told her that he had a wife formerly with three children. And that he still took care of them. He told her also he had been having some other sexual relationships in the past. Marijke did not care, as long as he could be true to her. She and John were now sexual partners for almost three years.

But soon after they started, Marijke began to feel jealous about all the female students hanging around John. But she did not mention anything in the beginning, because she enjoyed the status that she had at the school. And she knew that many of those students were jealous of her position and wished they were there. After one year, Marijke suddenly noticed heavy vaginal discharge: "It was yellow-greenish of colour and oh God, it stank! I had never experienced such thing in my whole life! I asked John immediately what it was. John said he did not know, but probably it was due to my hygienic practices." Marijke had been washing her vagina always thoroughly, from inside out with water indeed, but it was for her a puzzle. She felt that she always had cleaned her vagina from the inside and she had never experienced any problems. Why would she experience them now? It did not make any sense. She asked him if he experienced something as well. He said he did not, but he did not show her his
genitals. Marijke felt a strong gulf of mistrust: “I felt and I knew, I knew John was lying.” She knew that he had been having former sexual relationships, but did not know what the situation was now. Finally she told John, she will go to the doctor and he had to come too. He refused; he said he was sure about his fidelity and did not to have time for those kinds of things. He told her definitely to go to the doctor.

Marijke was diagnosed with Gonorrhoea. She was shocked, hurt, ashamed and felt enormously victimized. The doctor told her to bring her partner as well. Marijke knew already that John would not come. So she asked the doctor to prescribe medication for her partner as well. The doctor agreed to it. When Marijke met John again, she gave him the medication and confronted him with the STI she had. She told him, both angry and firm, with a high level of certainty that she knew that he is the only one who could have given it to her. She cornered John with the medical facts about Gonorrhoea and told him time and time again that the doctor would not lie. The doctor was an authority and an expert. Whichever excuse he would make about the condition, Marijke would not believe him. John finally admitted. He had been having sex with his former girlfriend, another Creole lady. Marijke cried a lot and felt so deceived. She thought God was probably punishing her for what she had done with her niece: “I had tried to take away Sara’s husband, to destroy someone’s home [relationship]. That’s why I was being punished now with a lying and deceiving partner. Maybe I deserved it.” John cried as well and told her he loved her and that he made a mistake. It would not happen again. Marijke’s heart was broken, but she gave him a chance. She felt only sympathy for him and herself.

Marijke still stayed with John, not because she loved him. In fact, she never had wanted to have a relationship with a Creole man. She was very discriminatory concerning colour: “I like white men. My family likes people who are light-coloured. With John, I know family members would laugh at me and would look down on me. And I just wouldn’t be able to take it.” Another issue was that John was not a rich and educated man. He earned just a bit of money, had a mother, sister and his own children to take care off. Marijke was ashamed because of John’s low financial and social status and kept her relationship with him secret for her parents. Her parents only knew that he was just a friend. She stayed with him, because with him she did not feel ugly, stupid or inferior. In comparison with him, she was a well educated, well organised and a well-off woman with a good job and a nice car. In fact, she finally found someone to whom she could feel superior to.

In the months that passed after the infection, Marijke found out that John did not give her the complete picture about his past. He did not have only three children; he was father of
many other children. He had been having sexual relationships with his former students and he was still in many other sexual relationships. She confronted John with all of this and they got many fights. But he swore by high and low that he was changing. He did have a rough past, but he finally found someone to really correct his life. Marijke did not believe him, but when he started to cry she felt sorry him and gave him the chance to change. After all, had she not met John, she would not have been in a miserable life eaten away by guilt. Of course the topic of HIV came up. John told her he did not have HIV, because he was not sleeping around with ‘dirty’ women. He had been having sexual relationships only with ‘clean’ women. Marijke came up with the idea of using a condom again, as they had been using it in the beginning of the relationship. John did not want to hear a word about it. “He consequently refused and told me I could stay away if I wanted to use the condom with him. He knows exactly how to get me.” John knew how to manipulate and control Marijke, he knew about her past and he knew about her inferior and guilty feelings about herself. Marijke gave in and despised having fights with John. She realised however, that she took enormous risks, because in her heart she knew he was not true to her. She took an HIV test just to be sure. It was negative. John became very confident and told her she could trust him.

But just six months ago, in the beginning of this year, Marijke found out that she had again heavy discharge. She confronted John with it and discovered again he had been lying to her. As a matter of fact, John’s outside girlfriend had just given birth to his child. First, Marijke felt empty about the situation. Then she was filled with fear and found herself to be living in a hell with John, but she could not leave him. He had started to threaten her if she dared to leave him. He would hurt her and would also commit suicide. Marijke could not understand how she could have landed in a relationship with such misery. She talked to her colleagues about her situation and they of course advised to leave John. But it was in the end she, who had to decide. Astrid was the only colleague who really tried to persuade Marijke about all the health risks she was taking and that having a social status at the gym was not worth all the misery. She tried to awaken Marijke’s dreams about being with a nice, white, educated man and lead a life of luxury. John knew that and told Marijke not to have contact with Astrid anymore. Out of fear, Marijke started shutting down the contact with Astrid. She cared about her and was afraid that John would harm Astrid. Marijke herself did not go to the medical doctor anymore. She was still walking around with the infection: “I don’t know why and I don’t understand myself. I think I’m just very tired or the situation. I know it’s not good for my own health, but I am a very revengeful woman. John has given this to me and he
refuses to use a condom. Let him then be infected again and infect the other women. Why would I care?"

2.4: Anita’s un-explained STI

When I met Anita at the Dermatological Service she was in company of her daughter. She came into my room and told her daughter to wait outside. To me, she came over as a steady, firm personality and that is how the conversation started as well. But very soon Anita broke down and started crying. She did not know her STI status and was terrified of having AIDS. But then she got herself together and started her story. She kept repeating that she never experienced the symptoms she had now, ever before and she could not explain how she got them. Anita was the first female informant I talked with at the Dermatological service. I had two recorded in-depth interviews with her and unrecorded conversations each time after the sessions. She was a very open informant and she talked in a very calm way about her situation but with constant worry in her voice. She was wondering about her STI status and obviously searching for explanations.

Anita was a 35 year old, Hindustani woman. Having gone through primary education only, she held a job as a housekeeper that was not paid very well. She lived with her mother and children in a place thirty minutes away from the city. They had no electricity in the house there and flooding had always been a major problem for them during the rainy season.

Anita had formerly been in a marital relationship for fifteen years, had four children with her husband but got divorced. Then she started another relationship with a married man, Kries, who had a wife and children in Holland. She stayed for two years with him, but according to Anita, Kries wanted to have only sex with her and was not interested in helping her out financially. As she sarcastically stated: "he could not miss the money for me." She finally left him for someone else, Harold, with whom she is in a steady relationship for five months now.

The relationship with Harold was without any problems. He showed her very much love and affection and he took care of her financially. She was accepted in his family and he in hers. But in the fifth month of her relationship, Anita spotted some ‘pimples’ in her vaginal area. At first she thought it was probably normal and it would go away after some hot baths with a medicinal plant. But after one week, more ‘pimples’ grew and Anita got panicked. She had never experienced such things before in her life and she immediately asked Harold whether he had something on his genital area. She also showed him the ‘pimples’ and accused him that he had given it to her. Harold told her he was a 1000 percent sure he was true to her.
He also did not have anything on his genital area. Anita wanted to believe him very much. And she did, as she tried to defend her accusation towards him: "it [the 'pimples'] gives you just-like-that a bad idea. You understand... just a bad idea, because you get panicked if you see such things." A thought that also went through her mind was that prior to seeing those 'pimples', she had used her nieces underwear. According to her, she could have been very well infected by using that underwear.

Anita was filled with fear when she came to the Dermatological Service. She had been crying all the time and what kept her most worried was the chance on having HIV. That was the most horrifying idea for her. "If I have HIV, what will happen to my children?", she had asked herself many times in despair. In the beginning of her discovery, Anita did not share her worries with anyone except for Harold. But later on, the burden became too much and she had told her mother and her, now 17-year old daughter. Both of them had talked hope into her and told her to wait for the results. Anita was diagnosed with Condylomata Acuminata, genital warts. She also did an HIV test, which came out negative.

Once the results were in, she became more confident about herself. Anita believed on one level that Harold was telling the truth, but on another level she still accused him and wanted to know whether he was lying to her. She used the doctor's explanation to confront him: "Doctor said it's through sexual intercourse. That's why". And to add more weight to what the doctor had said she added: "...and it's the man who is responsible for it". Harold held on to what he had said before and to prove his innocence, he even had sex with her without condoms while she was still on treatment. Anita said she did not want to, but he persuaded her by telling her he loved her and if he would be infected, then they would both be in the same situation. Harold went to the doctor for a check up as well. He did not have any warts.

For Anita it is a puzzle how she got infected: "If Harold did not have any symptoms, and I never experienced having warts in my former relationships, where did I get it from then?" Anita did not care about Kries anymore. She did not intend to find out if he had been the one responsible for her situation. If he was, she did not care, because she was being treated now. Harold did have a relationship with a commercial sex worker, a woman from Santo Domingo, prior to having a relationship with her. But that was not important for Anita, because he told her he always used condoms with that lady. In the beginning of their relationship Anita also used condoms with Harold, but very few times. She trusted him, but she felt very guilty, because her health was now in danger. However, the most important issue
was that Harold did not have anything and he knew about her situation. She wanted to keep her good relationship with him and that was all that mattered to her.

2.5: Dealing with an STI: Mafo’s ‘ignorance’

I met Mafo at the Dermatological Service. She did not seem very preoccupied about her STI status; as she said: “it was something that could happen to anyone and you just have to deal with it.” In the first instance, I was surprised with her attitude towards it. I could not ask her questions about secrecy, because there was no secrecy in her behaviour. It was probably her partner who had secrets. I found Mafo to be short and open in her response. I had only one conversation with her which lasted two hours. She did sign a letter of consent, but did not want me to record the conversation. After the interview, she told me it was a pleasure to have talked with me about her situation. In my heart, I somehow stayed surprised.

Mafo was 20 years old. She was a Maroon and moved to the city five years ago. Sometimes she slept at her mother’s place, 40 minutes away from the city, and stayed other times with her boyfriend, Siko, who lived fifteen minutes away from the city. Mafo had gone to primary school and did not finish secondary school. She was part of a big family. She had one sister and three brothers from her mothers’ side. From her fathers’ side she had five sisters and three brothers. Mafo was unemployed and her boyfriend took care of everything.

She had been in a steady relationship with Siko for four years. Their relationship was currently better than before. Siko was a very jealous man and he used to hit Mafo in the beginning whenever he saw her talking to another man. She told him she had always been true to him. To the contrary Mafo used to find messages of other women in Siko’s cellular phone and when she confronted him, he denied everything. Siko said that women were jealous of her and tried to come in between them. But according to Mafo everything was going better now: “He does not hit me anymore, everything I ask I get from him, he loves and helps me with everything. If I have to go somewhere, he’ll bring me, even if it is not important.” The reason for his change was the fact that she was pregnant. As she told: “Every time I was two weeks overtime, and I menstruated, he accused me of taking away the belly. He told me he would leave me if I would not get pregnant this year.” Mafo, Siko and also his family were happy that she was pregnant.

In the fourth month of her pregnancy, Mafo felt a small wart at the inside of her vagina. She did not have attention for it until she had to go to the hospital due to some bloody discharge in the first week of the fourth month. In the hospital she washed her vagina and got frightened when she felt a lot more warts. When the medical doctor examined her, everything
was fine with her pregnancy, but he told her she had an STI and referred her to the Dermatological Service to get treated. She had to take her partner as well.

Mafo felt worried, because she thought of HIV and called Siko. She told him she had a ‘SOA’, the Dutch abbreviation for STIs. He was very surprised and told her he did not even know what ‘SOA’ meant. Then she told him she had genital warts. Siko had them as well and told her that he had been having those things from his childhood. She could not really remember whether she had seen warts on his penis, but according to her she never had experienced it until now.

Mafo had told her mother-in-law about the warts who said not to worry. She referred her to the doctor and advised her to get treated as quickly as possible. Mafo also informed a niece of hers, the daughter of her mothers’ sister. According to her, that niece knew everything about STIs. The niece explained that it had to be an STI and that her boyfriend had probably given it to her.

At the Dermatological Service the doctor confirmed the diagnosis earlier made. Mafo did have genital warts. She knew she had been infected by her partner, but she did not know how he got it. She asked him whether he had other sexual relationships. Siko denied. Although Mafo felt a bit worried, she did not dig into the matter. She did not trust Siko, because according to her “men always walk out on women.” But there was no reason to have fights about it. “We just have to talk our way out”, she said with a smile.

2.6: Between life and death: Annemieke’s sadness

I was on my way to the treatment room of doctor Hu, when I first saw Annemieke. She came out of the doctor’s consultation room, wearing a nice white dress and looking very beautiful. With her appearance still in my mind, I asked the nurse whether there were more STI patients for the day. The nurse replied positively and told me that the doctor was just about to send a patient to me. I walked back to my room and after a few minutes Annemieke knocked on my door. When she entered, I greeted her. She greeted me back. She was smiling when I made her a compliment about her nice appearance, but I also immediately felt she had an aura of sadness around her. I could not yet understand why and started the conversation. After I had her consent, Annemieke told me she came to the clinic to get her genital warts treated. She was sad about it, but that was not the only reason why.

Annemieke was a 31-year old woman with a mixed ethnic background (Hindustani, Chinese and Creole), but according to herself she was more a Creole. She had only followed elementary education and worked at that moment as a babysitter. Annemieke was very sad
about her past. She had never really known her biological mother; when she was five years old, she got a step-mother and a brother of eleven years, with whom she did not stay for too long. Her father did not live with them and she was raised by her grandmother. About her grandmother she said: “not that I did not get affection from my grandmother. It was only that she had many children herself and did not have enough time since she was sewing clothes for a living.”

It was because of the lack of affection and attention, as Annemieke explains, she started having sex at a very young age, 17 years. She also saw herself back then as a teenager with the urge to explore her sexual identity. In the course of the time, she had sex with more than 50 men. As she put it: “I was always searching for love and safety. And I also had no friends. I had nieces, who wanted to see me destroyed, who were jealous and stimulated me to do bad things.” Annemieke was not consistent in condom use: “I just trusted the person, it is not written on his head. I took stupid chances.” She finally got into a steady relationship with a Creole man, Ramon, with whom she has been living for five years together with her nine-year old daughter, who is not Ramon’s child.

Annemieke found Ramon to be a loving and caring man who was very sociable. They could talk about a lot of things and she loved him. But in the first year of her relationship, she noticed Ramon had changed: “He would come home late at night and avoided me. Sometimes he also had red marks that other women made in his neck. He was clearly having other sexual affairs, but whenever I asked he just did not give any answer to me. He even had very red and pussy eyes.” Annemieke soon noticed vaginal discharge and found out to be infected with Gonorrhoea: “I felt very disappointed, but did not have fights with him. He never admitted anything.” Still she decided to stay with him, she had experienced already too much in her life with men. Two years after the Gonorrhoea infection, she started feeling unwell. Her body temperature went up and down. Since she did not trust the strange behaviour Ramon sometimes had when she asked him about other women, she decided to do an HIV test.

Annemieke did the test and got a positive result. She was infected with HIV. She herself was shocked and very sad. But she disclosed it calmly to Ramon since she did not know how she got infected, who had infected her and when she was infected. She had have unprotected sex with so many men. Still, she believed that Ramon had deliberately infected her. When she disclosed her HIV status, Ramon did not react very shocked. He only said: “It’s very hard.” And then he told her, after many discussions, that once he did have sex with a woman who was a drug addict. She was looking very good, but afterwards he found out that
she was HIV positive. After she persisted, Ramon also took a test. He too was found to be HIV positive.

Except for the medical professionals and Ramon, only her aunty, who she trusted deeply, knew about her status. But she believes her neighbourhood knows as well: "When I walk my neighbours look at me, they whisper. Once a girl even made a loud remark that I must have AIDS. But I do not care what people say. I myself know that many others in the neighbourhood also have HIV, because I know the symptoms." Annemieke tried to cope with her illness in her own way together with Ramon. They both had been on medication for two years now.

2.7: Surviving with a promiscuous man: Makeba’s worry
I met Makeba at the Dermatological Service, an open and very friendly woman. I met her twice and we had open conversations, which I was allowed to record. The red line in her story was her anxiety about her husband’s promiscuous sex life and her constant struggle to survive within that context. After she left, I kept asking myself what I would have done in a similar situation. Difficult to answer.

Makeba was a 44 year old Maroon woman. Together with her 49-year old husband, Kello, and eight children, she lived in district Sipaliwini, one hour away from the city. Two of the children are from a former relationship and six were from Kello, with whom she had been sharing her life for almost 22 years. She was a housewife; took care of the children and sewed clothes in her village to earn a small amount of money. Kello was working for a mining company in Suriname. According to Makeba, he also worked as a taxi-chaffeur during his spare time. Makeba had five sisters, but with one of them she had very close relationship. That sister was living very close by and Makeba could talk about all issues in her life with her.

One such issue was the never changing sexual behaviour of Makeba’s husband, Kello. Kello had a very promiscuous life. He had sexual affairs with several women with whom he had four children. According to Makeba he was currently involved in two sexual relationships with women she also knew: "They are women of the streets, two who don’t have a husband. It’s not a secret, I know it, everyone knows." And it was because of his very promiscuous behaviour that Makeba found herself to be in a difficult position.

For some three days on, she had been suffering from vaginal discharge, itching and pricking pain in her vagina. Because she had experienced being infected with Gonorrhoea three years earlier, she suspected it might be the case again. She told Kello to go to the Dermatological Service as well, but he was not suffering from any symptoms and refused to
go. Makeba had a hard time: “I was very angry with him. He agreed that I should go to the doctor, but he didn’t want to come. Only if the doctor demanded him to come through a letter, he would come.”

She went alone to the Dermatological Service for the first consultation and was diagnosed Trichomonas and Gardnorea Vaginitis. Because she knew how stubborn Kello was, she requested the doctor a letter in which he was called up for a consultation as well. With the doctor’s word, she would have more power to persuade him to go to the clinic as well. Makeba felt terrible and was not happy about the situation, but apart from talking to him, she did not feel she could anything else: “I have been living with that man for almost 22 years now, we have eight children. I don’t want to leave him and take another man. I don’t like that behaviour, take a man, leave a man, take another man...”

Makeba had requested medication for Kello as well. At home she gave him the medication and confronted him with the situation: “I told him that the doctor said it’s a disease you get when you sleep around with other women.” He did not react on that and took the tablets. He came up with a possible explanation. Makeba: “...but then he thought it’s a disease he already had in his abdomen a long time ago, the doctor could not find anything. He had also x-rays made. It’s possible that that thing is disturbing him now. So he thinks of going personally to the doctor and find out what it is. He thinks that the disease we have, he had for such a long time already, more than 20 years. But the doctor couldn’t find the disease and he thinks that it’s coming out now.”

Makeba claimed not to believe him at all. If the doctor could not find anything after many x-rays back then she cannot believe it’s that illness: “The illness he was talking about could be an unexplained illness he caught in the bush, but the thing I’m here for, it’s not a ‘busi sani’ (bush thing).” She knew she was infected through sexual intercourse and that her husband was the culprit. Diplomatically she tried to warn him about his other sexual partners as well: “I did not tell him to go to the other women. But I told him that the doctor said that the women you’re visiting will have the same thing as well. If you don’t believe me, you will hear it from the doctor yourself.” Kello agreed. He told her he will tell them to go and if the women refuse to see the doctor, he will not have sex with them anymore.

However, Makeba also believed something else could be causing their condition. Since her husband was very promiscuous and walked out on her on every woman he liked, she believed that someone could have done black magic: “Someone could have put something for him so it could get to me. He doesn’t belief so, he trusts the women. But I told him as well, it seemed like the other women had put something on him, so it could get to me. Because my
vagina pricks like needles are inside, like something is cutting me. Like a worm that’s eating your body away, that’s how I feel.”

Besides her belief that someone could be trying to harm her, Makeba knew she was in a risky position because of her husband’s risky sexual behaviour. She had heard about AIDS and she worried about it, also because of the influence it might have on her children: “In this time of living, you hear about everything. I have my children to take care of, to educate them. Then I do not want to die and leave my children behind. So, they will have to go on the streets and start begging here and there.” Makeba tried to negotiate condom use, but it was difficult due to his denying attitude: “I think of using the condom, and I even tell him, but he doesn’t want to. He’s claiming he’s not having sex with a lot of women and the one’s he’s having with are not promiscuous women. But I said it’s not possible, because ‘you don’t know what they’re doing if you’re not there. You can’t be sure they have only one man’. He knows they’re promiscuous and still he goes to have sex with them.” She sometimes tried to hold on to her conviction to use condoms she bought, but then Kello would express very aggressive attitude each time by shouting in the night and throwing things around. Her children would hear everything and even the neighbours would come out of their houses to ask what was going on. It often became very shameful to her and other than taking the risk of having unprotected sex with him, she felt she could not do more.

Makeba was trying to survive somehow in the relationship. As she emotionally expressed: “My heart bleeds all the time. I even think of leaving this man, but if I do so, I’ll be on the streets. I don’t work and the children. What will I eat and how will I survive with the children?” She only hoped he would change his behaviour in the future before it would be too late.

2.8: Mixed information about STIs: Gracita’s confusion
Gracita was an STI patient at the Dermatological Service. When I first started a conversation with her, she mad a secure impression on me, but I felt some restlessness. I asked her whether another time would be better, but she told me she had enough time. After the conversation it became evident to me, that restlessness was not the right description. It was more like being confused. I spoke twice to Gracita, the second time at the university campus. Both times, Gracita stressed how confusing she found the information to be about the STI she got.

Gracita was a young 23-year old Maroon women living fifteen minutes away from the heart of Paramaribo. Half of her family from her mothers’ side still lived in a village in the interior. Gracita had been in a steady relationship with a young Creole man, Alfred, for about
eight years. They had a child of two years. Gracita was studying at the Anton de Kom University of Suriname. She had a few more years to finish.

Gracita’s health situation became a worry since March this year, when she was preparing herself to walk out on Alfred for the first time in their relationship with Hubert, another Creole man: “For a steady partner you are not ashamed, even if you have a big lump there [vagina], he has to accept. But if you want to walk out, it’s another nature you’re going to meet. And you know how men are. If they got what they wanted, they can tell stories about you afterwards. So, I thought everything had to be in place before I went. I took a mirror, put my legs up and then saw some white very small things there. I didn’t even know they were called warts.” Initially she thought it was some white discharge, called ‘witte vloed’ and wiped her vagina, but the things she had spotted were still there. Alarmed she phoned her niece, Ann, who had once told her that she had experienced such thing. Gracita believed maybe Ann’s explanations back then could be valid in her case: “My niece told me you could also get it from the water of the city, because it has a different position than water from the interior. In the interior it’s sweet water. She also told me you could maybe get it if you hadn’t cleaned your vagina for a long time in the traditional way with hot water prepared with herbs.” But Ann could not compare the two cases since she experienced only one wart. Gracita called her sister and another niece of hers with whom she shared almost all her intimate matters: “Well, my sister said, maybe it comes from the ‘witte vloed’: if it’s too sour and too much, it can lead to infections. My other niece didn’t know anything about these things.”

Gracita then started to think: “What is it actually and what did it mean? Is it normal? Is it an STI? What is it? I just wanted to know what it was.” She called Alfred and started accusing him for it, because she knew he was having other sexual affairs since he had a child with someone else: “I told him, I hope it’s not an STI, because if it is, it must be from you, because I have never in my life walked out on you, I only have sex with you and no one else.” Alfred had always denied her accusations about other women, he even denied being the father of that child and this time he also reacted calm: “He told me he wouldn’t bring an STI for me. He knew what he was doing and how he was doing it.” Despite knowing about his affairs, Gracita did not use condoms with him, because in a way she also played her part pretending she believed him. However, when Alfred came home she showed it to him and looked at his penis as well. She saw small things on his penis as well; similar to hers and when she asked him about it, he said it was something he grew up with. She believed him, because: “I could
not remember whether I had seen it before, sometimes I thought I did, sometimes I don’t know. I thought it’s his body and I should believe him.”

They both decided to go to the doctor and went first to a doctor of the Regional Health Services. The medical doctor diagnosed an infection and told her the warts were due to ‘witte vloed’. It was not an STI. But Gracita could not understand why then both she and Alfred had to take a cure if it was not an STI. However, they took the doctors word for it and they did not bother anymore about it that much. Still, Gracita kept thinking about them, since she knew they were there. She had not taken the whole cure and whether it was the correct medication or not, according to her it had not worked.

In the mean time, Gracita did meet Hubert and had sex with him. The first time she did not mention anything about the warts, but was cautious and kept his hand from touching her vagina. Hubert did not notice anything. Gracita saw to it that he used a condom, because she had already put in her mind to have only protective sex if she would have it outside her steady relationship. When she met him the second time some weeks after, she told Hubert about it. They were in a car, she was still feeling awkward with the warts and in fact, she did not wanted to have sex in a car. Hubert reacted calm and even advised her to go to the doctor, because as a man with experienced he thought it was an STI. She only saw him one more time. It did not work out between them, since he was married. Each time she had sex with him she used a condom. They had not had oral sex, but he had fingered her while she still had the warts.

In between Gracita had also gone to the hospital for curettage. There she panicked more because the warts had grown more and bigger. The medical doctor there had noticed them and referred her to the Dermatological Service. She was diagnosed with Condylomata Accuminata, genital warts. According to Gracita, she had heard several conflicting explanations about the warts also at the Dermatological Service, because she was seen by assistants and just once by the doctor. “According to some experts”, as she sarcastically said, “...the warts were not due to an STI. Others said it was. Then I heard it was a virus living in my body for the rest of my life. It was all very confusing to me.” She still was confused and uncertain about what exactly genital warts were and how they were transmitted.

Gracita stopped continuing the relationship with Alfred. She thought he did not have respect and love for her by having multiple sex partners and even a child with one of them. And she was extremely angry because he always denied everything. They had fights many times because of that. On top of that she did not have his attention, he was not there for her
and that was also part of why she had walked out on him. She still was under treatment of the warts.

2.9: Deception and consequences: Rita’s revenge

When I met Rita, I was wondering how much different her story would be from the other women I had spoken to. Rita was at first short in her answers, but the more we talked the more she opened up. I got in contact with her through key-informants. I had three conversations with her, all of which I could make notes, but was not allowed to record. We could talk privately in the place Rita was living. After her story, life to me seemed like a drama.

Rita was a young Hindustani woman, aged 33. She lived in a rural area some 30 minutes from the city in her mother’s house by herself. But she had been in a steady relationship with a 35-year old Hindustani man, Deepak for two years now. Deepak, who was working as a contractor in the interior, stayed with her whenever he was free from work. He was not the man of her dreams, but she had decided to be with him because she had experienced already several broken relationships in her past. “Within the Hindustani community”, she explained, “girls with several sexual relationships are viewed negatively, as women with low morals. Therefore I wanted to settle now that I had my chance with Deepak.” Rita’s parents were divorced. Her mother lived in Guyana and her father in Suriname. Rita had two sisters; with one of them she had a very close relationship. With the other one she did not have contact anymore.

“In the beginning life was good with him. He took care of me and gave me enough money. But within one year he started to change and did not have that much attention for me. He gave me money, but the love I lacked.” Not happy with her situation Rita decided to look for a job, even though she did not have to work. She found a job in a shop and was happy to get in contact with many other people. Especially the men were crazy about her since she looked quite attractive. Due to Deepak’s changed behaviour and the sadness she felt being with him, Rita started enjoying being together with a male client, Ronald. Ronald would come and pick her up during the break and sometimes he even lifted her home. On the other hand she found more evidence Deepak was involved with another woman, his former girlfriend. She got into fights with him about that woman and Deepak denied everything.

One day Ronald took Rita out; she was already one-and a half year in her relationship with Deepak. From that day she started a hidden sexual affair with Ronald. “I felt I was finally able to take revenge on Deepak, because I knew he was lying.” In the beginning she used
condoms with him, but after a few times they stopped. Ronald told her she could trust him and she did. Back then Rita did not know Ronald was involved with another woman as well.

Three months after the affair with Ronald, she started to have a milky vaginal discharge: “I noticed my underwear to be wet and it was also lathering. I got so afraid, because it was a different vaginal discharge. I did not know what to do and what it was, but I did not want Deepak to know about it at all.” She told Ronald about it and asked him whether he noticed something; he had not. Rita had thought to find a solution with him. Instead; he changed his attitude and started accusing her of having an STI and infecting him deliberately. Rita: “I cried and I told him it was not true. I did not know what it was, but he did not believe me. Ronald broke off the relationship with me, like I was nothing and since then he never had contact with me.” She later found out, via another friend, that Ronald was having an affair with another lady as well. She felt betrayed, but she could not do anything about it: “I had been cheating myself with Deepak, I was not better than Ronald.”

Rita met her sister and described her situation. Her sister told her immediately not to wait and go to the doctor, because it sounded to her like an STI. But her sister advised her also to use some medicinal plants, maybe it would help. To Rita that sounded better. She did not want to go to the doctor because she was still afraid and was hoping it would go away from itself. She took up the advice of her sister and used warm water prepared with some medicinal plants to wash her vagina. But the discharge did not go away and in her heart, she knew it had to be an STI.

In the meantime, during the hidden relationship with Ronald, Deepak seemed again loving towards Rita. He showed her attention and affection as before. According to her it was “because he was afraid of losing me. He had probably stopped the contact with the other woman.” Rita was very much doubting whether to tell Deepak about the discharge or not. She did not want to lose him, but she did not know how to tell him. “I know Deepak would not forgive me, because after all he cares about me. And I don’t want to have a broken relationship again; my family would call me a whore.” She still was having unprotected sex with Deepak, but each time before having sex she washed herself very much with soap to smell good. And every time before letting him penetrate her, she took care he was sexually very much excited so his orgasm would come very quickly. She also checked his penis, but saw nothing wrong. She also very nonchalantly asked him whether he had pain in his penis, but Deepak did not feel anything. Rita, who still had the symptoms, started to doubt what it was that she had: “Maybe it was caused by something I had eaten, an allergic reaction.”
Then two weeks after the incident with Ronald, Rita found by accident a picture from Deepak with a baby in his arms. She had found it in the yard, probably fallen out of his pocket. She could not believe it. Deepak had kept lying to her and was only nice to her so she would not suspect anything. Rita was filled by feelings of anger, jealousy, betrayal and sadness. She again strongly suspected her situation to be caused due to an STI and she started thinking: “Maybe it was not Ronald after all that had given me this. Maybe it was Deepak himself.” Rita felt like getting mad but controlled herself. Revenge ripened in her. She felt also terrified, because maybe she could have HIV as well. She had taken many risks with the men in her life. She decided not to go to the doctor: “If it is an STI, Deepak will probably notice it by himself. If he doesn’t, he will probably notice it with me. Then the bomb will explode and I will confront him with that picture. Until then, I will keep having unprotected sex with him, let him get infected and with him, the other witch as well.” Rita did not go to the doctor, but her symptoms were getting worse. It was only a matter of time.
Chapter 3
Data analysis: strategies to manage relationships and sexual life

This chapter has been both challenging and a relief. Challenging, because writing this part required a congruent combination of the theoretical concepts with the research findings on an analytical level. A relief, because it was at the same time the beginning of the final part of my thesis. In this chapter I presented a deeper explanation of the theoretical concepts used and data is analysed within that context. The main themes chosen for analysis are: the social meaning of explanations, stigma and status disclosure, secrecy and lying and impression management. Although they are presented in different sections, they are often complementary to each other and difficult to separate. In the following parts they are highlighted and discussed.

3.1 Explanatory Models

One of the theoretical concepts used in this study is the ‘Explanatory Model’ for illness and disease, introduced by Arthur Kleinman, almost three decades ago. In his book ‘Patients and Healers in the Context of Culture’ (Kleinman 1980), he describes this model in detail and presents it as a theoretical framework for studying the way medicine, psychiatry and culture relate to each other. Kleinman views the processes of patterning, interpreting and treating an illness as Explanatory Models (EMs). Helman provides a short overview of the main aspects of EMs in his book ‘Culture, Health and Illness’ and sums up five main aspects of an illness. EMs provide explanations for: 1. the aetiology or cause of the condition; 2. the timing and onset of symptoms; 3. the pathophysiological processes involved; 4. the natural history and severity of the illness and; 5. the appropriate treatments for the condition (Helman 2000: 85).

Explanatory models are also used to understand personal and social meaning given to the experience of an illness. They help “individuals to explain, organize and manage particular episodes of impaired wellbeing” (ibid). Explanatory models are often used in the field of STI/HIV/AIDS as a theoretical framework to generate deeper understanding of how people perceive and explain their illness (Hodgson 2000:1; Mill 2001: 254; Schefer et al. 2002: 1380).

In my research, I will focus on the social meaning of the explanations women have for being infected with an STI.
3.1.1 Social dimensions of Explanatory Models

When an individual contracts an STI, the important question immediately becomes how to explain the STI? Studies done cross-culturally show people have different explanations about sexually transmitted infections, including HIV/AIDS; these explanations covered a wide terrain of both medical and non-medical explanations linking STIs to cultural beliefs and practices, spiritual and mystical phenomena (Mill 2001: 272; Terborg 2001: 49; Schefer et al. 2002: 1380; Helman 2002: 90-91). Indeed, "explanatory models do not exist in isolation. They can only be fully understood by examining the specific context in which they are employed, since this usually has a major influence on them" (Helman 2000: 86).

In my study, almost all of the women initially tried to explain the STIs in bio-medical terms. They thought their condition could be caused by something normal of the body or caused by daily hygienic activities such as washing vagina from inside. Other explanations blamed the problem on an accident during daily hygienic activities such as scratching with nails, cutting while shaving pubic hair or rubbing the vagina too rough with a bath towel or on a lack of hygiene, such as not washing the vagina enough or sharing underwear. Some of the women said they did not know what was happening to them initially. Women also explained their illness as caused by environmental factors. Gracita, for example thought the water in the city was different from the water of the interior and considered this a possible explanation for her condition. One woman, Makeba, was immediately aware that it had to do something with an STI, because she had already experienced something similar in her life before. But she also looked for an explanation within the supernatural world, believing also that maybe some other women, probably her steady partners’ other sex partners, had bewitched her through him. Mina thought in the same way, even though she also knew she could be having an STI. Women who walked out in their steady relationship knew they had been having unprotected sexual behaviour with other sex partners and related their symptoms to STI as well. However, possible external factors in a sense were brought up as an appeasement for themselves as well. Kleinman states in this regard:

"For instance, an individual, for entirely personal or sociocultural reasons, may evaluate early symptoms as not worth worrying about, minimal, natural, or not part of sickness but representing some other state, or he may deny their potential significance (Lipowski 1969). On the other hand, he may become frightened and view them as a threat or loss that must be immediately responded to. And his attitude will be different depending on his affective state and interpersonal situation at a particular time" (Kleinman 1980: 75)
One woman, Marijke, also believed that maybe ‘God’ had punished her for her actions and that she therefore was suffering from her illness.

Whatever explanations given to the aetiology of the disease, whether bio-medical, environmental or spiritual, the research findings indicate these explanations are steered by the social need of women: to keep the relationship going with the steady partner or with other sex partners despite the STI. Thus, women’s causal explanations have social implications. In explaining how they thought of being infected with the STIs, most of them tried to find reasons to cope with the STI without damaging their relationship with their steady partner. Anita felt as if the genital warts, which she could not explain ‘made’ her view her partner from a negative perspective and ‘made’ her question his fidelity. Although she did not trust him completely, she chose to stay in the relationship. Except for the love and financial security, her partner did not have any symptoms as well. Mafo, who did not trust her partner, took the inability to explain her partner’s genital warts as an acceptable excuse to carry on with the relationship. Even after being diagnosed with an STI and having the knowledge that their symptoms were due to a sexually transmittable infection, external factors were brought into picture to cover the ‘real’ underlying cause of the disease and in some cases, others were blamed to be responsible for their condition. In fact, women did not really try to explain the cause of their condition anymore, but they tried to interpret their condition and act upon that interpretation. Women socially interpreted their disease and socially reacted on the cause of that disease: giving medical explanations out of social necessity.

Explaining STIs for most women within steady relationships is difficult, especially within the Surinamese society where many women have in general a weak position in relation to the men. Women’s educational level is less than those of men; they are more often unemployed and are also part of the poorest groups in the society (Terborg et al. 2006: 64). Women often stay in steady relationships or other sexual relationships due to the weak financial position they have. In my research this is accentuated especially in the stories of Mina, Reshma, Anita and Makeba. Mina had another sexual relationship due to her financial situation and housing problems. Anita’s former partner could not or did not want to take care financially of her and her children; the reason why she chose to have a sexual affair with someone else. Reshma stayed in her relationship because of the luxurious life she could lead with her partner. Makeba was a housewife and earned just a bit of money by sewing clothes.

Besides the medical and other external explanations, in my study most women blamed their steady partners for their condition as well; even if the women themselves had practised unprotected sex with partners outside the relationship. This attitude had a social dimension as
well. Obviously, sexually transmitted infections are closely related to sexual behaviour. In the context of steady relationships having an STI can be a serious problem. Cultures vary in the way they define appropriate sexual behaviour (Nanda & Warms 2007: 266). In Suriname one of the core aspects of steady relationships is sexual commitment to each other, trust and fidelity. Dr. Terborg, a sociologist in Suriname and specialist in the field of gender, sexual and reproductive health issues, explained to me how steady relationships and the problem of STIs are viewed in the Surinamese society:

"Sexual behaviour, especially in our society, but also in all societies, is tied to strict rules of what is allowed and what’s not, especially for someone within a steady relationship. People are inclined to conform themselves to the rules as they apply in the public. And the rule is that if you, just say in a steady relationship have sex with only your partner, you, in fact cannot contract an STI. If an STI manifests itself then it’s in fact an indication of a problem. A problem within the relationship or outside the relationship in the sense that one of the partners has walked out on the other."

The crucial issue with STIs within a steady relationship in fact, is not what caused the disease, but since it is sexually transmittable, who caused it. Almost all women blamed their partners for their condition and in all cases men denied the accusations from the women. In Rita’s case, her sex partner outside even blamed her for giving him an STI. Interviews with key-informants in the Surinamese society show that the tendency to blame the female steady partner is not uncommon. It becomes easy for men, who have multiple sex partners outside the relationship, to blame women for their condition because of the dominant position they hold in the society. Parmila, a 42-year old nurse working for more than ten years with STI patients in a clinic, experienced this behaviour:

"To get rid of it, to put off the blame, and then they say ‘it’s not me, it must have been you’ and that you cannot proof. You cannot proof that the woman has not walked out and that’s why the man puts the blame on her. But because the woman knows she has only one partner, and she is very sure about that, she knows that she contracted it from the man."

Due to persistent inequality in gender relations, women become also more vulnerable for STIs and they are often found to be the victim of their partner’s unprotected sexual behaviour (Go et al. 2002: 201). In Suriname this is also the case. Makeba for instance; she had to accept her
husband's promiscuous sexual life, since she had nowhere else to go and did not want to leave her husband after many years of being together. Nurse Parmila told me:

“In all the years I have been working, I have seen many women with vaginal discharge. When it turns out to be an STI, it is most of the time the partner who has walked out on them. It’s very sad, women often don’t understand it. They also say they are going to ask their partner about it when they go home, but, as you know, women in our society are in an inferior position and under pressure, so they can’t come up for their rights.”

Cornelly, 47-year, who works at a voluntary counselling and testing site and often counsels people with STI, confirmed:

“Often times it’s the men, women are the victim. Then they [the men] ask ‘can’t I ask the doctor to tell my partner it’s due to something else?’ But that we can’t advise because it’s wrong. It’s incorrect information”

However, searching for external reason to explain health conditions, blaming steady partners for being infected or being blamed for causing infections are also rooted in issues of stigma and secrecy. In section 3.2 I will elaborate on these issues.

3.1.2 Health seeking behaviour and treatment choice

In general, bio-medical health services are well visited by people in Suriname, but especially with stigmatized diseases as STIs it is also known that people turn to the informal sector for treatment. Various studies, general knowledge and surveys of health seeking behaviour in many developing countries reveal that many people with symptomatic STIs seek treatment in the informal or private sector; this sector can include traditional healers, unqualified practitioners, street drug vendors as well as pharmacists (Van der Geest 1987: 276; Mayaud & Mabey 2004: 179; Terborg et al. 2006: 71; World Health Organization 2006: 2).

It is also mentioned that formal public health services will only be attended, if self medication or other alternative treatments have failed (Mayaud & Mabey 2004; World Health Organization 2006). A female medical doctor in Suriname stated:

“There are some other doctors where they prefer to go, because they know, if you use a lot of antibiotics, the discharge will maybe be cleaned up, but the problem is still there. Most of the time they come when they have tried everything else outside.”
In Suriname, like in many other countries, medication for treatment of STIs is also available on the streets. Theoretically antibiotics should not be sold without a receipt, but the practice is different. Illegal trade in medication from Guyana to Suriname by crossing borders in the west, also known as ‘back-track’ exists. This, together with unprofessional use of medication, is mentioned by some medical doctors as a big problem since it often leads to drug resistance. Domestic remedies made in particular within the Maroon society against STIs, especially Gonorrhoea, are also widely popular. Shops and drugstores selling medicine for STIs are also to be found in Suriname. During my fieldwork I managed to find a drugstore under the market place where all kinds of medication are being sold for people with STIs. As the sellers told, it was more for money making and of course ‘helping the people the easy way’. One of them remarked:

"If people don’t want to go to the doctor, what can we do? I want to sell my medicines. If we don’t have for example antibiotics for Gonorrhoea, we give bactrimel. For us, it is to make some money. It’s people’s own responsibility to take care of their health. Why don’t they go to the doctor? If they choose to buy things under the market, it’s their decision. If they are lucky and the symptoms go away, it’s okay. But if not, they will soon notice."

Since a major part of my fieldwork was done at the Dermatological service, there was no doubt about the women’s choice of treatment. From the nine women I spoke, six were STI patients of the clinic. And though I met the rest outside the bio-medical setting, two of them had been to the Dermatological Service for treatment as well. Only one woman had not been to the medical doctor yet. In terms of actions that they undertook since they noticed their symptoms I distinguished two stages. In the first stage, which I view as a more exploratory stage some women who were alarmed already started to seek help in the form of information: best girlfriends, sisters, mothers and nieces were contacted. Those who did not view their condition as threatening did not take any further actions.

In the second stage, a more action-oriented stage in my point of view, women paid closer attention to symptoms, especially when conditions were worsening. Women’s health seeking behaviour progressed towards direction of treatment in bio-medical health services. Others, who initially had not given their situation much thought, became more attentive and started looking for information within their intimate social network. Between the first and the second stage, some women used traditional medication as well such as hot baths with medicinal plants, but since no positive results were detected, help was soon sought in the bio-
medical circuit. This health seeking behaviour is probably stimulated by the nationwide attention paid in Suriname to HIV/AIDS. Symptoms in the genital parts of the body are most likely earlier brought in connection with HIV/AIDS than other types of STIs. For example, Mafo, became worried about her genital warts because she thought her condition could be caused by AIDS. Anita was horrified with her situation and in total despair only because she feared AIDS. Mina was only hoping not to have HIV/AIDS. HIV/AIDS is known to be lethal and therefore a more serious condition than any other STI. As Glenn Leckie, a clinical-psychologist and director of the Lobi foundation, a national family planning institute in Suriname explained:

"STIs are viewed as less important than HIV. We [institutions promoting STI/HIV/AIDS prevention] pay more attention to HIV and less to STIs, while STIs are a much greater problem than HIV. People view sexually transmitted infections [other than HIV] more as an influenza. You can just get it. The risk perception is there, but a series of tablets, an injection ..and it's gone!"

Many of the women came to the Dermatological Service to seek for help due to the fear for HIV/AIDS.

3.2 Stigma, status disclosure and condom use

As mentioned previously STIs are stigmatized diseases; much has also been written about stigma and sexually transmitted diseases (Inhorn 1986; Eng & Butler 1997; Nack 2000; Mill 2001; O'Farrell 2002). Stigma is broadly described by Erving Goffman (1963) who defined it as “an attribute that is deeply discrediting” (1963: 13) with the power to reduce individuals from being ‘normal’ to ‘deviant’. In terms of Goffman, an individual with an STI can be viewed as someone:

"possessing an attribute that makes him different from others in the category of persons available for him to be, and of a less desirable kind – in the extreme, a person who is quite thoroughly bad, or dangerous or weak. He is thus reduced in our minds from a whole and usual person to a tainted, discounted one. Such an attribute is a stigma, especially when its discrediting effect is very extensive" (Goffman 1963: 3)

Goffman describes stigma furthermore as “a special kind of relationship between attributes and stereotypes” (Goffman 1963: 14) and points out that the social identity of individuals can be distorted for others as well as for the individuals themselves. This because stigma,
according to him, constitutes "a special discrepancy between the virtual social identity and the actual social identity of people" (ibid: 12-13). The first part encompasses the perspective society has on an individual, a normative view; the second part accentuates the individual's characteristics and attributes. Goffman mentions three different types of stigma: (1) stigmas due to "physical deformities", (2) "blemishes of individual character perceived as weak will, dominating and unnatural passions, treacherous and rigid beliefs and dishonesty", and (3) "tribal stigma of race, nation and religion" (ibid: 14). Sexually transmitted infections as discussed in this study are more seen within the context of the first two types. Anita, for example, who had genital warts, felt terrible about the deformities in her genital area. In her explanation both types of stigma can be recognized:

"I am so afraid of those things, because I don't know what they are and how they came. I don't feel anything, because it doesn't hurt me. It doesn't itch me, I don't have pain. So it feels like I have nothing down there [vagina], but every time I go urinating, or I go to wash, my hands go there and than I feel them [the warts]. It gives me such a bad feeling, like I'm dirty, like I am so bad. And I was so ashamed of showing it to my partner. I was afraid my partner would see me as a woman of the streets and that he would blame me for cheating on him. But I never did...[broke down in crying]"

Goffman's explanation of stigma is often used to understand how people with stigmatized diseases cope with their illness (Inhorn 1986: 60; Nack 2000: 102). One of the major implications of stigma is within the context of disclosure. In her study "Genital Herpes: An Ethnographic Inquiry into Being Discreditable in American Society", Inhorn (1986: 60) describes that the greatest degree of discomfort for people with genital herpes was not really in the domain of physical pain per se, but rather in the area of psychological suffering about how to display information about their state. In words of Goffman:

"the issue is not that of managing tension generated during social contacts, but rather that of managing information about his failing. To display or not to display; to tell or not to tell; to let on or not to let on; to lie or not to lie; and in each case to whom, how, when, and where" (Goffman 1963: 42; cited in Inhorn 1986: 60)

Status disclosure becomes very difficult especially with diseases that are sexually transmittable. Studies reveal that in many societies talking about illnesses related to one's sexual life cross-culturally is difficult due to its link with promiscuity (Go et al. 2002: 201;
Schefer et al. 2002: 1377) and surrounded by issues of stigma and secrecy (Pliskin 1997: 92; O’Farrel 2002: 144; Lichtenstein & Schwebke 2005: 385). In the Surinamese society STIs are also viewed as stigmatizing due to their relationship with sexual behaviour. People, on societal level, in general are not easy with talking about issues of sex and sexuality. And especially with STIs, which in fact is seen within steady relationships as a result of sexual behaviour expressed against the existing moral values.

In my research the six women who did not have sexual side affairs and who suspected their husband to have other sex partners, disclosed their status to their partner. But when disclosing, accusations were often made to the steady partner. However, in the attitudes and comments they created enough space for their steady partner to come up with an explanation, which they either pretended to believe, or did not believe, but accepted. In Makeba’s story this is clearly noticeable:

“He said that it’s a disease he already had in his belly since a long time, the doctor had not been able to find anything. He had also x-rays made. He thought it was possible that thing is disturbing him now, that it’s coming out now. I don’t believe it, but the way he’s explaining it, it could be possible. I told him to go to the doctor and find out what it is. The doctor can tell us. He tries to find an excuse still, I believe, because when I got him the tablets he was very happy to drink it and get relief. But if that what he’s telling is true, the doctor will find it.”

The women who did not have other sex partners and who were certain about their partners’ sex affairs outside disclosed their status without any reservations. Still, they also did give chances to their steady partners to provide possible explanations, which they often did not believe, but which they accepted.

This tendency to ‘believe’ the steady male partner is probably recognized and used by men in Suriname. A young Creole man who I spoke to during my fieldwork illustrated this to me with his own story. He was in a steady relationship, but after unprotected sex with another woman he got infected with Gonorrhoea and via him his steady partner. He explained:

“Oh, she was mad yeah! She kept pushing and asking me how I got it. I just told her I hit myself [the penis] on the wooden stands when getting out of bed and that’s how I started to have the discharge. That was my story, time and time again. And she had to believe me, because more than that I would not tell. She finally, luckily, did.”
Women who did have multiple sex partners, but who knew or did not know from which partner they contracted the STI had different reactions. Mina, who had two steady partners Piet en Jan, disclosed to both of them. To Jan, she disclosed having a bacterial infection, to Piet she disclosed openly she had an STI. Reshma did not disclose to her sex partner outside, but she did disclose her problem to her steady partner. Rita did disclose to her outside sex partner, but not to her steady partner. But in disclosing their status, the communication and affection within the relationship, the personality, educational level, social position and sexual behaviour of all sex partners were deeply taken into consideration. In the case of Reshma, also her own social position in her cultural context was given much thought.

The situations described above can be viewed as social aspects of stigma. Goffman expressed a more individualistic perspective on stigma, but over the course of the years, there has been a shift from an individualistic focus towards an emphasis on the social aspects of stigma. A valuable contribution related to this is made by Yang and other social scientists in their recent and comprehensive overview article on stigma: ‘Culture and Stigma: Adding Moral Experience to Stigma Theory’ (Yang et al. 2007). In this article the authors present a descriptive overview of definitions and theoretical models of stigma from mainly sociological, anthropological and socio-psychological perspectives and how they developed over time. Building on the framework of other theorists about stigma as a social process, interpretive or cultural process they argue that “stigma in it’s essence is a moral issue in which stigmatized conditions threaten what is at stake for sufferers” (Yang et al. 2007: 1524). As they put it, “stigma threatens what matters most... And daily life matters often deeply. People have something to gain or lose” (ibid: 1528-1532).

With exposure to STIs, the women had definitely something to loose if they contracted HIV: their own life. As my study revealed, most of the women were tremendously worried about being at risk for HIV/AIDS as I elaborated in section 3.1.2. Most of them were also aware of their steady partners’ promiscuous sexual behaviour or at least they suspected it. Why did they not use the condom than? Makeba tried to negotiate condom use with her partner but it was not possible due to his dominant position. Besides, if she kept on, she would loose the financial stability and her own social status. Mafo, Gracita, Marijke, Annemiekke, Rita and Anita did not think it was necessary, because they could not prove their steady partners’ promiscuity or they trusted them. Besides, asking for condom use or proposing condom use could cause many social and relational conflicts since it was associated with infidelity and mistrust. Reshma and Mina could not afford condom use with her steady partners for the same reasons, as Makeba and the rest. Especially loosing trust was
a big consideration. Most of the women did not use condoms because, as Yang and colleagues point out, "stigmatized conditions threaten what is most at stake" (Yang et al. 2007: 1532). The social scientists also draw attention to the issue that stigma has a threatening effect on interpersonal engagements and at what is most at stake. They also propose that the concept of 'moral experience' or 'what is most at stake for actors in a local social world', as a new interpretive lens that enables to understand the behaviour of stigmatized people (ibid: 1524). I found this perspective very useful. Translating it to the research findings it becomes evident that condom use eventually comes down to the ambiguous question of what was really at stake: keeping the relationship with the risks of losing one's life or using condoms, saving one's life and losing the relationship. It is a matter weighing the one to the other, calculating and most of all, a matter of priority.

Status disclosure could be viewed in the same way. For many women in the Surinamese society disclosing their status in a 'diplomatic' way is the only option to survive both within the relationship as within their social life. Dr. Terborg exemplified:

"If you have a total hierarchical relationship, where one partner is very dominant and the other, in most cases women, has a subordinate position in which she has to submit to the rules and regulations of the man, then I think that she'll think very well before disclosing her status. Because she will take into consideration any possible consequences that can be disadvantageous for her."

My study showed that with status disclosure, thus informing one's partner about one's own health condition the issue became more of how and what exactly one disclosed, than the mere fact of 'überhaupt' disclosing the status. Telling your partner about noticed symptoms in your genital area can be extremely difficult, but disclosing the 'real' conditions under which you think you got those symptoms and actually saying that it is a sexually transmittable disease is the hardest part, especially if you are the one walking out in the relationship. It then comes down to thinking and re-thinking as an individual of what really is at stake and what exactly to keep secret or tell lies about.

3.3 Secrecy and lying: means to manage steady relationships in the context of STIs

Recurring thematic aspects in previous sections, whether it was in providing explanations for STIs or disclosing one's STI status to the sex partners, were aspects of 'secrecy' and 'lying. In my study secrecy is viewed as Sissela Bok (1983: 5) defines it: "secrecy as intentional concealment". Keeping a secret from someone then, is "to block information about it or
evidence from it from reaching that person and to do so intentionally” (ibid: 5-6). The defining characteristic of secrecy therefore is concealment or hiding.

Keeping secrets and telling lies specifically, I encountered in the cases where the women were involved in sexual relationships other than the steady relationship. I am referring to the stories of Mina, Reshma and Rita. These women kept their sexual affairs with other men a secret for their steady partner. From previous discussions about these women it became clear that for them keeping their sexual affairs a secret for their partners was a major strategy to survive within their steady relationship. But having a symptomatic STI did complicate matters. How then to keep it a secret and how to manage the sexual life?

In one way or the other, the women could hide their side sexual affairs. But symptoms such as soars, discharges and, or smells due to the STIs made it increasingly difficult for the women to hide. Keeping their health condition a secret for two women, Mina and Reshma, was not possible due to the level of severity; Rita kept it a secret for her steady partner, because her symptoms were not that severe. However, the two other women did not and in fact, could not, keep their condition a secret and disclosed their status. But in disclosing their status, they stayed in control of the information they displayed and told partial truths. Nack (2000: 102) views this the other way around as “covering” or in defining terms of Goffman, as telling deceptive stories. In her study about women managing the impact of stigma of sexually transmitted diseases, she found some of them portraying other images of their STIs (Nack 2000: 104), just like Mina for example in my study when she said that she had a ‘bacterial infection’ and when Reshma talked about ‘an infection due to hormonal changes’. In both cases, the information was bio-medically correct. But women used the term ‘infection’, but avoided the terms ‘sexually transmitted’. The underlying reasons for using specific terms was to create the impression that their condition was due to something they had no control over. And therefore, their condition could be excused and even sympathy from their steady partners could be evoked. At the same time intentional use of specific words also functioned as a verbal mechanism to prevent further questioning about the cause of the disease from their steady partner.

Mina and Reshma did not only tell partial truths, they lied to their steady partners as well. Reshma lied to her steady partner to cover her secret affair. Lying, and lying intentionally, functioned in this aspect as a facilitating element for secrecy. For Mina the situation was more complex. In fact, Mina’s relationships with both men were basically founded on lies. She lied to both men, since she was pretending to be faithful to both men. Lying in her case was not only a facilitating aspect of keeping secrets, it was a necessary
condition for her to control the situation and survive. Bok distinguished in this regard a difference between lying and secrecy:

"Lies are part of the arsenal used to guard and to invade secrecy; and secrecy allows lies to go undiscovered and to build up. Lying and secrecy differ, however, in one important aspect. Whereas I take lying to be *prima facie* wrong, with a negative presumption against it from outset, secrecy need not be. Whereas every lie stands in the need of justification, all secrets do not. Secrecy may accompany the most innocent as well as the most lethal acts; it is needed for human survival, yet it enhances every form of abuse" (Bok 1983: xv)

I asked Mina how she felt knowing that she cheated on both her sexual partners, that she has an STI and that she intentionally lied to both men all the time. Mina answered:

"When I think of Jan, I feel so guilty that I’m lying to him, because he is a good man and he never causes me any problems with other women. And here now, I have infected him. But maybe he is lying to me as well, the same way I am lying to him, and maybe he’s the one infecting me while I’m suspecting Piet. I don’t feel guilty when I think of Piet, because I know he’s been lying to me all the time about the other women in his life, still I feel bad when I think that I might be the one infecting him through Jan. I feel tormented about this situation, because I will never know the truth and from where I really got the disease. But I have to keep lying to get out of this situation, because if any of the men get to know I’m deceiving them I will stand nowhere."

Lying and secrecy were main strategies for the women to manage their relationships. The ‘real’ social setting causing their condition was kept a secret. Van der Geest (1994: 15) refers in this regard to the attitude of patients to keep their health status a secret especially if a disease is embarrassing or shameful and revealing it would cause stigmatization or banning. Secrecy take a central role when individuals realise their actions have severe consequences for their own survival. Dr. Terborg mentioned in this regard:

"The issue is..., how will the partner deal with the information? Because the information is not like ‘I have a problem, I have a disease you can get as well’, but it’s about what happened to the trust in the relationship. And trust is a sort of a fundament for every relationship. The moment someone contracted an STI from an outside relationship, then that’s the evidence that the trust is violated. Then it’s not about the disease anymore, but a bigger problem."
The reason for keeping the ‘real cause’ a secret for both Mina and Reshma was because revealing the situation could lead to the end of their relationship with their steady partner. For Mina this would be a catastrophe since she was unemployed, did have housing problems and no financial security. For Reshma it would mean giving up a financially secure and loving relationship. Rita kept her condition a secret to her steady partner, knew that once disclosed her relationship would end and she would be heavily stigmatized in her community as well.

On the other hand openness about their biological condition was a key component to manage their sexual life. For Mina it meant she could stop having sex with both of her partners until she cured. For Reshma it provided a means to keep having sex with her steady partner without suspicion. However, when it was clear that both she and her partner would have to use a cure, openness about it was again a strategy to stop having sex and to get cured. In Rita’s case, openness to her other sex partner was meant to find a solution for the problem and to manage her sexual life with both him and her steady partner. In stead, being open about her status complicated her situation since she in return faced accusations.

3.3.1 Responsibility and partner notification

When taking the economic, socio-personal and cultural context into consideration, the reasons for secrecy and lying could be understandable. But another aspect that kept coming back to me was the aspect of responsibility. How responsible was their behaviour towards their steady and the other sex partners? Could their actions, lies and secrets be morally justified? Bok wrote on the dangers of secrecy:

“The danger of secrecy, however, obviously goes far beyond risks to those who keep secrets. If they alone were at risk, we would have fewer reasons to try to learn about, and sometimes interfere with, their secret practices. Our attitude changes radically as soon as we suspect that these practices also hurt others. And because secrecy can debilitate judgment and choice, spread, and become obsessive, it often affects others even when it is not intended to. This helps explain why, in the absence of clear criteria for when secrecy is and is not injurious, many people have chosen to regard all secrecy as potentially harmful.” (Bok 1983: 26)

Sexually transmitted infections generate usually severe negative consequences for an individual’s health. People’s physical health, in terms of biological dysfunction, damage and deterioration, can suffer from it; mentally the idea of having an STI can become a burden and both the mental and physical health can influence the social health and well-being of people.
(Eng & Butler 1997: 2; World Health Organization 2006: 14). How important however, did the women view partner notification? While status disclosure referred to how individuals tell their partners about their own health condition, partner notification referred to the process of informing the individuals’ partner(s) about their exposure to the infection.

In my research, Mina expressed deep concerns for her own health as well as that of her sex partners. She managed to get medication for both her partners and made sure both partners were informed about the necessity of taking the medication as prescribed by the doctor. Mina had been lying and deceiving both partners, Jan and Piet. But since she had not told Jan it was a sexually transmissible infection, she could not openly tell him that he was infected as well. She did openly tell Piet, who she saw as the cause of her condition, she had an STI and he probably as well, since he was the one giving it to her. Reshma considered her own and her steady partners’ health as important. For them selves she managed to get medication and made sure her partner used it as prescribed. But since she as well did not tell Winston she had a sexually transmitted infection, notifying him about his condition in those terms was impossible. She mentioned it indirectly. To David, her other sex partner, she never disclosed her status and never notified him of his status, but dealt in another way with it by simply not pursuing the relationship. She felt not responsible for his sexual and reproductive health, because in a way she felt that he was the cause to the problem. Rita notified her other sex partner, because somehow she felt there were few endangering reasons to tell him about the problem. She did not notify her steady partner. She did not even know if it for sure was an STI and she did not contact the medical doctor. She reasoned her behaviour in terms of taking revenge on her steady partners’ suspected unfaithfulness.

In case of the other women, Anita for example left the possibility open that her former sex partner could have been the one responsible for her condition. She disclosed her status to her current steady partner and also notified him of his status, but did not notify the former partner of her condition. As she said: “I’m finished with him. His health situation is his problem, not mine anymore.” The other women did notify their partners because they were the one either suspected or believed to be the cause of their condition. The question of being responsible for one’s partner’s sexual health is probably related to the situational context in which the individual finds herself to be, and the feelings of that individual towards the partner. It will remain complex and ambiguous, just as it is with the issues of secrecy and lying. And it probably is also subject to the own individual’s sense of morality.
3.3.2 Medical doctors and their view on status disclosure and partner notification

In the section above I discussed partner notification done by the individuals themselves. However, partner notification could also be done by health personnel and individuals with STIs could be also given medication to deliver it to their partners (World Health Organization 2006: 32-33). In Suriname, specifically at the Dermatological Service, STI patients are referred to social workers for further information and support with partner notification and contact tracing. Often times, STI patients are provided with a letter for their partner to seek contact with the clinic. If the partners show up, they will be notified about their health status. The first contact of STI patients in whatever bio-medical setting however is with the medical doctor treating them. How delicate partner notification can be and how much it is dependent on the situation is described by dr. Terborg:

“If a client comes to the doctor with an STI, then it is most self-evident for the doctor to say ‘you have to inform your partner’, because your partner is at risk. But at the same time you don’t know as a doctor what the situation is within the relationship and what the consequences of informing the partner will be for the relationship, in general, but specifically for the person in matter. To be concrete, if the woman is in a violent relationship. And the man is used to abuse her. And due to all the problems she started a relationship with someone else outside who is understanding etcetera, but from who she gets an STI..., how will she tell that to the violent man home, without it having consequences for her. And then as a doctor you will have a dilemma. Should you force the woman to inform the partner with the risk that the partner is violent against her or should you leave the choice to the woman to decide herself whether she wants to disclose her status and when? Thus, you have to look at it from situation to situation and the doctor has a very important role in it, in the sense that they have to guide it.”

The medical doctors I have spoken to had different points of view about partner notification. Doctor B. has been a medical doctor for more than 20 years in Suriname and has dealt many times with STI patients. About partner notification, he said:

“What I do, I treat the partner. But what I do, in the course of the years you get to learn that...then you say: ‘hee listen, you’re going to tell the person [the steady partner] already for what the person comes here. It should not be a surprise to the person for what he or she is coming’. I have already agreed that with the person. If their steady partner does not know, I tell them not to bring her to me then. I put them under pressure as well. That’s the power you have as a medical doctor. Because it’s not I who have to tell the partner, because I also have an oath of secrecy, right? If you come to me and you tell me
something, then I am not allowed to tell it to anyone else. Some doctors tell, that's their point of view. But I will not tell it under any circumstances to your partner, you have to do that yourself."

The oath of secrecy secures the right on confidentiality and privacy for patients and every individual has that right without any doubt. But at the same time being blocked by that system in displaying or sharing information with relevant others, in my study, the steady sex partner of the STI patients thus, provides a helpful opportunity for medical doctors to avoid sometimes very complex and difficult social relationships in which the patients might be finding themselves. For doctor B., as long as partners were notified, it did not matter how many; treating them was not a problem for him. He only collaborated in terms of treatment and explicitly stated what he saw as his main task:

"They bring the person, because the person has to be treated. Some people are very easy and they say: 'listen, doctor, I'll bring the one today and the other one the next day and the other one the day after.' And then I collaborate with them as a doctor. Only because you should know your position very well, as a medical doctor. I'm not a priest or someone who has other moral positions in the society. My task is to take care that the cases of STI within the society maintain within certain borders, so that you don't get epidemics. That's my task."

Another medical doctor had a strict point of view and believed partner notification was a must. She expressed her point of view firmly, exemplifying it with informing a female patient about her STI status:

"I tell her [the partner] what she has because she must have an injection yet. I tell her, 'your husband has it as well'. Then I ask her 'what complaints does your husband have and how do you get it? Yes, you have it from your partner'. That's why they don't like me, but I'm hard. It cannot be that I or he will not disclose his status to his wife or steady partner. If he doesn't then I do not treat him as well, then he has to find another doctor, because I can't work in that way. That's my attitude."

In trying to keep their condition a secret, many people request collaboration from the side of medical doctors in helping them to manage their situation. Doctor P., another medical doctor I spoke, explains until which level he collaborates:
"Some men also request me not to tell their partner and provide medicines without saying for what. But that is of course not possible. Look, I have to tell the partner and I have to give the medicine. I tell her [the female partner] ‘you’re infected, you have an STI and therefore you get the medicines.’ And most of the time they ask: ‘how do I get that doctor?’ and then I say ‘you get it through sexual intercourse’, but most of the time I do not say you got if from your partner. That’s something what they have to find out for themselves."

But sometimes health workers also believe partner notification might not even be the issue. As nurse Parmila states:

"It sometimes is not even necessary to notify the partner. Patients, if they know they haven’t exposed their partners to the risk of getting infected, should just take care of themselves and get treated."

Common in Suriname is that doctors provide medication to the patient to treat his or her partner, if the patient requests so. In my research all the women asked medication for all their sex partners or in some cases only for the steady partner; or brought them for the medical doctor to be treated. Medical doctors do collaborate in treating several partners, but patients are seen as the main responsible person to display their status to their partners. Matters of secrecy stay that way for some medical doctors; for others disclosure or openness is the best option. Medical doctors are tied to their oath of secrecy, but moral views and personal opinions are influential factors in how they respond to requests of people with STIs in steady relationships.

3.4 Impression Management

In this final section, I want to draw attention to the ‘theatrical’ aspect of the women’s behaviour in relation to others, specifically their sex partners, when dealing with their STIs. Goffinan’s perspective of people’s social life and social interactions in terms of a theatrical performance on stage is, in this regard, a very useful one. In his book ‘The Presentation of Self in Everyday Life’ (Goffinan 1959), Goffinan elaborates on that perspective and discusses ‘acts’ individuals perform in their daily life and views people in binary oppositions as ‘actors’ and ‘audience’. The stage, according to him is the world, the surroundings in which people live and in which changing roles are performed. These roles can be different from situation to situation and when playing these roles individuals can guide and control the impression others
form from him. This social interaction he terms ‘impression management’: controlling the impressions to be given off by an individual in order to control the way others relate to the individual. Goffman focuses on several techniques and processes guiding social interaction. Concealment is, according to him, an important aspect of impression management.

Taking Goffman’s perspective up to the level of analysis in my research, it can be noted that all three women with STIs who were having secretive sexual affairs outside their steady relationships tried to constantly manage their partners’ impression of them. One way or the other concealing the social setting under which they contracted the STIs was a key aspect in their lives. The women were the ‘actors’ and their partners to whom they kept their outside sexual life a secret, were the ‘audience’. The women performed social roles, consisting of several parts presented to the ‘audience’, the sex partners, on several occasions. In fact they had been staging their life within the steady relationships since they started other sexual affairs. They had been keeping the affairs a secret for their steady partners, but the presence of an STI complicated the matters. Goffman speaks in this regard of:

“facts which, if attention is drawn to them during the performance, would discredit, disrupt, or make useless the impression the performance foster. These facts may be said to provide “destructive information.” A basic problem for many performances, then, is that of information control; the audience must not acquire destructive information of the situation that is being defined for them” (Goffman 1959: 141)

Sexually transmitted infections can be seen in this same light and can be considered as ‘facts’ with destructive information by the women suffering from it. Reshma’s account on the difficulty of concealing her condition in this regard is enlightening:

“Look, I had been lying to Winston all the time. I always told him, he could trust me and that I was true to him. But when I started to smell that disgusting scent coming out of my vagina, I started fearing that my life could be over now. I was washing my vagina with warm water for a longer time, I used soap, I used body lotion between my thighs, I even perfumed my underwear so that the smell would go away, but I’m telling you; with no help of Gods’ I could ignore the stink. It was like I had been rubbing rotten fish against my vagina! Yes, of course I had to do something...”

In order to prevent these ‘facts’ from disrupting their social life with their steady relationships, women had to control the impression they wanted the partners to receive. In discussing their
health condition with their steady partner they staged a performance. Reshma described one such act very detailed:

"I think I can become Suriname's greatest actress. I'm telling you, Winston could not catch me, even if he would be the greatest detective. I knew sooner or later he would really start noticing the smell and the discharge and I knew throwing the matter at the table was the best way to handle the situation. When I told him I noticed a smell and I did not know why it smelled that way, I took care that my face and the expression of my face was like a bit confused. I was pretending to be so innocent. My voice broke down, like I was really worried and I could really not explain what it was. I also stood naked for him, when telling him because then he could see I was not trying to hide anything. And I watched him constantly, his reaction. I would know it if he did not believe me. But lucky for me, he did. What a fool he was!"

Reshma had thought out the act in every detail, watching her 'audience' closely so she could control the situation and intervene immediately when needed. Goffinan, in this matter, points out that disclosure can be a threatening element for staging a performance, since it is related to the type of secret being revealed (Goffinan 1959: 141). Here, I believe, Goffinan's description of a 'dark' secret is applicable: "Dark secrets are, of course, double secrets: one is the crucial fact that is hidden and another is the fact that crucial facts have not been openly admitted" (Goffinan 1959: 141-142). Disclosing such secrets is a very fragile matter and impressions have to be carefully calculated and managed before sending off to other partners. The issue of course is to control their behaviour and response. In Goffman's terms:

"Regardless of the particular objective which the individual has in mind and of his motive for having this objective, it will be in his interests to control the conduct of the others, especially their responsive treatment of him. This control is largely by influencing the definition of the situation which the others come to formulate, and he can influence this definition by expressing himself in such a way as to give them the kind of impression that will lead them to act voluntarily in accordance with his own plan." (Goffinan 1959: 4)

The most important goal to achieve for the three women was to persuade their partners in believing their innocence or, in other words, to prevent them from finding out the truth about the 'real' conditions under which the women were infected with STIs. In this statement lies the assumption that indeed the sexual behaviour of the women outside their steady relationship caused the infections to occur, but there is no exclusive conclusion about that.
Since the conversations were held with the women only and not their other partners the 'real' conditions, in fact, remain hidden. However, to achieve their goals as previously stated, women cautiously expressed themselves in different ways. Behavioural expression is a function of both the situation and personality (Argyle 1969: 315). Main elements are: 1. vocabulary and strong verbal communication skills; 2. effective non-verbal bodily gestures; 3. extensive or minimal use of facial expressions, and 4. presentation of the self in terms of clothing, place and time. These elements are all part of what Goffman calls, the “front stage” (Goffman 1959: 22): the socio-personal and materialistic setting in which the performances take place. In the front stage the role is performed with an audience and appearance of the actor matters. In the “backstage” (Goffman 1959: 112), the performance can be prepared. The backstage refers to a more socio-private setting in which the individual can be reflexive towards himself. In the context of my study, the scenarios played out in the minds of the women about how to manage their situation within their relationships, even being with their social contacts such as close family members or friends and expressing their worries, were part of the backstage. My study also showed that the women changed in controlling the impression they gave off to their close ones, depending on the social and emotional necessity of their circumstances. Like Mina told me:

“At first I did not want to tell my mother about it, because I did not want her to worry about me. So I pretended everything was fine with me. I know if she would get to know about my situation, she would start asking around and before you know everyone would know about my private life and I really don't like that. But I started to think that if I had AIDS I would not want my mother to hear it from someone else. So I told her about it.”

However, all the mental efforts in terms of thoughts, calculations and possible explanations of the women with STIs about their condition, especially those who walked out on their steady partner and those who suspected their steady partner to be involved in other sexual affair, have been powerful forces in facilitating the way women managed their sexual lives and relationships. Women, in the process of coping with themselves and their condition, have tried several strategies to manage their sexual life and relationships. Explaining, acting, pretending, believing, disclosing, calculating, telling and facing lies and secrets: all parts of their arsenal to survive.
Conclusions

Before proceeding to the conclusions, the research question will be presented here again, so that one can relate easier and more concrete to the findings of my research. My main research question was: "How do women manage their relationships when they have a symptomatic sexually transmitted infection; do they disclose their status to their steady or other sex partner(s) or do they keep it a secret and why?" In answering the main question, the guiding sub-questions are taken into consideration:

1. Which explanations were given by the women for their STIs and why?
2. If women decided to visit the clinic for treatment of an STI, how was their health seeking behaviour prior to that and what made them visit the clinic?
3. How did the women with STIs deal with status disclosure and partner notification and in which way did stigma affect those aspects?
4. How did doctors respond to requests of STI patients regarding status disclosure and partner notification?
5. What was the role of secrecy in the women’s life and how did that correspond to the management of their partners’ impression of them?
6. In what way did the women with STIs think about being at risk for attracting HIV and did they use condom use in their sexual relationships?

Based on my research findings, I concluded that women with sexually transmitted infections managed their relationships and sexual lives by applying different strategies on different levels within their specific socio-personal setting, economic and cultural context. These strategies were closely connected to aspects of stigma related to STIs and sexual behaviour, issues of secrecy and lying, status disclosure, partner notification and women’s causational explanation for their health condition. My research further showed with status disclosure, thus informing one’s partner about one’s own health condition the issue became more of how and what exactly one disclosed, than the mere fact of ‘überhaupt’ disclosing the status. Most of the women with STIs in this study disclosed their status in a ‘diplomatic’ way, to their steady partners and, or to their other sex partner. This ‘diplomatic’ disclosure could vary in degrees of openness depending on the relational context of the women. Only one woman kept her status a secret for her steady partner, because revealing it could lead to the end of her relationship.
In my study, almost all of the women initially tried to explain the STIs in bio-medical terms. They thought their condition could be caused by something normal of the body and, or caused by daily hygienic activities such as washing vagina from inside; 2. something caused by an accident during daily hygienic activities such as scratching with nails, cutting while shaving pubic hair or rubbing the vagina too rough with bath towel and, or: 3. as a lack of hygienic activities, such as not washing the vagina enough or sharing underwear. Some of the women explained also not to know what was happening to them initially. Women also explained their illness caused by environmental factors, due to witchcraft or as a punishment of ‘God’. Women who experienced an STI before in their lives were aware their condition could be caused by an STI.

Whatever explanations given to the aetiology of the disease, whether bio-medical, environmental or spiritual, the research findings indicate these explanations are steered by the social need of women: to keep the relationship going with the steady partner or with other sex partners despite the STI. Therefore, I conclude women’s causal explanations have social implications. In explaining how they thought of being infected with the STIs, most of the women tried to find reasons to cope with the STI without harming their relationship with their steady partner. Even after being diagnosed with an STI and having the knowledge that their symptoms were due to a sexually transmittable infection, external factors were brought into picture to cover the ‘real’ underlying cause of the disease and in some cases, others were blamed to be responsible for their condition. In fact, women did not really try to explain the cause of their condition anymore, but they tried to interpret their condition and act upon that interpretation. Women socially interpreted their disease and socially reacted on the cause of that disease: giving medical explanations out of social necessity.

Explaining STIs for most women within steady relationships is difficult, especially within the Surinamese society where many women have in general a weak position in relation to the men. Women’s educational level is less than those of men; they are more often unemployed and are also part of the poorest groups in the society (Terborg et al. 2006: 64). Many of the women in my research did have financial or other social problems and keeping their relationship was therefore a priority. For other women keeping up a personal social status towards themselves or their community played also a role in wanting to protect the relationship. Besides the medical and other external explanations, in my study most women blamed their steady partners for their condition as well; even if the women themselves had practised unprotected sex with partners outside the relationship. This attitude had a social dimension as well. Sexually transmitted infections are stigmatized diseases due to their link
with promiscuous sexual behaviour. Core elements of steady relationships in Suriname are trust, fidelity and sexual commitment; having an STI within steady relationship can therefore cause serious relational problems.

Taking the health seeking behaviour of the women and actions that the women undertook since they noticed their symptoms, into account I distinguished two stages: 1. the exploratory stage and 2. the more action-oriented stage. In the exploratory stage some women who were alarmed started seeking help in form of information within their social network: selected friends and family members. Those who did not view their condition as threatening did not take any further actions. In the second stage women started seeking treatment in biomedical health services and those who initially had not given their situation much thought, became more attentive and started looking for information within their intimate social network. In between some women used traditional medication as well such as hot baths with medicinal plants, but lack of positive results lead to seeking help at the clinic. Based on my research findings, I conclude that this and also fear for HIV/AIDS urged the women with STIs to visit the clinic. Due to nationwide attention to HIV/AIDS symptoms in the genital parts of the body are most likely earlier brought in connection with HIV/AIDS then other types of STIs.

STIs are viewed as stigmatized diseases in the Surinamese society and this often complicates status disclosure. In my research I focused more on the social aspects of stigma and used the interpretive perspective of Yang and other social scientists to look at stigma more as a moral issue threatening what matters most (Yang et al. 2007: 1528-1532). On the basis of my research findings, I concluded that for most of the women what really was at stake was their own social life within the steady relationships and their own socio-cultural status rather then their health. Most of the women did not use condoms because, as Yang and colleagues point out, “stigmatized conditions threaten what is most at stake” (Yang et al. 2007: 1532). Because, although they felt they were at risk for attracting HIV, negotiating condom use was a difficult issue. It became evident that condom use eventually came down to the ambiguous question of what was really at stake: keeping the relationship with the risks of loosing one’s life or using condoms, saving one’s life and loosing the relationship. It was a matter weighing the one to the other, calculating and most of all, a matter of priority.

My research showed further that Status disclosure could be viewed in the same way, since revealing one’s status required thinking and re-thinking as an individual of what really was at stake and what exactly should be kept secret or told lies about. I concluded that the relational setting of the women in my study strongly influenced the way they disclosed their
status. Women who did not have side sexual affairs and who knew their steady partner had other sex partners, openly disclosed their status to their steady partners. But when disclosing they were always open for negotiating the 'real' cause of their condition. Women who were true to their steady partner, but who suspected them of promiscuous sexual behaviour did also disclose their condition; but only in the sense that they had noticed symptoms. What exactly the symptoms meant or were due to, were not fully disclosed. Women who did have multiple sex partners, but who knew or did not know from which partner they contracted the STI had different reactions. One woman disclosed fully to one partner and partial to the other. Another one did not disclose to her sex partner outside, but she did disclose her problem to her steady partner. And one other woman disclosed to her outside sex partner, but not to her steady partner. In disclosing their status, the communication and affection within the relationship, the personality, educational level, social position and sexual behaviour of all sex partners were deeply taken into consideration. The women’s own personal and socio-cultural situation steered their view on priority issues in their lives. Disclosing their status without reservations could end their relationship.

While status disclosure referred to how individuals tell their partners about their own health condition, partner notification referred to the process of informing the individuals’ partner(s) about their exposure to the infection. This could either be done by the individuals themselves, by health personnel or by taking prescribed medication for the partners by the individuals. My research showed that all women requested medication for their sex partners, both for the steady one and, or for the others outside. Reasons for requesting the medication were often related to the partner’s inability or unwillingness to come to the doctor for treatment. In cases where the type of STI did not have prescribed medication and personal attendance was required, partners were brought to the medical doctor to be treated. For women with other sex partners outside their relationship, verbally notifying their partners was either impossible or partially possible, since their own sexual practices outside the steady relationship were kept a secret. Women with only one steady partner verbally notified their partners fully or partially. The latter was more an implicit notification as a result of the women’s status disclosure. The moral experience of stigma is, in this regard, a cross-cutting issue as well.

At the Dermatological service in Suriname, where I conducted part of my fieldwork, STI patients are referred to social workers for further information and support with partner notification and contact tracing. Often times, STI patients are provided with a letter for their partner to seek contact with the clinic. If the partners show up, they will be notified about
their health status. The first contact of STI patients in whatever bio-medical setting however is with the medical doctor treating them. The medical doctors I spoke to in my research expressed different opinions about partner notification and status disclosure, but patients are seen as the main responsible person to display their status to their partners and, or to notify their partners. In case collaboration is requested in supporting the management of their relationship by STI patients, medical doctors do collaborate up to the level of treating several partners. I further concluded that medical doctors are tied to their oath of secrecy, but moral views and personal opinions are influential factors in how they respond to people with STIs in steady relationships.

I also explored issues of secrecy and lying in my research, to understand how the women tried to manage their relationships. I focused specifically on the stories of women who had other sexual affairs outside the steady relationship. One of the important aspects I encountered in my research was on the aspect of secrecy as intentional concealment and intentionally lying to keep hiding secrets (Bok 1983: 6-7). My research showed that the three women with STIs who were involved with other sexual relationships as well, did not keep their health condition a secret, but the ‘real’ cause of the condition, namely their own promiscuous behaviour. Two of the three women informed their steady partner about the symptoms they noticed, but stayed in control of the information. They lied about the exact nature of their diseases, but told partial truths: STIs were mentioned as ‘a bacterial infection’ or ‘an infection due to hormonal changes’, the terms ‘sexually transmitted’ were avoided. The underlying reasons for using specific terms was to create the impression that their condition was due to something they had no control over. And therefore, their condition could be excused and even sympathy from their steady partners could be evoked. At the same time the women in this way could also avoid further questioning about the cause of the disease from their steady partner.

I also concluded that secrecy take a central role when individuals realise their actions have severe consequences for their own survival. The reason for keeping, in one case, the STI and the side sexual affair and in the two other cases the ‘real cause’ a secret was because revealing the situation could lead to the end of their relationship with their steady partner. Secrecy and lying was for these women a strategy to manage their relationships. At the same time openness about their biological condition was a key component to manage their sexual life. For one woman it meant she could stop having sex with both of her partners until she cured. For the other it provided a means to keep having sex with her steady partner without suspicion. However, when it was clear that both she and her partner would have to use a cure,
openness about it was again a strategy to stop having sex and to get cured. Only in one case, openness to the other sex partner lead to, instead of finding solutions, facing accusations. For one woman lying was not only a facilitating aspect of keeping secrets, it was a necessary condition for her to control the situation and survive.

In my research I used Irving Goffman’s perspective of people’s social life and social interactions in terms of a theatrical performance on stage (Goffman 1959) to analyse how women with STIs, in particular those with other sex partners, presented themselves to them. According to him all individuals play changing roles in their social lives, being one time an ‘actor’ and the other time an ‘audience’. These roles can be different from situation to situation and when playing these roles individuals can guide and control the impression others form from him, a form of social interaction termed ‘impression management’; concealment is, according to him, one of the important aspects.

Based on Goffman’s theory I concluded that all three women who were having secretive sexual affairs outside their steady relationships did try to constantly manage the impression they gave off to others, especially to their sex partners. Concealing the social setting under which they contracted the STIs was a key aspect in their lives. The symptoms they experienced complicated matters however and were seen as ‘facts’ with destructive information. To prevent these ‘facts’ from disrupting their social life with their steady relationships, women had to control the impression they wanted their partners to receive and staged great performances when disclosing their status. These acts were strategically planned and impression were carefully calculated and sent off to other partners.

The women were successful in keeping their other sexual relationship a secret and in convincing that their condition was not like that due to sexually transmitted infections. The main elements in the management of the impressions they sent off to their steady partners and, or other sex partners were: 1. vocabulary and strong verbal communication skills; 2. effective non-verbal bodily gestures; 3. extensive or minimal use of facial expressions, and 4. presentation of the self in terms of clothing, place and time. These elements and other mental efforts in terms of thoughts, calculations and possible explanations of the women with STIs about their condition have been powerful forces in facilitating the way women managed their sexual lives and relationships. My study also revealed that the women changed in controlling the impression they gave off to their close ones, depending on the social and emotional necessity of their circumstances. In the end I concluded that in my study, explaining, acting, pretending, believing, disclosing, calculating, telling and facing lies and secrets were all parts of the women’s arsenal to survive.
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## Annex 1

### Main STI pathogens and the disease they cause

<table>
<thead>
<tr>
<th>Pathogen</th>
<th>Clinical manifestations and other associated diseases</th>
</tr>
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<tbody>
<tr>
<td><strong>Bacterial infection</strong></td>
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<tr>
<td>Neisseria gonorrhoeae</td>
<td>Gonorrhea: Men: urethral discharge, epididymitis, orchitis, infertility / Women: cervicitis, endometritis, salpingitis, pelvic inflammatory disease, infertility, preterm rupture of membranes, perihepatitis / Both sexes: proctitis, pharyngitis, disseminated gonococcal infection / Neonates: conjunctivitis, corneal starring and blindness</td>
</tr>
<tr>
<td>Chlamydia trachomatis</td>
<td>Chlamydial infection: Men: urethral discharge, epididymitis, orchitis, infertility / Women: cervicitis, endometritis, salpingitis, pelvic inflammatory disease, infertility, preterm rupture of membranes, perihepatitis; commonly asymptomatic / Both sexes: proctitis, pharyngitis, Reiter’s syndrome / Neonates: conjunctivitis, pneumonia</td>
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<tr>
<td>Chlamydia trachomatis (strains L1-L3)</td>
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<tr>
<td>Treponema pallidum</td>
<td>Syphilis: Both sexes: primary ulcer (chancre) with local adenopathy, skin rashes, condylomata lata; bone, cardiovascular and neurological damage / Women: pregnancy wastage (abortion, stillbirth), premature delivery / Neonates: stillbirth, congenital syphilis</td>
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<tr>
<td>Haemophilus ducreyi</td>
<td>Chancroid: Both sexes: painful genital ulcers; may be accompanied by bubo</td>
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<tr>
<td>Klebsiella (Calymmatobacterium) granulomatis</td>
<td>Granuloma inguinale (Donovanosis): Both sexes: nodular swellings and ulcerative lesions of the inguinal and anogenital areas</td>
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<tr>
<td>Mycoplasma genitalium</td>
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<tr>
<td>Ureaplasma urealyticum</td>
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<tr>
<td><strong>Viral infections</strong></td>
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<tr>
<td>Human immunodeficiency virus (HIV)</td>
<td>Acquired Immunodeficiency Syndrome (AIDS): Both sexes: HIV-related disease, AIDS</td>
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<tr>
<td>Herpes simplex virus (HSV) type 2</td>
<td>Genital Herpes: Both sexes: anogenital vesicular lesions and ulcerations / Neonates: neonatal herpes (often fatal)</td>
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<tr>
<td>HSV type 1 (less commonly)</td>
<td>Genital Warts: Men: penile and anal warts; carcinoma of the penis / Women: vulval, anal and cervical warts, cervical carcinoma, vulval carcinoma, anal carcinoma / Neonates: laryngeal papilloma</td>
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<tr>
<td>Human papillomavirus (HPV)</td>
<td>Viral Hepatitis: Both sexes: acute hepatitis, liver cirrhosis, liver cancer</td>
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<tr>
<td>Hepatitis B virus (HBV)</td>
<td>Cytomegalovirus Infection: Both sexes: sub-clinical or non-specific fever, diffuse lymph node swelling, liver disease etc.</td>
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<tr>
<td>Cytomegalovirus</td>
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<tr>
<td>Molluscum contagiosum virus</td>
<td>Molluscum Contagiosum: Both sexes: genital or generalized umbilicated, firm skin nodules</td>
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<tr>
<td>Kaposi sarcoma associated herpes virus (KSHV or human herpes virus type 8)</td>
<td>Kaposi Sarcoma: Both sexes: aggressive type of cancer in immunosuppressed persons</td>
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<td><strong>Protozoal infections</strong></td>
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<tr>
<td>Trichomonas vaginalis</td>
<td>Trichomoniasis: Men: urethral discharge (non-gonococcal urethritis); often asymptomatic / Women: vaginosis with profuse, frothy vaginal discharge; preterm birth, low birth weight / Neonates: low birth weight</td>
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<tr>
<td><strong>Fungal infections</strong></td>
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<tr>
<td>Candida albicans</td>
<td>Candidiasis: Men: superficial infection of the glans penis / Women: vulvo-vaginitis with thick curd-like vaginal discharge, vulval itching or burning</td>
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<tr>
<td><strong>Parasitic infections</strong></td>
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<tr>
<td>Phthirus pubis</td>
<td>Pubic lice infestation</td>
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<tr>
<td>Sarcoptes scabiei</td>
<td>Scabies</td>
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