

## Gender Perspectives of Sexual and Reproductive Practices of People Living with HIV/AIDS in Enugu, South East Nigeria

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### Abstract

**Background:** a major focus of attention in the efforts at controlling the spread of HIV infection has become the role of gender inequality.<sup>1,2</sup> The objective of the study was to compare the sexual practices of HIV-positive male and female patients who received counselling and treatment at an Anti-retroviral Clinic in Enugu, South-East Nigeria.

**Method:** A comparative cross-sectional descriptive study of patients attending the free anti-retroviral clinic at the University of Nigeria Teaching Hospital Enugu was done.

**Results:** A total of 146 males (30.8%) and 328 females (61.9%) were studied. Although there was no significant difference in the prevalence of sexual activity between the sexes, the reasons for sexual practices differed. Females indulged in risky sexual activity principally in obedience to the demands of their male partners and were more likely to have sexual partners who were unaware of their seropositivity than males.

**Conclusion:** Risky sexual behaviour among women living with HIV/AIDS in Enugu despite exposure to intensive counselling was still mainly driven by the subordinate traditional gender roles of women in this culture.

**Key words:** Perspectives, gender, sexual/reproductive practices, PLWHA, Nigeria

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### Introduction

With over 30 million people currently infected with HIV in Sub-Saharan Africa and the spread of the infection heavily weighed against young women, a major focus of attention in the efforts at controlling the spread of HIV infection has become the role of gender inequality.<sup>1, 2</sup> Young women between 15 and 24 years are, at least, three times more likely to be HIV positive than young men in Sub-Saharan Africa.<sup>2</sup> Although in virtually all societies,

men have more power than women, in Sub-Saharan Africa, men are also the prime decision makers about sexual activity, fertility and contraceptive use of women.<sup>3-5</sup>

Among the people of South East Nigeria, cultural norms demand that women be completely subordinate to their men in decisions regarding sexual activity, contraception and childbearing. In fact, according to the National Demographic and Health Survey 2008, the percentage of women who think that a wife is justified in refusing to have sexual intercourse with her husband who has a sexually transmitted infection is lowest in the South East Nigeria.<sup>6</sup>

HIV prevention efforts have traditionally focused on people who are not currently diagnosed with HIV. However, many people with HIV continue to have sex, some unprotected leading to new infections.<sup>7-11</sup> Likewise many people living with HIV in Sub-Saharan Africa continue to have children.<sup>10-12</sup> It is however unclear whether among those living with HIV/AIDS sexual, reproductive and contraceptive practices differ from the traditional cultural pattern between males and females after exposure to education and counseling in clinic settings. It is rational to expect that intensive education and counselling in clinic settings would empower women living with HIV/AIDS to avoid risky sexual and reproductive practices, even if doing so means abandoning traditional norms.<sup>7,13</sup>

Previous reports from South East Nigeria suggest that over 50% of HIV positive women continue to indulge in unprotected sex<sup>10</sup> and that many women indulge in such sex in search of pregnancy.<sup>11</sup> However, little is known about the sexual and reproductive practices of women living with HIV/AIDS after exposure to counselling and treatment among the Igbos of South East Nigeria and whether the sexual and reproductive health practices of such women differ from the traditional subordinate practices. This study was therefore carried out to

describe the gender differences in sexual and reproductive practices among people living with HIV/AIDS in Enugu who are exposed to counselling and treatment and the implications of such differences for measures to reduce further spread of the infection.

## Methods

### Study setting

The study was carried out at the antiretroviral clinic of the University of Nigeria Teaching Hospital Enugu. The clinic offers free counselling and antiretroviral drugs to people living with HIV/AIDS across the South-east geopolitical zone of Nigeria. The zone made up of five states has an estimated population of 20.6 million people of the Igbo ethnic group.<sup>14</sup> The clinic attends to about 2300 cases annually.

### Study period

The study took place between January 1<sup>st</sup> to December 31<sup>st</sup> 2009.

### Study Population

The study population included all people living with HIV/AIDS who attended the clinic for care and treatment.

### Sample size

The sample size for this study was calculated based on the prevalence of sexual activity among people living with HIV/AIDS. Assuming an error margin of 5%, 95% confidence level and an assumed population prevalence of sexual activity of 50% from a previous study in Nigeria<sup>15</sup>, the minimum sample size  $n$  is given by  $n = (Z_{\alpha/2})^2 \frac{p(1-p)}{d^2}$  where  $p$ =assumed population proportion,  $d$ =error margin;  $z$ =appropriate  $z$  value for 95% confidence interval. With  $p=0.8$ ,  $z=1.96$  and  $d=0.05$  the minimum sample size  $n$  is 384.

### Sampling technique

This was by systematic random sampling using the daily clinic attendance register as a sampling frame. All patients were required to write down their names as they came to the clinic each day. While they waited to be attended, names were selected from the attendance list at specific intervals after a random start. Consenting patients among those selected were given the questionnaires to complete and were instructed to return the completed questionnaires before leaving the clinic

### Data Collection

Data was collected using semi-structured anonymous self-administered pre tested questionnaires

### Data analysis

Data analysis was by done using SPSS version 15.0 for Windows (SPSS Inc. Chicago IL). Analysis was done generally and also stratified based on sex. Tests of significance were done using the analysis of variance (ANOVA) for the difference in means and Pearson's chi-square (or Fischer's exact test where appropriate) and odds ratio for the difference in categorical variables at 95% level of confidence. P-value of less than or equal to 0.05 or odds ratio that excluded unity was considered significant.

### Ethical clearance

Ethical clearance was got from ethics committee of UNTH

### Results

A total of 474 patients completed their questionnaires out of 500 questionnaires distributed giving a response rate of 94.8%. About 98% were of Igbo ethnic extraction. There were 146 males (30.4%) and 328 females (69.6%). Their mean age was  $36.1 \pm 9.2$  years. Ninety percent had formal education. Fifty three percent were married, 28.8% single, 16.5 % widowed and 1.7 % separated or divorced. The mean duration since diagnosis with HIV was 18 months  $\pm 1.7$ . About 66 % were on antiretroviral drugs. About 75.6% rated their state of health as fair or good although only 11% were asymptomatic. The spouse/partner was aware of the respondent's sero-positivity in 48% of cases. Of those aware of their partner's sero-status, 35% were sero-concordant with spouse/partner while 44.7% were sero-discordant.

**Table 1** shows the comparison of the distribution of socio-demographic characteristics of the patients stratified based on sex. There was a significant difference between the sexes in age distribution, occupation, educational status and marital status.

Analysis of variance showed that there was significant difference in the mean ages of the males and females (males- $40.1 \pm 7.9$  vs. females- $34.3 \pm 9.3$ ,  $p=0.00$ ) but no significant difference between the sexes with respect to the mean duration since diagnosis, the mean duration since commencement of antiretroviral drugs and the mean numbers of living ( $p>0.05$  for all variables). However, a greater proportion of women were on antiretroviral drugs than men ( $p=0.04$ ).

Males were more likely to have partners who were aware of their sero-positivity than females ( $p=0.00$ ).

There was no significant difference between the sexes with respect to self-rated health status ( $p > 0.05$ ).

About 73.4% were sexually active. Out of those sexually active, 68.4 % used no form of protection, while 29.8% used condom for protection. About 90% of those who are sexually active engaged in heterosexual sex, while 0.6% engaged in homosexual sex.

With respect to childbearing practices, 11.4% had had children since their diagnosis.

Table 2 shows the comparison of the prevalences of sexual and reproductive practices of male and female patients. There was no significant difference between the sexes in the prevalence of sexual activity, unprotected sex, use of contraceptives or childbearing after diagnosis with HIV infection. However, significantly more males had intention for further childbearing than females.

Table 3 shows the comparison of the reasons for the sexual and reproductive practices of male and female patients. Males differ significantly from females in the reasons they had for continued sexual activity and indulgence in unprotected sex ( $p = 0.05$ ). While males indulged in unprotected sex out of personal choice or for the purpose of childbearing, females did so mainly in acquiescence to demand from their male partners. There was no significant difference in reasons for use of contraception and reasons for having children despite their HIV infection ( $p > 0.05$ ).

Table I. Showing comparison of the socio-demographic characteristics of a sample of male and female persons living with HIV/AIDS in Enugu, Nigeria

Characteristic	Sex		2 or FET	P-value
	Male (%) n=144	Female (%) n=330		
Age category (years)				
10-20	0 (0)	12 (3.6)		
21-30	18 (12.5)	114 (34.5)		
31-40	64 (44.4)	132 (40.0)		
41-50	52 (36.1)	54 (16.4)	44.35	0.00*
51-60	6 (4.2)	16 (4.8)		
61-70	4 (2.8)	2 (0.6)		
Occupation				
Unemployed	10 (6.9)	64 (19.4)		
Civil servant	20 (13.9)	60 (18.2)		
Trader	94 (65.3)	132 (40.0)	35.90	0.00*
Farmer	18 (12.5)	38 (11.5)		
Student	2 (1.4)	36 (10.9)		
Educational status				
No formal education	6 (4.2)	36 (10.9)		
Primary education	70 (48.6)	94 (28.5)	37.13	0.00*
Secondary education	52 (36.1)	126 (38.2)		
Graduate	12 (8.3)	74 (22.4)		
Postgraduate	4 (2.8)	0 (0)		
Christian denomination				
Roman catholic	68 (47.2)	182 (55.2)		
Anglican	14 (9.7)	52 (15.8)		
Pentecostal	46 (31.9)	68 (20.6)	13.93	0.02*
Methodist	8 (5.6)	8 (2.4)		
Baptist	0 (0)	4 (1.2)		
Others	8 (5.6)	16 (4.8)		
Marital status				
Married	92 (63.9)	182 (49.1)		
Single	44 (30.6)	90 (27.3)		
Widowed	4 (2.8)	74 (22.4)	32.60	0.00*
Separated	2 (1.4)	0 (0)		
Divorced	2 (1.4)	4 (1.2)		
Number of children				
0	54 (37.5)	116 (35.2)		
1	26 (18.1)	52 (15.8)	1.15	0.76
2-4	44 (30.5)	106 (32.2)		
e5	20 (13.9)	56 (16.9)		

\*significant

FET-Fishers exact test

2 chi-square

Table II showing comparison of sexual and reproductive health practices of male and female persons living with HIV/AIDS in Enugu, Nigeria

Sexual/reproductive Health practice	sex		odds ratio	95% C. I.
	Male (%) n=143	Female (%) n=330		
Sexual activity since diagnosis				
No	44 (30.6)	82 (24.6)	0.74	0.38, 1.44
Yes	100 (69.4)	248 (75.4)		
Contraceptive Use				
Condom	32 (22.2)	72 (21.8)		
Oral pills	2 (1.4)	0 (0)	1.26	0.59, 2.69
Injectable hormonal	0 (0)	2 (0.6)		
None	66 (45.8)	174 (52.7)		
Type of sexual practice				
Homosexual only	2 (1.4)	0 (0)		
Heterosexual	85 (58.8)	229 (69.5)	0.33	
Masturbation only	13 (9.3)	19 (5.9)		
Childbearing since diagnosis	(n=61)	(n=108)		
Yes	16 (26.1)	38 (35.2)	0.65	0.34, 1.25
No	45 (73.9)	70 (64.8)		
Intention for further childbearing				
Yes	106 (73.6)	176 (59.4)	1.98*	1.04, 3.76
No	38 (26.4)	134 (40.6)		

C.I.-confidence interval \*significant

Table III Showing comparison of Prevalences of reasons for sexual, contraceptive and childbearing practices among HIV positive patients in Enugu, Nigeria

Reasons	male (%)	female (%)	p-value <sup>2</sup>
Principal reason for sexual activity	n=100	n=182	
Pleasure	60 (60)	34 (13.7)	
Child bearing	17 (36.7)	106 (42.6)	112.34
Demand from partner	3 (2.7)	77 (31.1)	
Coercion from partner	1 (0.7)	31 (12.6)	
Principal reason for unprotected sex	n=66	n=174	
Demand from partner	1 (2.0)	58 (33.1)	0.00*
Personal choice	31 (47.5)	3 (1.9)	
Childbearing	23 (35.4)	56 (32.0)	119.63
Coercion	1 (1.0)	54 (31.0)	
Felt it was safe	7 (11.1)	3 (1.5)	
To get other person infected	2 (3.0)	1 (0.4)	
Reasons for use of contraception	n=34	n=75	
Prevent pre-marital pregnancy	8 (23.5)	19 (25.0)	4.65
Space children	7 (19.6)	24 (32.1)	
Prevent infection to partner	29 (84.3)	53 (71.4)	
Prevent infection with other strains HIV	31 (92.2)	68 (91.1)	
Prevent infection to newborn	17 (51)	62 (83.0)	
Reasons for having children after diagnosis	n=16	n=38	
No child yet	5 (31.2)	11 (29.8)	4.63
To sustain marriage	4 (25.0)	10 (27.2)	0.46
To complete desired family size	4 (25.0)	9 (20.2)	
Pregnancy does not worsen disease	0 (0.2)	6 (15.8)	
Can prevent transmission to baby	2 (12.5)	1 (2.6)	
Others	1 (4.2)	2 (4.4)	

<sup>2</sup> chi-square

\*significant

## Discussion

The level of sexual activity among persons living with HIV/AIDS in this study is higher than that reported by an earlier study in Nigeria.<sup>10, 15</sup> The high level of sexual activity however agrees with studies from other parts of Africa.<sup>13, 16</sup> The comparable levels of sexual activity between males and females may suggest that one gender determines the other's sexual practices. This thinking is corroborated by the reasons given for sexual and reproductive practices by females which suggest that even among those living with HIV/AIDS male dominance still determined sexual behaviour. Thus about two-thirds of women living with HIV/AIDS indulged in unprotected sex voluntarily or forcibly to please men. This suggests that exposure to counseling and treatment may not have empowered women to overcome cultural pressures for risky sexual behaviour dictated by men.

The study also shows that about a third of women indulged in unprotected sexual activity for the purpose of childbearing. This agrees with a previous study from South East Nigeria. This is perhaps because the desire

to be in marriage is culturally strong among the south eastern people of Nigeria and having children is thought to stabilize marriages. The implication of this is that gender sensitive care for women living with HIV/AIDS in this part of the world needs to emphasize empowering women to have children in a way that is safe. This implies that measures to prevent mother to child transmission must be vigorously promoted alongside any measures to improve the maternal health of women living with HIV/AIDS.<sup>13</sup>

This study further shows that females are more likely than males to have partners who are unaware of their sero-positive status. In a society where decisions concerning sex are entirely dominated by men, this finding is not surprising. It may be that women deliberately conceal their sero-positive status to avoid reprisals from men. Continuing sexual activity by women living with HIV with men unaware of their sero-positive status may pose substantial risk for further spread of the disease. This scenario is made more frightening by the low rate of barrier contraceptive and a high level of sexual activity found in this study.<sup>15</sup>

The major drawback of this study include possible bias arising from the fact that patients used were those sufficiently motivated to present themselves for treatment. This may tend to highlight sexual and reproductive practices because such people are expected to have more positive attitude to living than those who do not present for treatment.

However despite this drawback, we conclude that women living with HIV/AIDS in Enugu engage in sexual, reproductive and contraceptive practices at rates comparable to men with the disease and that the impact of living with the disease and exposure to counselling and treatment may not have empowered women to resist subordinate gender roles that involve risky sexual and reproductive practices. We therefore recommend that clinic-based information, education and communication that target cultural gender roles that subjugate HIV-positive women to the dictates of men. Community education on the need for people living with HIV/AIDS to insist on safe sexual practices should be emphasized in HIV control programming to empower HIV-positive women to resist risky sexual and reproductive practices.

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