Socio-Demographic Factors, Condom Use and Sexually Transmitted Infections among Married Men in Ibadan, Nigeria

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ABSTRACT

Data from 415 married men from the three socio-economic zones in the commercial city of Ibadan, Nigeria, were analysed to identify the presence and pattern of sexual networking, as well as obtain information on sexually transmitted infections (STIs) in the community. Of the men interviewed, 43.6% had steady girl friends, 25.8% had new girl friends, 19.8% were polygamous and 10.6% patronised commercial sex workers (CSWs). Over 65 per cent of all these men had ever used condom before. Ninety-two (22.1%) of the men reported a lifetime history of sexually transmitted infections. Of this number, 37(40.2%) got the most recent infection from new girlfriends, 35(38%) from steady girlfriends, 18(19.6%) from CSWs, 1(1.1%) from casual contact and 1(1.1%) from wife. Commonest place for treatment of STI was private clinic (40.9%), followed by traditional healers (28%) and government hospitals (17.2%). Self-medication was reported in 10.8% of men and only 2.2% went to designated STI clinics. Sexually transmitted infections are likely to be grossly under reported particularly in the younger men below 30 years in this city. (*Afr J Reprod Health* 2000; 4[2]:85-92)

RÉSUMÉ

Facteurs socio-démographiques, l'emploi des préservatifs et les infections sexuellement transmissibles chez les hommes mariés à Ibadan, Nigéria. Les données recueillies auprès de 415 hommes de trois zones socio-économiques dans la ville commerciale d'Ibadan au Nigéria, ont été analysées pour identifier la présence et le modèle du réseau sexuel et pour obtenir aussi des renseignements, sur les infections sexuellement transmissibles (IST) dans la communauté. Parmi les hommes interviewés, 43,6% avaient de petites amies régulières, 25,8% avaient de nouvelles amies, 19,8% étaient des polygames et 10,6% fréquentaient des prostituées. Plus de 65% de ces hommes avaient jamais utilisé les préservatifs avant. Quatre-vingt-douze (22,1%) des hommes ont signalé qu'ils ont eu toute une vie marquée par les infections sexuellement transmissibles. 37(40,2%) de ce nombre ont signalé qu'ils ont attrapé l'infection la plus récente de la part de nouvelles petites amies, 35(38%) de la part de petites amies régulières, 18(19,6%) de la part des prostituées, 1(1,1%) des contacts fortuits et de la part de leurs femmes. Les cliniques privées étaient les lieux les plus communs pour le traitement des IST(40,9%), ensuite viennent les guérisseurs traditionnels (28%) et les hôpitaux gouvernementaux (17,2%). 10,8% des hommes ont indiqué qu'ils pratiquaient l'auto - médication et 2,2% ont fréquenté des cliniques désignées pour le traitement des IST. Il est probable que les infections sexuellement transmissibles soient grossièrement sous-signalées en particulier chez les jeunes hommes ayant moins de 30 ans dans cette velle. (*Rev Afr Santé Reprod* 2000; 4[2]:85-92)

KEY WORDS: *Sexually transmitted infections, male sexual networking, condom, HIV/AIDS, STI treatment, developing country*

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Introduction

Statistics provided by the World Health Organization on human immunodeficiency virus (HIV) and the acquired immunodeficiency syndrome (AIDS) show that 3 persons are infected globally every minute; suggesting also that the sexual behaviour of people has not changed much. While high risk groups of HIV/AIDS in USA include the homosexuals, bisexuals and intravenous drug users (IDU), the highest infection rates in Africans, over 80%, were found in heterosexual men in normal sexual relationships.[1] The majority of female AIDS victims have been shown to be infected by their male partners. More than 16 million adults and one million children had been infected with HIV by mid 1994.[2] In Africa, where the AIDS pandemic has hit hardest, about 700,000 children were born to HIV infected mothers by 1993.[3]

The first HIV case in Nigeria was reported in 1986; by March 1990, 0.45 per cent of the population were said to be HIV positive.[4] Currently, between 2.5 and 5.4% of the total population are infected with the virus.[4-6]

Even though conventional family structures and mores exist side by side, there is evidence to support the existence of sexual networking among married men in selected parts of the country.[5-7] In a study, it was found that males' extramarital relations were blamed on the postpartum abstinence period.[6] It is however not clear to what extent the traditional African system has contributed to this behaviour, as many men still hold the belief that post-pubertal male continence is unnatural and unhealthy.[8] The traditional proscription of sex by women during pregnancy, breastfeeding and, in some cases menopause,[4,9,10] leaves many married men with no sexual access to their wife for varied lengths of time.

What do men do during these periods? The hardest hit by the AIDS/HIV scourge in Africa and Nigeria in particular are families. As human behaviour plays a dominant role in the transmission of all sexually transmitted diseases, in the provision of reproductive health care, it is required that a more comprehensive understanding of the activities of married men, namely, sexual networking, be fully determined. Following the Beijing conference, it is desirable to empower men to play a more active and responsive role in promoting the health of family members and preventing disease. This cross sectional, community-based, exploratory study was designed as a pilot study in order to obtain baseline data on male sexuality and networking in the city of Ibadan, focusing on high risk practices, as this will ultimately help to highlight areas that need urgent attention.

Materials and Methods

Ibadan, the study area, is a civil service town and one of the oldest state capitals in the federation. With a population of about 2 million people, the highly urbanised city is located at the southwestern part of the country. Ibadan is made up of 3 distinct zones, namely, the inner core, made up of traditional areas; the traditional zone; and the sub-urban periphery.[11] The inner core is characterised by indigenous people whose occupations are mainly petty trading and subsistence farming. The people are of low economic status. The transitional zone consists of both indigenous and non-indigenous people who are mostly Yoruba in ethnic origin. They are civil servants or are engaged in trading. They represent the middle socio-economic class. The periphery consists of people from diverse ethnic origins but mostly Yoruba. People in this area are professionals, businessmen and highly qualified academicians and top civil servants. They represent the higher socio-economic class. Using a two-stage stratified sampling technique, all the working and commercial areas of the three socio-economic zones were identified and put into clusters. A cluster was randomly selected from each of the 3 zones for the study. Ogunpa was chosen for the inner core, Mokola/Dugbe for the transitional, and University of Ibadan/state secretariat for the periphery zones.

Purposeful sample of married men from both the private and public sectors were enlisted from each cluster for the study and interviewed. Selection criteria included married men whose wives had delivered a baby in the last 36 months prior to the study. The tool was a pre-coded questionnaire with open and closed ended questions. The questionnaire was developed in English and then translated into the indigenous language and then retranslated to English to ensure that the original meaning was retained.

Male interviewers conducted the interviews and questions were asked in a conversational style. For the highly educated, questionnaires were self

administered on request and these were put into a ballot box for confidentiality after completion. In order to encourage frank revelation about potentially sensitive matters, names were not recorded and respondents were assured that their answers would remain anonymous.

The institution of marriage is highly regarded by both the traditional and modern members of the community. Marriage for the purpose of this study was defined as customary, church/civil, Muslim and mutual consent of both families. Social classification was based on a modification of the registrar general classification of occupations into social class.[12,13] This is dependent on the general standing of the occupations within the community and not a classification of individuals. The higher social class includes the professionals such as lawyers, physicians and bankers and top civil servants; the middle social class is made up of the intermediate occupations and the skilled occupations; while the lower social class is made up of both the partially skilled and unskilled.

Networking was defined as having sexual relations with two or more partners either serially or concurrently and within a specified time period.[6-14]

Results

Data from the 415 men interviewed on sexual networking, STIs and condom use were analysed and the results are hereby presented.

Condom Use

Two hundred and seventy (65.1%) of all the men had never used condom before. Proportions of men who had never used condom were highest with men in the lowest socio-economic class; men with primary education; and men who embraced traditional religion. Significantly more men in the lower socio-economic class had never used the condom, when compared with men in the higher socio-economic class (Yates corrected $\chi^2 = 5.52$, $p = 0.081$). None of the 4 men in the traditional religious group had ever used the condom. The difference in use between Christians and Moslems was not significant ($\chi^2 = 1.5$, $p = 0.22$) (Table 1). More men at both extremes of age had never used condoms before and men aged 30–39 years, men aged 20–29 years were more likely to have used the condom.

Condom Use and History of Sexually Transmitted Infections (STIs)

Table 2 shows that fewer men (41 or 17.1%) among those who claimed to have used the condom "always" have had STI when compared with 25/104 (24.0%) in the group who claimed to use condom "sometimes". The difference was however not significant ($\chi^2 = 0.8$, $p = 0.362$). There was also no significant difference in STI rates among men who claimed to use condom "always" and "never" (60/270 or 22.2%) ($\chi^2 = 0.56$, $p = 0.45$).

Steady Girlfriends

Of the total number of men interviewed, 181(43.6%) had steady girlfriends (SGF). Of this number, 78/181(43.1%) did not want the girl to get pregnant, 77(42.5%) were afraid of contacting a sexually transmitted infection from the girl but only 57(32.8%) used condom with the girls.

Table 1 **Non-use of Condoms among 415 Married Men in Ibadan by Socio-Economic Class, Level of Education, Religion and Age, 1999**

	Number and percentage of those who have never used condom
Socio-economic class	
Higher (n = 36)	15 (41.7%)
Middle (n = 108)	63 (58.3%)
Lower (n = 271	192 (71.1%)
N = 415	270 (65.1%)
Educational level attained	
Non formal (n = 12)	8 (66.1%)
Primary (n = 95)	76 (80.0%)
Secondary (n = 191)	126 (66%)
Post secondary & university (n = 117)	60 (51.3%)
N = 415	270 (65.1%)
Religion	
Christianity (n = 179)	108 (60.3%)
Islam (n = 232)	157 (67.7%)
Traditional (n = 4)	4 (100%)
N = 415	270 (65.1%)
Age	
15–19 (n = 1)	1 (100%)
20–29 (n = 101)	66 (65.3%)
30–39 (n = 191)	106 (55.5%)
40–49 (n = 80)	58 (72.5%)
50–59 (n = 34)	32 (94.1%)
60–69 (n = 8)	7 (89.5%)
N = 415	270 (65.1%)

Table 2 **Condom Use and History of STI among 415 Married Men in Ibadan, 1999**

History of STI	Condom use Always	Sometimes	Never	Total
Yes	7	25	60	92 (22.2%)
No	34	29	210	323 (77.8%)
Total	41 (9.8%)	104 (25.1%)	270 (65.1%)	415 (100%)

Table 3 **Ages of Respondents and Place of Treatment of STI for 415 Married Men in Ibadan, 1999**

Age (years)	Total number of men	Place of Treatment					Total no of men with STI history
		Government hospital	STI clinic	Private hospital	Traditional healer	Self medication	
20–29	101	1 (3.2%)	–	12 (38.7%)	13 (41.9%)	5 (16.1%)	31 (30.7%)
30–39	191	6 (14.6%)	1 (2.4%)	23 (56.1%)	8 (19.5%)	3 (7.3%)	41 (21.5%)
40–49	80	7 (46.7%)	1 (6.7%)	1 (13.3%)	3 (20%)	1 (20%)	14 (17.5%)
50–59	34	2 (40%)	–	1 (20%)	1 (20%)	1 (29%)	5 (14.7%)
60–69	8	–	–	1 (100%)	–	–	1 (12.5%)
Total	415	16 (17.4%)	2 (2.2%)	39 (42.4%)	25 (27.1%)	10 (10.9%)	92

Commercial Sex Workers

Forty-four men (10.6%) patronised commercial sex workers (CSWs) and only one person (2.3%) was concerned that the woman would get pregnant. A higher proportion 23/44(52.3%) was afraid they would contact an infection from the CSW, and only 13/44 (29.5%) used condom when they are with the CSWs.

New Girlfriends

New girlfriends were distinguished from steady girlfriends because they were new contacts. One hundred and sixty-seven out of 415(25.8%) men had girlfriends. Of this number, 53(49.5%) expressed fear of pregnancy, 65(60.7%) were afraid they would contact a disease, while 35(32.7%) used condom when with new girlfriends.

Another Wife

In the study population, 82 out of 415(19.8%) men were polygamous. Of this number 9/82(11.0%) did not want the other wife to get pregnant "now", 26(31.7%) were afraid they would contact a STI, while only 22(26.8%) used condom. Condom use was lowest when with commercial sex workers and another wife, and highest with new girlfriends and steady girlfriends.

Sexually Transmitted Infections (STIs) and Place of Treatment

Ninety-two (22.1%) of the men reported having at least one episode of sexually transmitted infection while 324(77.9%) denied ever having STI. Of the ninety-two with confirmed history of STI, 37(40.2%) got the last infection from new girlfriends, 35(38%) from steady girlfriends, 18(19.6%) from commercial sex workers, 1(1.1%) from casual contact, 1(1.1%) from wife.

The commonest place for treatment of the STI was private clinic, where 38/92(40.9%) received treatment. This was followed by traditional healers, where 26(28%) were treated, and then the government hospitals 16(17.2%). Ten (10.8%) men used

self-medication or bought medicine from chemist or from patent medicine stores, while only 2(2.2%) went to designated sexually transmitted disease clinics. One (1.1%) combined treatment received from government hospitals with that received from traditional healers. Prevalence of STI reduced with increasing age of the men.

Figure 1 shows where the men received treatment. STI clinics are grossly under utilised and are particularly likely to under-report STIs in men younger than 30 years, as they are more likely to be patronised by older men aged 30–59 years. On the other hand, the private hospitals were visited mainly by younger men aged 29 years and below as well as by men above 59 years.

Young men (< 30 years) used traditional healers more. These younger men were more likely, in general, to patronise traditional medicine men, private clinics or to self-medicate.

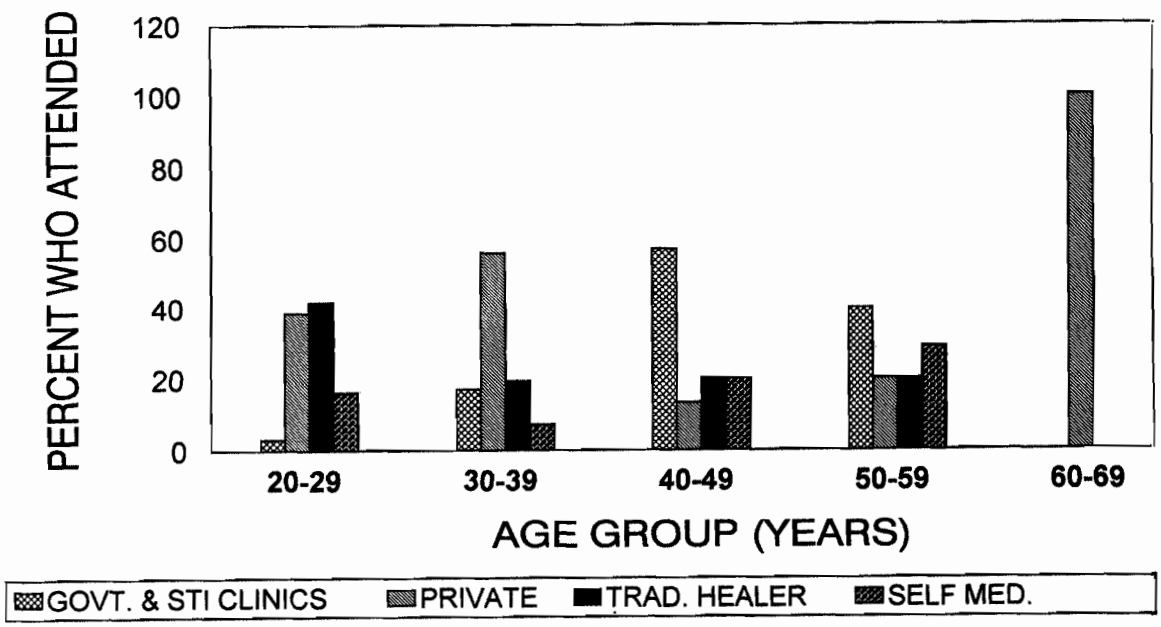

Figure 1 ***Place where STI Treatment was Received***

Post-Treatment Checkup

Forty-five of 92(47.4%) men went for the recommended post-treatment checkup. Ten (66.7%) of those treated in government hospitals, 2(100%) of those treated in STI clinics and 25(65.8%) of those treated in private hospitals returned for post-treatment checkup. Only 5(27%) and 2(20%) of those who went to traditional healers and medicine stores, respectively, returned for post-treatment checkup. Orthodox health institutions are more likely than the others to have clients returning for post-treatment care (OR = 7.40, 95% CI, 2.5–22.69).

Discussion

Acquired immune deficiency syndrome (AIDS) and sexually transmitted infections (STIs) have major demographic, economic, social and even political impact on populations, particularly in sub-Saharan Africa.[15] In 1993, the World Bank estimated that for those aged 15–44 years, STIs, excluding human immunodeficiency virus (HIV), were the second cause of healthy life lost in women after maternal morbidity and mortality. In men in the same age group, HIV ranks first and considerably higher than STIs. In contrast, STIs have become the most common group of notifiable diseases in most countries, particularly in the age group of 15–50 years.

Sexually transmitted infections are now said to be hyper endemic in many developing countries including the rural areas where facilities for diagnosis and treatment are usually inadequate. As at early 1991, about 70% of all global HIV infections were estimated to have spread by sexual intercourse between men and women, and it is projected that over 80% of all infections will result from heterosexual intercourse by the year 2000. From the data presented, condom use was generally low. Higher condom use have been found in developed compared with the developing countries and this difference has been attributed to the higher actual or perceived risk of STIs by men in the developed countries.[16] This may in fact not be so in this case as many men in this study were aware of the risks they had taken but still did not use the condom, which had the dual advantage of protecting against unwanted pregnancy and STIs. Why the men chose to take these risks is not altogether clear, more studies are required to determine the motivating factors for such behaviour. In a risk assessment study carried out in the United Kingdom, men were found to value sexual pleasure more than safer sexual practice. The proportion of men who had never used condoms in this urban study is relatively high.

The Nigeria Demographic and Health Survey of 1990,[17] showed that only 21.6% of currently married men knew about the condom while only 2% had ever used this method, and current use then was only 0.4%. Information obtained from this study, which shows a relatively low use of the device, is therefore a great improvement over what was found in the first part of this decade. There is a need to help men assess their risk taking sexual behaviours and improve condom use. There is ample evidence to show that sexual networking, visits to CSWs, sexually transmitted infections and condom neglect fuel the HIV/AIDS epidemic in Africa.[18,19] Therefore, it is necessary to increase HIV awareness in this population believed to be at the verge of an HIV epidemic. Such activities have successfully reduced and reversed the rate of new HIV infections.[1]

It is generally known that sexually transmitted diseases are under reported in this country.[17] In December 1992, the Federal Ministry of Health reported 32,613 cases of STIs excluding AIDS, making it the seventh most reported disease that year.[20] While only 22.1% of the men in the study population reported having had a STI, over 80% of the men went to private hospitals and traditional healers or received over-the-counter treatment and self-medication. These places of treatment are less likely than the government owned facilities and STI clinics to notify appropriate health authorities of such infections, and up to three-quarters of STIs can be said to be unreported in this city.

STIs contribute to the spread of AIDS, as the disease is more likely to be contacted by people with genital ulcers resulting from STIs.[21-23] Many people hide their STI while government hospitals and STI clinics are grossly under-utilised. The findings on this issue are consistent with previous reports from this and other cities in Nigeria; that the vast majority does not go to STI clinics but to herbalists, patent medicine stores and pharmacist stores.[24-26]

A family planning survey carried out in 1994 by the Federal Office of Statistics in Nigeria,[27] showed

that only 36% of the adult population believed that there is protection against AIDS while 64% believed that there is none. The implication is that most men are not likely to use condoms since they do not believe it provides protection. Earlier studies reported that a high proportion of men in Nigeria were unwilling to use condoms for the same reason.[28]

Current concerns that have to be addressed include improving diagnosis and treatment of sexually transmitted infections possibly by integrating the clinics at the primary care level. This is because opportunity for providing information, education and condom promotion are already established in the family planning clinics at that level.

In addition, a lot of attention has been given to women in respect of fertility control, which is good. However, male behaviour and responsibility in family and reproductive health issues have not received enough attention among researchers and health care providers in many developing countries with established patriarchy. Following the Cairo and Beijing resolutions, it is improper to empower women without carrying the men along, as they make most of the reproductive decisions in the family; the wives have little control over their husband's extramarital affairs.[29]

Widespread sexual networking seen in the data presented is likely to have a profound negative effect on the health of the men's female partners especially for those in polygamous relationships. Such activities facilitate the spread of HIV/AIDS and STIs. Faithfulness to partners rather than multiple sexual contacts should be encouraged among the men.

In conclusion, sexual networking occurs among married men in Ibadan. The women they network with include steady girlfriends, new girlfriends, casual contacts and commercial sex workers. Reported lifetime use of the condom was low. Current concerns, which should be addressed urgently, include helping men assess their risk taking behaviours and improving condom use. Integrating sexually transmitted infection clinics with primary care level should be done, as this is likely to improve the diagnosis and treatment of such infections. Attention to these issues would certainly go a long way towards reducing the transmission of HIV/AIDS and STIs in many developing countries with heterosexual pattern of transmission.

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