

SEXUAL PRACTICES OF PEOPLE LIVING WITH HIV IN SOUTH EASTERN NIGERIA.

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ABSTRACT

Background: Couples could be in serodiscordant or seroconcordant sexual relationship. The seroconcordant could be seroconcordant positive or negative in a heterosexual or homosexual or bisexual relationship. The various sexual practices include vaginal sex; anal sex fisting; oral sex fellatio, cunnilingus; masturbation mutual or exclusive and a host of others. These sexual practices outside safer sex guidelines will lead to HIV transmission among couples.

The study is set to determine the sexual practices of people living with HIV (PLWHA) in Southeast Nigeria.

Method: This is an analytical epidemiological study. A total of 300 subjects were studied using interviewer administered questionnaires. Data is presented in tables and figures. Analysis was done using SPSS 11.0 statistical package.

Results: Most respondents were in heterosexual relationship (97%). The married couples in serodiscordant relationship were 25.3% while the singles in serodiscordant relationship were 20%. About 56% do not use condom for the adopted sexual practice although 65% believe that condom use would protect against HIV transmission.

Conclusion: Couples in seroconcordant seronegative relationship have it as a challenge to remain so. This study suggests that the PLWHA are very important in the spread of HIV infection as they are still sexually active, in non-cohabiting conjugal unstable relationship, and they do not use the condom consistently. There is an urgent need to target this population with effective behavioural change communications that will translate to safer sexual behaviour. The practice of safer sex should be taught in every health care center, in schools and in village gatherings by qualified health care workers. This will help curb the transmission of HIV.

Key Words:

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INTRODUCTION

HIV is a major public health problem world wide and especially in the Sub-Saharan Africa which has continued to bear the greatest burden of the HIV and AIDS epidemic. Approximately 63% of the total number of people living with HIV, 65% of the 4.3 million total new infections and 72% of the 2.9 million deaths in 2006¹ were in Sub-Saharan Africa. Also by the end of 2006 in Nigeria, at least 2.99 million people were living with HIV and AIDS and 305,080 new HIV infections were in adults^{1,2}. Unprotected heterosexual sex is the single most important factor in the transmission of HIV infection worldwide³ and as a result, the rate of new infection has reached alarming rate among women and adolescent girls including those who are married³. The male to female transmission of HIV is 2 to 4 times higher than female to male transmission among sero-discordant couples engaging in unprotected sex⁴.

Males are twice as more likely than women to bring HIV infection into a marriage, presumably through extra marital sexual behaviour⁵.

Married adults particularly women, with HIV infected spouses are at very high risk of being infected⁶. Vaginal, anal and oral sex have been associated with transmission of HIV infection. Anal sex has the highest risk of transmission of HIV infection by sexual route. Studies of homosexual men have consistently shown that the receptor (bottom) is at higher risk of HIV infection^{7,8}. Oral sex is much less risky than anal or vaginal sex. The presence of other STIs, high viral load, stage of HIV infection (both early and late stages) and douching enhances transmission of HIV infection. The practice of safer sex with the use of condom can prevent HIV transmission amongst those with multiple sex partners and sero-discordant couples⁵. When condom is used correctly and consistently, it is 80-90% effective in reducing the risk of HIV transmission⁸.

There is a visible need to educate the populace on safer sex practices bearing in mind the increasing prevalence of HIV in the country.

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Many HIV positive clients are ignorant of safer sexual practices and so go on to infect their partners. Knowledge of the sexual practices of the HIV positive clients will help decide better ways to control the spread of HIV infection through sexual contact. This study is therefore set to determine the sexual behaviour, sexual knowledge, and socio-demographic factors of people living with HIV.

SUBJECTS AND METHOD

The study was carried out in Nnamdi Azikiwe Teaching Hospital Nnewi, HIV referral clinic. This clinic manages PLWHA from Nnewi, Anambra states as a whole and neighbouring states like Abia, Imo, Delta, Enugu and Ebonyi. Majority of the clients are Igbo's of South Eastern Nigeria. They are mostly Christians. The climate and vegetation is consistent with that of the tropical rainforest.

The sample size was calculated using the formula

$$n = \frac{Z^2 Pq}{d^2}$$

Where n = sample size

Z = a constant = 1.96

P = an estimate of correct proportion 50% value was used in this study

q = 1-p = 1-50% = 0.5

d = precision or degree of accuracy. I assumed 94%.

Sample size = $1.96^2 \times 0.5 \times 0.5$
 $\frac{0.06^2}$

$$n = 266$$

But for convenience 300 questionnaires were administered to respondents.

Systematic sampling method was used to select the study population of 300 out of all the people living with HIV (PLWH) who attended the special treatment clinic at Nnamdi Azikiwe University Teaching Hospital Nnewi Nigeria in May 2006. Only the old patients who have been on treatment or follow up in the clinic were recruited. Data collection was concentrated on one month selected randomly to eliminate double entry because the clients were given a monthly follow up appointment in the clinic. Newly diagnosed patients referred to the clinic from the counselling and testing centre or from other health facilities were excluded. This exclusion is because their sexual behaviour before the diagnosis would not have been influenced by their HIV status. Verbal consent was obtained from each respondent.

The study was carried out using a structured questionnaire which has three segments. The first segment of the questionnaire obtained the biodata of the respondents, while the second tested their sexual practices and the third obtained information on their perception and practice of HIV infection preventive

methods. The questionnaires were administered to the PLWH by the researchers. Confidentiality was assured as the names, addresses and the phone numbers of the respondents were not required. The data from the survey were entered into a personal computer and analysed with SPSS 11.0 for windows version.

RESULTS

Two questionnaires were excluded because of inconsistent answers given by the respondents leaving 298 (99.3%) questionnaires for analysis. The mean age of the respondents was 36.6 years \pm 3.2 SD with a modal age group of 30-39 years (Table 1a). Of the 298 respondents, 193 (64.5%) were females and 105 (35.2%) were males; 165 (55.4%) live in rural area and 133 (45.6%) live in urban centres. The majority of the respondents 160 (53.7%) were in monogamous marriage, while 74 (24.8%) were single. The rest of the marital status is as shown in Table 1b. The respondents have been living with the HIV infection for a mean duration of 2.3 years \pm 1.6 SD with a range of 1 to 11 years (Table 2).

Seventeen (5.7%) of the respondents had no formal education, 100 (33.6%) had primary education, while 139 (46.6%) had secondary education and 42 (14.1%) had tertiary education. Majority of the respondents 292 (98.0%) were Christians with 148 (50%) Catholics, 70 (23.5%) Anglicans and 74 (24.8%) Pentecostals. The remaining 4 (1.3%) were of traditional African religion and 2 (0.7%) did not disclose their religion.

Heterosexual intercourse was the commonest sexual practice accounting for (289)97.3% of our respondents. Homosexual and bisexual intercourse was practiced by (4) 1.3% and (5) 1.7% of the respondents respectively. In the past six months 41.3% of the respondents had abstained from sexual intercourse while 58.6% were sexually active. The mean number of sexual partners of the respondents is 1.4 \pm 2.1 SD with a range of 1 - 10 (Table 3). Although all the respondents have heard of condom, (172) 57.7% had never used it during sexual intercourse, while (71) 23.8% used it sometimes and (52) 17.5% used it consistently (Table 4). The use of condom was believed to be protective of HIV infection by 65.1% (194) of the respondents as shown in Table 4. The sexual partners were aware of the HIV status of the respondents in (178)59.7% while (101) 33.9% were not aware and 6.4% (n = 19) were not sure whether their partners were aware of their HIV status or not. On the other hand, 54 (73.0%) of the single respondents do not know the HIV status of their sexual partners while 182 (81.6%) of the married respondents knew their spouses HIV status as shown in Table 5. Sexual intercourse was identified as the mode of transmission of HIV by almost all the respondents with vaginal, oral and anal sex being selected by 95.5%, 64.4%, 63.4% of the respondents respectively (Table 6).

Table 1: Age and Marital Status Distribution of the Respondents.

A. Age (years)	Frequency	Percent	Cumulative Percent
20-29	79	26.5	26.1
30-39	121	40.6	67.1
40-49	61	20.5	87.6
50-59	31	10.4	98.0
>60	6	2.0	100.0
Total	298	100	
B. Marital status			
Single (never married)	74	24.8	24.8
Married to one wife	160	53.7	78.5
Married to > one wife	5	1.7	80.2
Separated	10	3.4	83.6
Divorced	2	0.7	84.3
Widow	38	12.7	97.0
Widower	8	2.7	99.7
No Response	1	0.3	100
Total	298	100	

Table 2: Duration of the time the Respondents have been Living with the HIV Infection.

Duration of HIV Infection (years)	Frequency	Percent	Cumulative Percent
<1	159	53.4	53.4
1-5	121	40.6	94.0
6-10	12	4.0	98.0
>10	6	2.0	100
Total	298	100	

Table 3: Number of Sexual Partners of the Sexually active Respondents in the past six Months.

No of Sexual Partners	Freq	Percent	Cumulative %
1	101	57.7	57.7
2-4	16	9.1	66.8
5-10	2	1.2	68.0
Do not know	56	32.0	100
Total	175	100	

Table 4: Condom use During Sexual Intercourse and Knowledge of its Protection against HIV.

Condom Use during sex	Freq.	%	Condom Protects against HIV infection	Freq.	%
Never	172	57.7	Yes	194	65.1
Sometimes	71	23.8	No	27	9.1
Always	52	17.5	Do not know	74	24.8
No Response	3	1.0	No Response	3	1.0
Total	298	100	Total	298	100

Table 5: Respondents' Knowledge of HIV Status of the Sexual Partner.

Married Respondents			Unmarried (single) Respondents		
Spouses' HIV status	Freq.	%	Sexual Partners' HIV status	Freq.	%
Positive	123	55.1	Positive	5	6.7
Negative	59	26.5	Negative	15	20.3
Do not know	41	18.4	Do not know	54	73.0
Total	223	100	Total	74	100

Table 6: Respondents' knowledge of the Possibility of Transmission of HIV by Type of Sex.

Knowledge of HIV transmission	Oral sex	Vaginal sex	Anal sex	Dry sex	Interfemoral sex	masturbation
Yes	192 (64.4)	284 (95.3)	189 (63.4)	10 (4.4)	13 (4.4)	3 (1.0)
No	26 (8.7)	2 (0.7)	25 (8.4)	268 (89.9)	30 (10.0)	277 (93.0)
Do not know	80 (26.9)	12 (4.0)	86 (28.9)	20 (6.7)	255 (85.6)	18 (6.0)
Total	298	298	298	298	298	298

DISCUSSION

As the rate of sexually transmitted disease and HIV increase among the general population, there is the need to evaluate the sociodemographic factors and sexual behaviours among the people living with HIV. Several studies have been done among different population with little or no attention on the victims of this scourge. The contribution of this population to the spread of the disease and how they are coping with their sexual life since they were diagnosed to be living with HIV needs to be appreciated. The finding that most of the respondents were in a monogamous marriage is similar to findings in other studies³. This buttresses the fact that marriage per se is not really protective against HIV. It may also depict that the level of promiscuity and infidelity among people in the so called monogamous marriage is high as the stigmatization of sexual relationship outside of marriage particularly in our environment may be responsible for the denial of multiple relationships. It could be a manifestation of the fact that premarital sexual activity is prevalent among Nigerians and so some of them may have been infected before they went into marriage⁹⁻¹¹.

The fact that nearly 50% of the respondents were not in stable relationship means that PLWHA undergoing treatment are of great importance in the continuing spread of the infection. There were also other determinants of risky sexual behaviours such as being sexually active, multiple sexual partners, unstable non-conjugal relationships and non use of condoms. This is similar to the findings in the general and some selected study populations by other studies^{12,13}. These respondents were all living with HIV and undergoing treatment at NAUTH special treatment clinic. They have undergone several counselling sections and are therefore supposed to be well informed about the disease, its mode of transmission and methods of prevention; yet risky sexual behaviours continued to abound among them. We could not define whether this was a deliberate attempt to infect others or pretence and denial of their state especially the single respondents. Other workers have observed similar

trend in general and selected populations^{11,14}. This finding exposes the fact that healthy PLWHA are exposed to re-infection and they also contribute immensely to the spread of the disease. The fact that the respondents cut across the Christian denominations means that religious orientation may not be protective. This may be a manifestation of the laxity of the religious groups in preaching and or inculcating moral values into their followers. The preponderance of the catholic members among the respondents is similar to the finding in a Kenya study which reported that being a catholic was an independent predictor of HIV infection¹⁵.

Only 65.1% of the respondents believed that condom is protective against HIV infection. This is much lower than the figures from other study populations like Zambia where 94% believed that condom could prevent the sexual transmission of HIV¹⁶. However, there is low prevalence of condom use as shown in this study and other studies in different parts of Nigeria¹⁷⁻¹⁹ including the Nigeria National Survey on condom use which reported that only 30% of men use condom to prevent sexually transmitted infections²⁰.

This study suggests that the PLWHA are very important in the spread of HIV infection as they are still sexually active, in non-cohabiting conjugal unstable relationship, and they do not use the condom consistently. There is an urgent need to target this population with effective behavioural change communications that will translate to safer sexual behaviour. The practice of safer sex should be taught in every health care center, in schools and in village gatherings by qualified health care workers. This will help curb the transmission of HIV.

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