Intimate partner violence among women living with human immunodeficiency virus attending a tertiary health facility in southwest Nigeria

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Abstract

Globally intimate partner violence (IPV) is a major health problem and disproportionately affects more women than men. In Africa, women living with human immunodeficiency virus (HIV) face increased IPV risk, low record of disclosure and higher chance of transmission of HIV to their spouse. This study determined the prevalence and pattern of IPV and its association with disclosure status to partner among women living with HIV(WLHIV).

This was a mixed method study among WLHIV attending HIV Anti-Retroviral (ART) clinic at the University College Hospital, Ibadan. Data was collected from 316 participants selected by systematic random sampling using a semi-structured questionnaire developed by the researcher. In-depth interviews were conducted among 20 participants using a guide. Frequency, percentages and proportion were used to summarize categorical variables and means and standard deviation for continuous variables. The test of association was by Chi square and statistical significance was set at $p<0.05$.

Mean age of participants was 37.6 ($\pm$ 7.4) years and most, 146(46.2%) were aged 30-39 years. One hundred and sixty-eight (53.2%) of the participants had IPV. The most reported form of IPV was physical 92(54.7%) while emotional and sexual accounted for 59 (35.1%) and 17 (10.2%) respectively. Two hundred and seventeen (69.0%) had disclosed their status to their partner and 69(21.9%) of their partners were HIV positive. The participants' perspectives about IPV were appropriate. There was a statistically significant association between non-disclosure of HIV status and increased prevalence of IPV ($p<0.005$).

The study observed that there is high prevalence of IPV among WLHIV, especially where there is non-disclosure of HIV status to partner. There is need to encourage disclosure of HIV status to partners and more public enlightenment to reduce IPV.

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Key words: Intimate partner violence, Women living with HIV, AIDS, Antiretroviral therapy clinic, HIV status disclosure.

Introduction

Intimate partner violence (IPV) has been defined as a type of gender-based violence which involves physical, sexual and psychological harm from an intimate partner.[1,2] IPV is an issue of global concern, occurring at all levels, among all socioeconomic, ethnic and religious groups and with women mostly being the victims.[3] In sub-Saharan Africa and Nigeria, 30-50% of women are reported to have experienced IPV.[4–6] The consequences of IPV are diverse and may include physical, psychological, emotional, and reproductive and pregnancy related health issues.[4,7,8]There could be direct trauma resulting into fractures and damages to internal organs in the body, chronic health problems depression, anxiety, and phobia. More worrisome are the negative sexual and reproductive health consequences such as unwanted pregnancies, unsafe abortions, pregnancy complications, pelvic inflammatory diseases, urinary tract infections and sexual dysfunctions. During pregnancy, IPV has been associated with miscarriages, stillbirths, premature labour and births, fetal injuries and low birth weights infants.[4.8]

Globally, women account for about half of the 38.4 million people living with HIV and in sub-Saharan Africa, where its epidemic is worst, women make up to an estimated 57% of adults living with HIV.[9] Several factors such as low level of education, multiple sexual partners, low socioeconomic status, drug abuse, patriarchal societies and lack of women`s civil rights group has been associated with IPV.[10]

Some studies have shown that WLHIV is a risk factor for IPV, especially among those who disclose their status to their partners,[11-14] however there is scanty information on factors associated with IPV and non-disclosure of HIV status among WLHIV attending ART clinic at the University College Hospital, Ibadan. This study was therefore designed to determine the prevalence, pattern and risk factors associated with IPV and the association with disclosure of HIV among WLHIV.

Materials and Methods

Study location: This study was conducted in Ibadan, the capital of Oyo State, with an estimated

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population of 3.6 million people and the seventh largest city in Africa.[15] Ibadan has 11 local governments consisting of five urban local government and six rural local governments.

Study design: It was a mixed method cross-sectional study among women living with HIV.

Study population: Ibadan has major HIV treatment clinics in the tertiary and secondary health facilities and satellite drug collection centers in all the primary health care clinics. The ART at the University College Hospital, Ibadan is the first in Oyo State and has facility for all the tests needed for evaluation and monitoring of people with HIV and serves males and females population. The study was conducted among women living with HIV and attending ART clinic at the University College Hospital, Ibadan for treatment. The clinic has various categories of medical personnel providing clinical services and psychological support to clients.

Inclusion and exclusion criteria: Women in reproductive age attending the clinic and on antiretroviral treatment were included in this study while women who were not in intimate relationships were excluded.

Sample size calculation: The sample size was calculated using the formulae for cross-sectional study [16] and a IPV prevalence rate of 21% among WLHIV from a previous Nigerian study.[14]

Sampling method: Three hundred and twelve participants were selected through systematic random sampling technique. The total population was used to determine the sampling fraction 1/k and sampling interval k. the first unit to be selected was selected at random between 1 and k, thereafter every kth unit was selected.

Data collection instrument: Quantitative data was collected using semi structured questionnaires developed by the researchers based on available literature. It sought information about socio-demographic and socio-economic characteristics such as age, marital status, type of marriage, level of education, employment, disclosure of status to partners and intimate partner violence. The questionnaire was pretested among 20 women attending the gynecological outpatient's department and appropriate corrections were made. Qualitative data were collected through in-depth interviews among 20 randomly selected participants.

Data analysis: Data were checked for completeness, cleaned, edited, coded and entered into Statistical Package of Social Sciences (SPSS) version 20 for analysis. Qualitative data were analyzed using themes while Quantitative data was analyzed using frequency, percentages and proportion were used to summarize categorical variables and means and standard deviation for continuous variables. The test of association was by Chi square and statistical significance was set at $p<0.05$.

Ethical consideration: Ethical approval was obtained from the UI/UCH Institution Research Board and ethics committee. Permission was also sought from the health facilities where the study was conducted. Written informed consent was obtained from selected participants and confidentiality was ensured throughout the study.

Results

The age range of participants was 27-53 years with a mean of 37.6 $\pm$ 7.4 years. The majority of the participants (272; 86%) were below 50 years and had secondary level of education (138; 43.7%). Most of the participants were married and self-employed. Slightly more than half (159;50.3%) were Christians. This is shown in Table 1.

Table 1: Socio-demographic characteristics of the participants

Variable	Frequency N=316	Percentage
Age (in years)		
20-29	45	14.2
30-39	146	46.2
40-49	81	25.6
50-59	38	12.0
60-69	6	1.9
Highest Educational level		
None	27	8.5
Primary	112	35.4
Secondary	138	43.7
Tertiary	39	12.3
Marital Status		
Single	5	1.6
Married	257	81.3
Divorced/Separated	16	5.1
Widowed	38	12.0
Marriage Type		
Monogamy	191	60.4
Polygamy	125	39.6
Religion		
Christianity	159	50.3
Islam	157	49.7
Traditional	0	0.0
Employment Status		
Formally Employed	26	8.2
Self-employed	286	90.5
Unemployed	4	1.3

Table 2:Awareness of partners HIV status and disclosure of HIV status to partners among the study participants

Variable	Frequency	Percentage
Partner's HIV status		
Positive	69	21.9
Negative	206	65.1
Unknown	41	13.0
Disclosure of status to spouse		
Yes	217	68.7
No	95	30.0
Missing	4	1.3
Concordancerate of HIV(n=275)		
Sero-concordant	69	25.1
Sero-discordant	206	74.9

One hundred and sixty-eight (53.2%) of the participants had IPV, with physical abuse the commonest (92; 54.7%). Other forms of abuse experienced were emotional (35.1%) and sexual (10.2%). This is shown in figure 1.

Disclosure of HIV status to their spouses revealed mixed responses, while one participant responded that *"I explained to him, and he accepted", another participant said that "It was my husband that discovered I had HIV".* The majority of the participants (275; 87%) were aware of their spouse's HIV status and two hundred and seventeen participants (68.7%) have disclosed their HIV status to their spouse. Among couples with known HIV status of participants and spouses, two hundred and six couples (74.9%) were sero-discordant. This is shown in table 2 .

In-depth interviews of WLHIV revealed more information on their perception of the different forms of IPV and there were mixed responses on whether IPV was increasing or decreasing amongst them. It also revealed whether WLHIV are at an increased risk of IPV depends on the level of respect the couples had for each other, and that divorce is acceptable if distrust and irreconcilable differences occur. This is shown in Table 3.

Table 4 shows the association of the spouse's HIV status and different forms of IPV with disclosure of HIV status to partners. Participants who had not disclosed their status to their partners had higher incidences of emotional (X^2; p=<0.001), physical (p=<0.001) and sexual (p=<0.001) abuse.

Table 3: Perceptions about IPV from the in-depth interview

Variable and selected responses of participants
Description of IPV
"*Intimate partner violence means beating of wife by the husband while the forms of violence known to me are beating, pushing or shaking, slapping, threatening and insult".*
Intimate partner violence is a form of gender inequality among couples while the forms of violence known to me includes husband beating their wives, insulting, humiliating and harassing her.
"Intimate partner violence refers to husband maltreating his wife beating, insulting and maltreating are forms of violence known to me".
"Intimate partner violence is a process in which the husband fight his wife and did not trust her while fight and mistrust are the forms of violence I know.
Whether WLHIV are at an increased risk of IPV
"*It depends on the level of understanding of the couples".*
"If the wife is submissive, there is a higher chance that she won't experience violence from her spouse".
Factors responsible for IPV
"Lack of love, trust and unity among couples".
"If the husband is having extra-marital relationship, it could cause a reason for intimate partner violence, as there would be no love among them".
"Disclosure of status to the partner, especially when he is not reactive to the virus, as well as the misconception we have had about the virus could be the reason for intimate partner violence".
Husband with two or more wives too can cause it, if there is no love among them".
Perception on being victim of IPV
"No one will feel good at such".
"I won't be happy and I will really feel depressed".
Ways on reducing IPV
"Husband and wife should have a codified agreement among them and they should love each other. With love among couples, there would be no violence even when they have disagreements on things".
"Counseling: there should be love among women living with HIV, and there should be care for them".
"'There should be an agreement between the husband and wife and if they cannot reach the agreement: in which the husband keep on violating the wife due to her status, divorce should be done immediately".
"There should be unity, love and trust between partners and among women living with HIV".
"Praying to God to let it stop; love; trust; care and endurance among women living with HIV in their homes".
"When the woman is diagnosed of HIV and the husband is not reactive, I will suggest that they should separate if they cannot cope with each other".

Table 4: Associations with disclosure of HIV Status among the study participants

Variable	Disclosure of HIV Status		χ^2	p value
	Yes (%)	No (%)		
Spouse HIV Status				
Positive	60(87.0)	9(13.0)		
Negative	154(74.8)	52(25.2)		
Unknown	6(14.6)	35(85.4)	80.0	<0.001
Emotional abuse				
Yes	18(30.5)	41(69.5)		
No	219(85.2)	38(14.8)	76.6	<0.001*
Physical abuse				
Yes	24(26.1)	68(73.9)		
No	192(85.7)	32(14.3)	107.2	<0.001*
Threaten to physical abuse				
Yes	16(21.9)	57(78.1)		
No	206(84.7)	37(15.3)	106.1	<0.001*
Sexual assault				
Yes	4(23.5)	13(76.5)		
No	255(85.3)	44(14.7)	32.5	<0.001**
Isolation from friends and families				
Yes	13(23.6)	42(76.4)		
No	220(84.3)	41(15.7)	86.3	<0.001*

* Significant
** Yates correction

Discussion

The study corroborates the findings of previous studies that found IPV to be associated with HIV.[11-13] The violence experienced ranged from physical, to sexual and psychological/emotional. Physical violence ranked highest with 54.7% reporting they experienced it. This is similar to 50.4% and far higher than 5.9% prevalence of physical violence observed in previous studies.[17,18] Emotional or psychological violence accounting for 35.1% ranked next to physical violence in this study which is also a bit higher than 27.5% observed in a previous study among Nigerian WLWHIV.[18] The least reported was sexual violence among 10.2% of the study participants and this may be due to women less likely to report such forms of violence, though previous study had reported higher prevalence.[19] The increase in IPV observed in this study might be due to difference in reference populations and the methodology adopted. The mixed method adopted in this study might have enabled more participants to freely express themselves thereby giving a true prevalence of the condition.

This study showed that 87% of HIV positive women attending the antiretroviral clinic were aware of their partner's HIV status and this has improved from the low number previously, but efforts must be continuously put in place to sustain or improve this rate.[19.20] However, fewer number of participants (68.7%) had disclosed their HIV status to their spouse, showing that there is disparity between awareness of partner's HIV status and disclosure to partners by HIV positive women. This gap needs to be bridged by continued counselling on the benefit of disclosure and creating friendly and accessible HIV services.

Our study also revealed among the study participants with known spouse HIV, a sero-discordant of HIV status of 74.9%. This is high and might be a major factor why many of the participants did not reveal their status to their spouse because they know that most spouses may be HIV negative so there is no need in putting themselves at some of associated risk with disclosure. Other reasons for non-disclosure may be the fear of IPV as have been documented in previous studies on women with HIV. [19,21-23]However, there are tremendous benefit of disclosure such as reducing, the prevalence of HIV, risk of acquiring new strains, early access to treatment of HIV positive spouses, access to reproductive options and an improved quality of life and survival.

Our study also revealed that the spouse's HIV status may be a major determinant in disclosure as 87.0% of those who were that their spouse was HIV positive had disclosed their HIV status, though the rate of disclosure was slightly less (74.8%) among those with HIV negative spouses. Another important outcome of this study is the relationship between disclosure and risk of IPV. Unlike some previous studies, we found that disclosure of HIV status reduced the chances of IPV. This may be because non-disclosure of HIV status to partners may lead to not wanting to engage in sexual intercourse because of fear

of infecting their partners. This may lead to more conflicts as the partners may not understand the situation and resort to increased emotional, physical and sexual abuse. Our study also shows the benefit of disclosure as it may lead to better understanding and adoption of safer sexual practices by the partner leading to decreased conflicts and IPV. Many of the participants had not disclosed their HIV status to their partners because of the perceived fear of IPV. Our finding will be very helpful in counselling those women with HIV to disclose to their partners however larger studies will need to be done to confirm our findings.

The qualitative aspect of the study revealed that the participants were able to describe the various forms of IPV. One participant described IPV as "*Intimate partner violence means beating of wife by the husband while the forms of violence known to me are beating, pushing or shaking, slapping, threatening and insult". Most of the description focused on physical and emotional abuse suggesting that women do not feel free to talk about sexual abuse. Regarding why IPV occurs was linked to submissiveness of the woman with a participant saying "If the wife is submissive, there is a higher chance that she won't experience violence from her spouse" however another felt that with good understanding among couples IPV can be reduced. A common identified factor responsible for IPV identified by the participants is lack of trust and love, especially where there are extramarital relationships. Preventive strategies such as counselling, couples discussing freely on their worries and care were suggested and divorce when there are irreconcilable differences.*

In conclusion, our study has revealed that IPV is common among HIV positive women and the risk is more for women in sero-discordant relationships and with non-disclosure of HIV to their partners. There is therefore the need to improve disclosure of HIV status to partners, institute preventive strategies for IPV and support women who are victims of IPV.

Conflict of interest

There is no conflict of interest.

Sponsorship

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