

INTIMATE PARTNER VIOLENCE IN A COHORT OF HIV POSITIVE WOMEN IN NIGERIADr. Okeke O.O.*¹, Jamda A. M.², Maduoma C.³ and Abegunde O.¹¹Department of Family Medicine, Wuse District Hospital, Abuja, Nigeria.²Department of Community Medicine, University of Abuja, Nigeria.³Department of Family Medicine, Maitama District Hospital, Abuja, Nigeria.***Corresponding Author: Dr. Okeke O.O.**

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ABSTRACT

Background: Intimate Partner Violence (IPV) and HIV/AIDS are two major issues of public health and social concern that require comprehensive and collaborative interventions. Females who experience both conditions are at risk of health and non-health complications. This study was undertaken to determine the prevalence and predictors of IPV among female clients attending the HIV clinic in two public hospitals in Nigeria. **Methods:** The study was a hospital based cross sectional study involving three hundred and forty consenting HIV seropositive females aged 15years and above. An interviewer administered questionnaire was used to collect data on socioeconomic and family characteristics of the respondents as well as the experiences of IPV by the respondents. Data was entered into MS excel spreadsheet and analyzed using SPSS-21 software package. Prevalence and pattern of IPV experienced was documented using percentages and the association between other variables and IPV was expressed using chi-square statistics. Predictors of IPV were determined by logistic regression and P-value was assumed to be significant at ≤ 0.05 . **Results:** The mean age and standard deviation was 31.5 ± 7.04 years. The prevalence of IPV was 83.5% (284). Controlling behaviour (84.6%) was the most common type of IPV experienced by the respondents followed by psychological IPV (59.8%), physical IPV (41.4%) and sexual IPV (23.1%) respectively. Following logistic regression analysis, predictors of IPV included place of residence, (Odds ratio=2.8, 95% CI: 1.1-7.2; $p=0.030$), alcohol use in the respondent (Odds ratio=7.1, 95% CI: 2.0-25.6; $p=0.003$), and alcohol use in her partner (Odds ratio=5.3; 95% CI: 1.9-14.5; $p=0.001$). **Conclusions:** The prevalence of IPV amongst females living with HIV/AIDS is high. This high prevalence is more prominent in females who take alcohol and those whose partners take alcohol too. Thus, routine HIV services should include screening for IPV and alcohol use among female clients in order to reduce the risk of IPV amongst this vulnerable group.

KEYWORDS: Intimate Partner Violence (IPV), HIV/AIDS, Females.**INTRODUCTION**

Intimate Partner Violence (IPV) and Human Immunodeficiency Virus/ Acquired Immunodeficiency syndrome (HIV/AIDS) are two major issues of public health and social concern. Women continue to be disparately impacted by the co-occurring epidemics of HIV and intimate partner violence (IPV).^[1] Intimate partner violence (IPV) is the most common form of violence that women experience globally, although IPV applies to women and men, girls and boys.^[2,3] Intimate Partner violence which is a significant component of gender based violence has been viewed worldwide as a violation of basic human rights.^[4] The World Health Organization (WHO) refers to intimate partner violence as behaviour by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behaviours.^[5] According to WHO

in 2018, the worldwide prevalence of IPV showed that nearly 30% of women have been subjected to physical and/or sexual violence by an intimate partner or non-partner sexual violence or both.^[5] At the end of 2020, the Joint United Nations Programme on AIDS (UNAIDS) reported an increase in this prevalence to 35%.^[6] The lifetime prevalence estimates across WHO regions ranges from 20% to 33% with Africa and South-East Asia having the highest burden.^[5]

In Nigeria, the 2018 Demographic and Health survey revealed an increasing trend of physical violence experienced among women since the age of 15 from 28% in 2008 to 31% in 2018.^[4] The overall prevalence of women age 15-49 in Nigeria who have experienced either physical or sexual violence is 33%.^[4]

Globally HIV/AIDS continues to remain an epidemic. According to UNAIDS in 2020, 37.7million people were living with HIV and 53% of all people living with HIV/AIDS being women and girls.^[6] Also in 2020, 680,000 people died from AIDS related illnesses.^[6] People who became newly infected with HIV in 2020 were 1.5million people with 50% of these being women and girls.^[6] Women who have experienced physical or sexual intimate partner violence are 1.5 times more likely to acquire HIV than women who have not.^[6]

Intimate partner violence is both a predisposing factor for and sequelae of HIV infection.^[7] Center for Disease control and prevention (CDC) report on the intersection of IPV and HIV in women shows that mechanisms of exposure to IPV can increase women's risk for human immunodeficiency virus (HIV) infection.^[8] These mechanisms include forced sex with an infected partner, limited or compromised negotiation of safer sex practices and increased sexual risk-taking behaviours.^[8] In Nigeria, women living with HIV/AIDS represent a more vulnerable group for IPV and the impact on them is more severe in terms of psychological, physical, and pathological consequences.^[9] IPV limits a woman's decision-making power regarding her reproductive health, putting her at risk for unwanted pregnancies and sexually transmitted infections (STIs) including HIV/AIDS.^[10] IPV may also delay or prevent HIV testing and HIV status disclosure to partners and exacerbates the vulnerability of women living with HIV.^[11] The risk factors associated with IPV and increased likelihood of acquiring HIV include forced sexual activity, injuries to vagina or other body parts, microscopic lacerations and tears to the anal and buccal mucosa as well as nail injuries to skin and other sensitive areas thereby increasing viral contact to the raw wounds and increasing transmission rates.^[12] Many African societies are patriarchal in nature and have conferred the male partner with factors associated with perpetrating IPV.^[7] Some of these male partner-related factors include having multiple sexual partners and other risky sexual behavior, history of abuse in childhood, alcohol and substance use, being unemployed, having a history of violence, having a domineering personality, and possession of economic power.^[7] The risk factors for IPV among the women include being younger than 20 years, low level of education, low socioeconomic status, or having less household decision-making power.^[7]

Since IPV and HIV are highly interrelated, it is important for healthcare workers who care for women living with HIV to identify and manage IPV when it is present. The objectives of this cross-sectional study was to determine the prevalence, predictors and pattern of IPV amongst the HIV positive women attending the HIV clinic.

MATERIALS AND METHODS

Study Location: The study was conducted in two HIV Clinics located in the Federal capital territory of Nigeria. One of them is in the city center while the other is in the

suburban region of the territory. According to the National Population Commission of Nigeria, in 2016, FCT has an extrapolated population of 3,564,126 persons with females constituting about 49% (1,746,422) of the total population.

The HIV clinics in these hospitals are each run one day in a week and cater for thousands of PLWHA using an appointment-based system. In both hospitals, there exists a social welfare team which works in conjunction with the FCT Sexual and Gender-Based Violence secretariat in handling cases of domestic violence and other related acts.

Study design: A hospital based cross-sectional descriptive study was done.

Study period: Data was collected within the period of November 2019 to January 2020.

Sample size: The sample size was obtained using Leslie Kish formula for estimating sample size in health studies, and the following item measures were used: 95% confidence level, an estimated prevalence of IPV among Nigerian females according to the 2013 Nigerian Demographic Health Survey of 33% and a 5% margin of error. The minimum sample size for the study was 340.

Study procedure: Three hundred and forty (340) participants who met the inclusion criteria and consented were enrolled into the study by systematic random sampling. One hundred and seventy respondents were selected from each hospital. The inclusion criteria included all HIV seropositive females 15 years or older, who were enrolled into care. The patients who were too sick for clinic consultation were excluded from participating in the study.

Data Management: Data was gathered by the researcher and two trained research assistants using a structured interviewer-administered questionnaire. The questionnaire was used to collect information on the respondents' socio-demographic and family characteristics as well as their clinical data. Information about experience of IPV was collected using the World Health Organization Multi-country study (WHOMCS) on women's health and life experiences questionnaire. This questionnaire which measures controlling behavior, psychological, physical and sexual IPV by the intimate partner, was developed for use in different cultures and is cross-culturally appropriate.

Ethical considerations

The study was approved by the Federal Capital Territory Health Research Ethics Committee, Abuja. The study was also conducted following the standard ethical guidelines on conducting gender-based violence studies as stipulated by the WHO and the recommendations prescribed in the ethical and safety guidelines for

research on domestic violence. A written informed consent was obtained from the respondents.

Data Analysis

Data was entered into MS Excel spreadsheet and analysed using SPSS software version 21. Descriptive statistics included frequencies, means and standard deviation. Associations of quantitative variables were evaluated using Pearson's chi square test and the P value of less than 0.05 was considered statistically significant. Logistic regression was used to determine predictors of IPV, and odds ratio and 95% confidence intervals were determined as measures of association.

RESULTS

The mean age \pm standard deviation of the 340 respondents was 31.5 years \pm 7.035 years. Among the respondents, 176 (51.8%) were above 30 years of age while 164(48.2%) were aged less than 30 years. Over half (178, 52.4%) were married while 41.7% (142) were single. Six (3.5%) were separated while 3 (1.8%) were divorced. The distribution according to areas of domicile showed that two hundred and ten (61.8%) lived in urban areas while 130 (38.2%) lived in rural areas. Concerning their level of education, 10 (2.9%) of them had no formal education while the rest had some form of education. About 282 (82.9%) of them were Christians while 58(17.1%) were muslims. Regarding their monthly income, 266(78.2%) earned between N18,000 and

N50,000 while 34(10%) respondents earned less than N18,000.

Three hundred and fourteen (92.4%) respondents were in a monogamous family while 26(7.6%) were in a polygamous family. One hundred and eighty-six (54.7%) had been with their current partners for over three years. One hundred and thirty-two (38.8%) of them had been with their current partners for one to three years while twenty-two (6.5%) had spent less than one year with their current intimate partner.

One hundred and eighty respondents (52.9%) had no living children while 138 (40.6%) had between one and three children and 22(6.5%) had more than three children. Among the respondents, most of them (308; 90.6%) denied alcohol intake. Only 32 (9.4%) admitted that they took alcohol. Two hundred and seventy-six (81.2%) respondents reported that their partners took alcohol while 64 (18.8%) persons said their partners did not take alcohol. Two hundred and twenty-four (65.9%) of them reported that their partners were also HIV positive while 66 (19.4%) reported that their partners were HIV negative. Twenty five (14.7% of them did not know their partners' HIV status.

This is shown in Table 1 below.

Table 1: Showing the characteristics of the study respondents.

Variables	N=340 (%)
Age	
<30years	164(48.2)
\geq 30 years	176(51.8)
Marital Status	
Single	142(41.7)
Married	178(52.4)
Divorced	6(1.8)
Widowed	2(0.6)
Separated	12(3.5)
Place of residence	
Rural	130(38.2)
Urban	210(61.8)
Educational Status	
No formal education	10(2.9)
Primary education	6(1.8)
Secondary education	188(55.3)
Tertiary	136(40.0)
Religion	
Christianity	282(82.9)
Islam	58(17.1)
Average monthly income	
<N18,000	34(10.0)
N18,000- N50,000	266(78.2)
>N50,000	40(11.8)
Family Type	
Monogamous	157(92.4)
Polygamous	13(7.6)

Number of years with current partner	
<1year	11(6.5)
1-3 years	66(38.8)
>3years	93(54.7)
Number of children	
No children	90(52.9)
1-3 children	69(40.6)
>3 children	11 (6.5)
Alcohol intake in respondent	
Yes	16(9.4)
No	154(90.6)
Alcohol intake in partner	
Yes	138(81.2)
No	32(18.8)
HIV status of partner	
HIV Negative	33(19.4)
HIV positive	112(65.9)
Unknown	25(14.7)

Prevalence of IPV

The prevalence of IPV among the study participants was 83.5%.

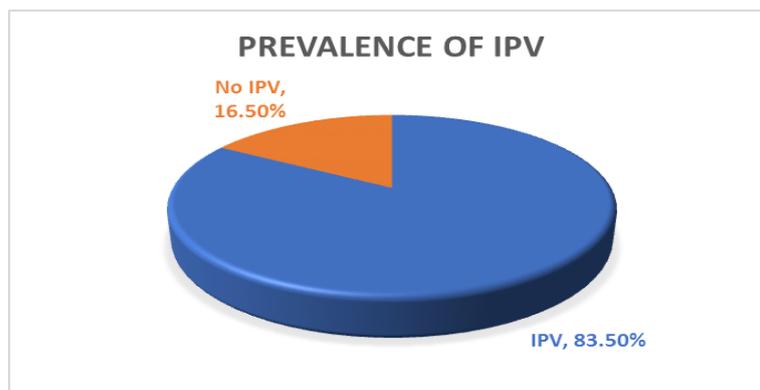


Figure 1: Showing the prevalence of IPV among the respondents.

Pattern of IPV

Figure 2 shows the pattern of IPV among the respondents studied. Many women had experienced more than one form of IPV. When reviewing the pattern of IPV experienced by the respondents, it was discovered 143

(84.6%) experienced controlling behavior, 101(59.6%) experienced psychological violence, 70 (41.4%) experienced physical violence, while 39 (23.1%) respondents reported sexual violence.

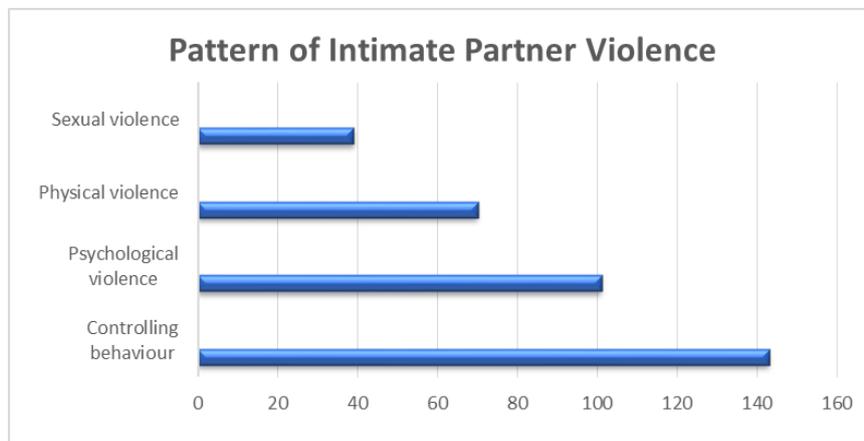


Figure 2: showing the pattern of IPV among the respondents.

Relationship between occurrence of IPV and the characteristics of the study respondents

The relationship between IPV and the socio-demographic variables is seen in Table 2. A statistically significant relationship was discovered between IPV and place of residence (Chi square=7.172, p value=0.007), family type (Chi square=177.074; p <0.001), use of alcohol in the respondents (Chi square=179.606, p value <0.001) and use of alcohol in the respondents' partners (Chi square=179.606, p value <0.001).

There was no significant relationship between IPV and respondents' age (Chi square=, p value=0.500), marital status (Chi square=, p value=0.067), educational status (Chi square=, p value=0.486), religion (Chi square=, p value=0.263), average monthly earnings (Chi square=, p value=0.800), duration of current relationship (Chi square=2.156, p value=0.624) the number of children the respondent had (Chi square=6.815, p value=0.835) and their partners' HIV status.(Chi square=2.062, p value=0.701).

Table 2: Showing the relationship between occurrence of IPV and the characteristics of the respondents.

Variables	IPV n=284	No IPVn=56	Chi Square	P value
Age <30years ≥30 years	138 (48.6) 154 (51.4)	26 (46.4) 30 (53.6)	15.286	0.500
Marital Status Single Married Divorced Widowed Separated	122(43.0) 142(50.0) 6 (2.1) 2(0.7) 12 (4.2)	20 (35.7) 36(64.3) 0 (0.0) 0 (0.0) 0 (0.0)	19.56	0.067
Place of residence Rural Urban	172 (60.7) 112 (39.3)	48 (33.8) 94 (66.2)	16.65	0.007*
Educational Status No formal education Primary education Secondary education Tertiary	8(2.8) 4(1.4) 164(57.7) 108(38.0)	2(3.6) 2 (3.6) 24(42.9) 28(50.0)	15.286	0.486
Religion Christianity Islam	228 (80.3) 56 (19.7)	54(96.4) 2(3.6)	19.568	0.263
Average monthly income <₦18,000 ₦18,000- ₦50,000 >₦50,000	32(11.3) 222(78.2) 30(10.6)	10 (17.9) 42 (75.0) 2(7.1)	15.286	0.800
Family Type Monogamous Polygamous	260(91.3) 24(8.4)	54(96.4) 2 (3.6)	177.074	<0.001*
Number of yrs with current partner <1year 1-4 years >3years	18(6.3) 106 (37.3) 160(56.3)	4(7.1) 26 (46.4) 26 (46.4)	2.156	0.624
Number of children No children 1-3 children >3 children	148 (52.1) 116(40.8) 20 (7.0)	32(57.1) 22(39.2) 2(3.6)	6.815	0.835
Alcohol intake in respondent Yes No	18(6.3) 266(93.7)	14 (25.0) 42 (75.0)	185.89	<0.001*
Alcohol intake in partner Yes	246(86.6)	30(53.6)		

No	38(13.4)	26(46.4)	193.307	<0.001*
HIV status of partner	46(16.2)	20(35.7)		
HIV Negative	194 (68.3)	30(53.6)		
HIV positive	44 (15.5)	6 (10.7)	2.062	0.701
Unknown				

Predictors of IPV

Following Logistic regression analysis of the significant relationships, the predictors discovered include place of residence, alcohol use in the respondents and alcohol use in her partner. The respondents who lived in rural areas were about three times more likely to experience IPV compared to others who lived in urban areas (OR=2.8 and p-value=0.030). Also, those who took alcohol were

about 7 times more likely to experience IPV compared to women who did not take alcohol (OR=7.1 and p-value=0.003). Those females whose partners took alcohol were about 5 times more likely to experience IPV compared to women whose partner did not take alcohol (OR=5.3 and p-value<0.001). This is shown in table 3 below.

Table 3: Showing Logistic regression determining predictors of IPV in the respondents.

Predictors	Crude Odds Ratio (CI)	Adjusted Odds ratio (CI)	p value
Place of residence	1.0	1.0	
Urban			0.030*
Rural	1.4 (1.3-6.2)	2.8 (1.1-7.2)	
Family type	1.0	1.0	
Monogamous			0.452
Polygamous	1.1 (0.3-1.2)	2.4 (0.7-1.9)	
Alcohol use in respondent	1.0	1.0	
No			0.003*
Yes	3.4 (1.8-11.2)	7.1 (2.0-25.6)	
Alcohol use in partner	1.0	1.0	
No			0.001*
Yes	2.4 (1.4-10.2)	5.3 (1.9-14.5)	

DISCUSSION

IPV is both a predisposing factor and sequelae for HIV infection.^[7] IPV increases the risk of acquiring HIV, may delay or prevent HIV testing and HIV status disclosure to partners and exacerbates the vulnerability of women living with HIV.^[11] This study was conducted with the intention of assessing the prevalence and predictors of IPV among HIV positive women.

Findings from this study confirm that violence against women is widespread as 83.5% of respondents reported having experienced some type of violence. Of these, 84.6%, 59.8%, 41.4% and 23.1% suffered controlling behaviour, psychological, physical and sexual IPV respectively. These findings are corroborated by results which reported higher exposure to IPV in women living with HIV than in other related HIV-negative sub-populations, in Sub-Saharan Africa and in various settings.^[13] This finding is high compared with studies conducted in other sub-Saharan African countries with an average prevalence of 36.6%.^[14] However, the findings of a study in Ilorin supports the current findings.^[15] The higher prevalence of IPV in this study may reflect the higher prevalence of IPV among women in the Nigerian general population than in other countries as reported by Silva et al.^[16]

Controlling behaviour has been documented to be a precursor of violence and it's directly related with

increased likelihood of acts of violence.^[17] Controlling behaviour reflects the increased vulnerability of women to be violated and this shows the patriarchal dominance of males in the family and the social norms that encourage men to exercise control over women.^[17] Results of the analysis demonstrated controlling behaviour as the most common type of IPV experienced by respondents at 84.6%. The findings in this study are higher than some prevalence of controlling behaviour in Nigeria and other parts of the world. Okenwa reported a controlling behaviour prevalence of 23% in Lagos,^[18] Owoaje reported a prevalence of 50.1% in Ibadan,^[8] Oche reported 53.5% in Sokoto.^[19] and Brooks et al reported 20% in Kenya.^[20] This may be due to difference in study population as our study involved only HIV positive women and not among pregnant women and women in reproductive age. Worthy of note however, is that the prevalence from our study is comparable to 82% reported by Kapiga et al in Tanzania.^[21] and 85% by Onigbogi in Lagos.^[22] The 41.4% and 23.1% prevalence of physical and sexual IPV in our study is in consonance with that from a Uganda National survey that showed that 32.1% and 28.3% of Women living with HIV in care had experienced physical and sexual violence.^[23] In contrast, a cross-sectional study in Kenya reported a 17% and 15% prevalence of physical and sexual violence respectively^[20] while a study in Togo reported a higher prevalence of 63.1% and 69.7% respectively.^[24] One reason for the disparity in prevalence may be differences

in survey questions between studies. Also, study region and instruments used to collect data on IPV were sources of heterogeneity.

This study found out that place of residence, partner alcohol use and alcohol use by respondents were significant predictors of IPV. Women living in rural areas experienced higher rates of IPV compared to women residing in urban areas. This is consistent with the findings that showed a higher prevalence of IPV, as well as a more accepting attitude toward various types of IPV such as wife-beating in rural areas compared to urban areas.^[25] Also, traditional gender norms are more prevalent in rural areas. In addition, in rural areas, cultural beliefs and traditions such as wife inheritance, polygamy, and religious factors may complicate the disclosure of any experience of IPV.^[25]

Partner alcohol use was significantly associated with IPV. Women whose partners took alcohol were five times more likely to experience IPV compared to those whose partners didn't. This is similar to what was reported by Olowookere et al in-South-West Nigeria.^[3] Other studies have also reported the relationship between partner alcohol use and experience of IPV.^{[11],[23]} Alcohol use is causally associated with IPV.^[23] It directly increases aggression via impaired cognitive and behavioral functioning.^[13]

Similarly, respondents who took alcohol were seven times more likely to experience IPV. This is because alcohol contributes to violence by reducing self-control as well as reducing judgment and the ability to recognize signs of danger. It is also possible that harmful alcohol consumption is a coping strategy adopted by victims to address the stress caused by violent situations.^[26]

CONCLUSION

IPV and HIV are two pandemics that require integrated and collaborative interventions. IPV is greatly interconnected with HIV and health outcomes of people living with HIV and may jeopardize the implementation and success of various elements of the HIV treatment cascade. The importance of targeting HIV positive women with specific interventions, given their vulnerability to IPV and to address factors exacerbating these risks and vulnerabilities cannot be over emphasized.

Conflict of interest: 'We the authors declare that we have no financial or personal relationship(s) which may have inappropriately influenced us in writing this paper'.

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