

Socio-cultural Determinants of HIV/Aids Transmission: Implications For Prevention in Fundong Health District, North West Region Of Cameroon.

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Abstract

Introduction Despite the efforts put in place by the Cameroon government to prevent the spread of HIV in Cameroon, new cases of infection keep increasing over the years. This is partly because the cultural aspect as a predisposing factor to the transmission of the virus is always neglected. The study was aimed at identifying cultural determinants that leads to the transmission of HIV, including sexual behaviors and challenges HIV patients face. The purpose is to present empirical evidence for stake holders and policy makers to utilize in order to curb the spread of HIV.

Methods A descriptive cross sectional study design was used where 288 HIV patients were randomly selected from HIV patients visiting Fundong District Hospital and St. Martin de Porres Catholic General Hospital, Njinikom . A consent form was signed by all those who participated in the research. A self-administered or nurse administered questionnaire was the sole instrument for data collection and the data was analysed with the use of SPSS Inc. version 22. An ethical clearance from the University of Nigeria Teaching Hospital (UNTH) Enugu, Nigeria was obtained for the study. Authorization from the Regional Delegate of Public Health for the NWR of Cameroon was obtained. Authorizations from the administrators of St Martin de Porres Catholic General Hospital Njinikom and Fundong District Hospital were given which were the centres for the collection of data.

Results Cultural determinants discovered were; the existence of wife inheritance (90.3%), extra marital sex for pregnancy (52.2%), and wife sharing in the community (17.27%). More than half of the subjects (52.8%) did not use condoms because of refusals by their partners ($P<0.05$). A shocking majority (90.97%) of the subjects reported that men have more than one sexual partners in the community. The main challenge faced by patients was poverty as responded by a majority (53.28%).

Conclusions It can be concluded that harmful cultural practices of wife inheritance, wife sharing and extra marital sex for pregnancy exist in Fundong health district. Male dominance of women leads to non-use of condoms. HIV patients face the problem of transportation to the treatment centres due to poverty. Therefore rural women should be empowered economically and traditional leaders receive education on the risk of harmful cultural practices in the transmission of HIV. Key words Culture, HIV, Fundong, Cameroon

Background

In Africa culture plays a very significant role in determining the health of the populace. Cultural diversity in the communities impacts diseases transmission especially HIV/AIDS which is predominantly linked to sexual behavior. Addressing the role of culture in HIV transmission remains the key to the prevention and care of people infected with the virus (1).

A cultural approach involves a thorough assessment of the populations' values, customs and beliefs in order to identify behavioral patterns vital to curbing the spread of the HIV epidemic (2).

According to Cameroon National AIDS Control Committee (3), sexual intercourse remains the principal route of transmission of HIV infection responsible for about 90 percent of new infections.

Fundong Health District (FHD) is located in the Boyo division of the North Wet Region (NWR). It is dominated by the KOM tribe, one of the principal ethnic groups in Cameroon and a [patriarchal](#) society. Wealth is measured by the number of wives a man marries resulting in the high practice of polygamy. The adult prevalence of HIV in this health district is 7.4 % according to Demographic Health Survey and Multiple Indicators Cluster Survey (DHS-MICS) (4).

1.1 Problem Statement

Risky sexual behaviors like polygamy, sex with multiple partners and low usage of condoms have been observed in People Living with HIV (PLHIV) which expose them to super infection and infection of their partners thus adding to the increase in number of new infections and PLHIV in the North West Region of Cameroon (5). The government of Cameroon conducts sensitization campaigns to combat the spread of HIV by targeting mostly abstinence, fidelity and condom use but little or nothing is done to address other cultural factors that lead to the transmission of the virus. Cultural practices remain one of the

facilitating factors to the acquisition of HIV in Cameroon and particularly in the NWR where there is a strong attachment to tradition in the communities.

It is normal for a man to accommodate any pregnancy the wife brings from outside of the marriage even with the husband's knowledge. This attitude encourages sexual promiscuity and will continue to contribute to an increase in HIV transmission if not addressed. Like many other Cameroonians, the Kom people drink a lot of alcohol and youths engage in dangerous consumption of drugs like tramadol; and marijuana; mind altering substances which leads to lack of self-control in sexual activities. This study is aimed at investigating the cultural determinants in the spread of HIV.

1.2 GENERAL RESEARCH QUESTION.

What are the cultural determinants that facilitate the spread of HIV in Fundong Health District?

1.3 SPECIFIC RESEARCH QUESTIONS

- What are the traditional beliefs affecting the HIV/AIDS epidemic in Fundong Health District?
- What are the sexual behaviors that expose the people to HIV?
- What challenges do people of Fundong health district face in the prevention of HIV?

1.4 GENERAL OBJECTIVE

To assess the cultural determinants in the transmission of HIV in Fundong Health District

1.5. SPECIFIC OBJECTIVES

- To identify traditional practices affecting HIV/AIDS epidemic in Fundong Health district.
- To investigate sexual behaviors that predisposes the community to HIV transmission.
- To examine challenges faced in Fundong Health District in the prevention of HIV.

Methods

2.1 STUDY AREA

Fundong Health District is one of the 19 Health Districts in the North West Region of Cameroon. It covers a surface area of 145 km², about 4/5th of the land surface area and population of the Boyo Division. It is bordered by Ndop and Kumbo West Districts to the East, to the West by Wum to the North by Nkambe and to the South by Tubah and Bafut Health Districts respectively. The District head-quarter, Fundong is about 88km from Bamenda the Regional headquarter and the two are linked by a tarred road. The District is made up of 3 out of the 4 subdivisions which make up Boyo Division, namely: Fundong, Njinikom, and Belo, though there is an extension into the 4th subdivision (Bum) because of the Konene Health Area. The District is generally hilly with most of the towns located on hills and valleys like Fundong and Njinikom, except Belo which is separated by deep valleys. The terrain is generally difficult for travel in that; it is hilly; rocky with fast flowing streams rendering the limited road infrastructures in a poor state most of the time. Local efforts at road maintenance are usually not adequate due to the state of the terrain. Most of the Health Areas are relatively inaccessible throughout the year; one of them (Mbengkas) is totally cut off from the District Headquarters. The District has typical savannah grassland with eucalyptus growth. Forest of the equatorial tropical type is found in parts of Mentang, Kikfuini and Mbengkas Health Areas. The population of Fundong health district in 2019 was estimated to be 158245.

2.2. STUDY POPULATION

The study population was HIV patients who receive HAART at the main treatment centers of Fundong District Hospital and St. Martin de Porres Catholic General hospital Njinikom. These treatment centers receive patients from different parts of the health district and serve as referral hospitals for 27 different health centers. All individuals tested positive for HIV in the health district

during voluntary counseling and testing, and are strictly followed up by community health workers and the nurses to be linked to treatment centers.

2.2.1. INCLUSION CRITERIA.

- HIV/AIDS patients receiving HAART in the treatment center.
- Adult patients age 15-49 years
- Indigenes and residents of Fundong Health District
- Those who willfully signed the consent form

2.2.2. EXCLUSION CRITERIA

- Non HIV/AIDS patients.
- Children below 15 years
- Those who are not both indigenes and residents of Fundong Health District
- Those who refused to willfully sign the consent form

2.3. STUDY DESIGN

A cross sectional descriptive study design was used to collect data for the study targeting the patients who receive HAART in the health district.

2.4. SAMPLING METHOD

A systematic sampling technique was used to collect data from the participants. The total population of patients who receive treatment from these two centres was about 2820. The population size was divided by the proposed sample size (2820/288) with a result of approximately 10. A simple random sampling was done from the 10 participants and the random number chosen was 3. A sampling frame was drawn from daily patients received in the treatment centers. Questionnaires were administered on an interval of 3 patients each day until the desired sample size was achieved.

2.5. DETERMINATION OF SAMPLE SIZE

According to Chika O (6), the following formula was used;

$$n = \frac{Z^2 \times P \times (1-P)}{d^2}$$

Where

n= the desired sample size

Z=the standard normal deviate usually set at 1.96, which corresponds to the 95% confidence interval

P= the adult prevalence rate of HIV in Fundong Health District which is 7.4%

d=the degree of accuracy desired set at 0.05

Therefore;
$$n = \frac{(1.96)^2 \times 0.074 \times (1-0.074)}{(0.05)^2}$$

$$=3.84 \times 0.074 \times 0.926$$

$$0.0025$$

$$=105.25$$

Adding 10% attrition rate will give $105.25 + 10.5 = 114.75 = 115$

Due to the cooperativeness of patients and to make the sample size robust, it was increased to 288.

2.6. DATA COLLECTION

Data collection was done with the use of a structured questionnaire with open and closed ended questions. The questionnaire was divided into four sections. Section A contained the demographic data, section B was the challenges face by HIV patients, section C contained sexual behavior and section D was the traditional beliefs of the participants. The questionnaires were inserted into envelopes with pens for confidentiality and were self-administered.

2.7. DATA ANALYSIS

Data analysis was done with the use of Statistical Package for Social Science (SPSS) Inc. version 22. Pearson chi-square was used to find the significant differences. The level of significance was set at 5% with a 95% confidence interval.

2.8. DATA PRESENTATION

Data was presented with the use of tables and figures.

2.9. ETHICAL CONSIDERATION

A research proposal was submitted to the researcher's supervisor which upon approval led the researcher to obtain ethical clearance from the ethical committee of UNTH. An application for authorization, a copy of the ethical clearance and the research proposal was submitted to the Regional Delegate of Public health for the NWR of Cameroon. The delegate issued an authorization for the researcher to carry out the research in the health district. An application to carry out research was written to the Director of Fundong District Hospital and the Matron of St. Martin de Porres Catholic General Hospital Njinikom. The participants were politely met and provided with explanation of the study. A written informed consent form was signed by the participants who voluntarily agreed to participate in the study. Consent was taken from parents for participants who were minors. Information in the consent form consisted of the aim of the study, benefits of the study, right to participate or withdraw, and assurance for confidentiality. Nurses working in the treatment centers where the study took place helped in the interpretation of the content of the consent form in the local language (Kom) to participants who were illiterate.

2.10 LIMITATION OF THE STUDY

The main limitation of the study was the illiteracy of the HIV patients. As of the patients are unable to read and write, such nurses who speak the local Kom language were recruited to facilitate the administration of the questionnaire

Results

DEMOGRAPHIC DATA

A total of 288 participants completed the survey. Tables 1 and 2, more than three-quarters of the respondents were females (75.7%). The majority was mostly farmers (54.9%), practiced monogamy (47.2%) and was Catholics (45.8%). Mean age is 39 SD ± 1.4 . The larger number of respondents was married (47.2%) and belongs to the age group 30-39 (25.7%). A total majority of those who were singles (9.8%) were above 40 years. In figure 1, half of the respondents (50%) had primary education as their highest educational level.

Place of residence of spouses, number of sexual partners and condom use

According to tables 3 and 4, majority of the respondents (63.9%) had their spouses living with them in Boyo division (Fundong health district) and most had only one sexual partner (70.2%). Even though they are HIV positive, 30 patients (12.3%) have 2 or more sexual partners. There is no significant difference between place of residence and number of sexual partners ($P=0.99$).

A cumulative majority of respondents (63.9%) do not use condoms consistently. The main reason for non-use was refusal by their partners as reported by 30% of the participants ($P=0.000$).

Cultural practices

It can be seen in Table 5 that most of the respondents with a cumulative percentage of 90.3% reported the existence of the practice of wife inheritance in the health district; married women have extra marital sex to get pregnant as reported by a cumulative percentage of 52.2% and they practiced post-partum abstinence (59%). It can be seen in Figure 2 that majority of the respondents (75.54%) refuted the practice of wife sharing while a cumulative minority of 17.27% confirmed frankly that the practice exists.

Sexual Behaviors And Challenges Faced

In Table 6, of the respondents with a partner over two-thirds (69%) said their partners are aware of their HIV status, while 31% did not disclose their status to their partners. The main reason for women engaging in extra marital sex is poverty, as reported by half of respondents (50.7%). Table 7, shows 90.8% of respondents does not take drugs and 75% have never had anal intercourse. A total of 5.8% of respondent takes drugs and also have had anal intercourse with their partners, the relationship is statistically significant ($P=0.04$). According to Figure 3, a total overwhelming majority of 90.97% said men have more than one sexual partner in the health district and can be seen in Figure 4 that most of the respondents (53.28%) faced the problem of poverty to undergo paid immunological and biological tests and hampers their transportation to the treatment centres to collect free drugs.

Discussion

Demographic results shown in Table 1 indicate that most of the respondents were females (75.7%). A majority of 54.9% were mostly farmers. Farming is the main activity in this district where women labor mostly in domestic roles in the farm and kitchen. The majority of the people were Catholics (45.8%). Catholicism is the most religious denomination in Fundong Health District moreover one of the hospitals where the study was carried out is a Catholic institution. Contrary to the polygamous nature of the Kom people, a majority of the respondents practiced monogamy (47.2%). The monogamous nature of the people's marriages is a key factor in HIV prevention. According to Table 2, 47.2% of respondents were married, 27.7% belong to the age group 30-39. Of those who were singles (9.8%) were above 40 years. There is a significant difference between age and marital status ($p<0.05$). The older the single person is the higher the propensity of exposure to HIV because women who marry late have more life time sexual partners with high premarital sex which is an important factor HIV acquisition (7).

From Figure 1, half of the respondents (50%) had primary education as their highest educational level. The high rate of HIV in women is partly due to their lack of knowledge and control of their health (8). Maureen Mswela (9) in South Africa found out that young girls are affected mostly by lack of education, which exposes them to unplanned pregnancies, early marriages, and vulnerability to HIV infection.

From Table 3 a majority of the respondents (63.9%) had their spouses living with them in Boyo division (Fundong health district) and had only one sexual partner (59%). Most of the participants live with their spouses in their various villages this may be the reason why most of them have one sexual partner. However there is no significant difference between place of residence of their spouses and their number of sexual partners ($P=0.99$). Living together with spouses is not a guarantee for having one sexual partner hence place of residence of spouses does not determine the number of sexual partners an individual will have but self-control and attitude does. Even though they are HIV positive, 9.7% of respondents have two or more sexual partners. The

practice of multiple partners propagates the spread of the virus to uninfected individuals, and the contraction of new strains of viruses which may lead to drug resistance.

According to Table 4 a total majority of respondents (52.8%) used condoms inconsistently or not at all and their main reason for the non-use was refusal by their partners (25%). There is a significant difference between inconsistent use of condoms and the reasons for non-use ($p < 0.01$). Men most often refuse the use of condoms in Africa (10).

From Table 5 almost all of the respondents (90.3) confided that there is a practice of wife inheritance in Boyo division. Wife inheritance is still a predominant practice in Africa especially in the rural areas where women are persuaded to have sexual intercourse with their inheritors even with unknown HIV status (11).

Slightly more than half of the participants (52.2%) confided that married women had extra marital sex to get pregnant if their husbands cannot impregnate them. A similar study was carried out in Tanzania by Sylvester DB Ndile and Bashemera (12) who discovered in some tribes, close relatives of barren couples are said to have unprotected sexual intercourse with women in order to impregnate them and after which are restored to their husbands; a practice which can expose the couples to HIV.

The majority of the respondents (59%) said sex is prohibited between couples during the post-partum period. This is cultural practice which prevents the man from having sex with the nursing mothers was to allow healthy growth of the baby and recovery of the mother. It is a good means of birth control but unfortunately men always seek sex during this period outside of their marriages thereby exposing themselves to HIV infection which may one of the reasons for high prevalence in the region.

More than three-quarters of the respondents (75.5%) from Figure 2 said wife sharing is not practice in Fundong Health District while a total minority of 17.27% confided frankly that the practice exists. This practice, if done for sex increases the risk of HIV infection if any of the partners is infected with the virus (13).

According to the Figure 3 a total overwhelming majority of 90.97% said men have more than one sexual partner in the health district. A similar study carried out by Constance R Ambassa-Shisanya (14) in Western Kenya concluded that a preference for multiple sexual partners in men is one of the cultural factors that render girls and women vulnerable to HIV infection.

According to Table 6, of the respondents with a partner, over two-thirds (69%) said their partners are aware of their HIV status, while 31% did not disclose their status to their partners. The dangerous practice of not disclosing positive HIV status to a partner may be due to fear of loss of the partner or avoidance of stigmatization, but this predispose the uninfected partner who is unaware of the status of the patient to take necessary precautions hence HIV infections increases in the community.

The main reasons for women engaging in extra marital sex in Fundong Health District is due to poverty (50.7%) and sexual satisfaction (29.9%). The results are similar to that of Janet W. McGrath et al (15) in Kampala Uganda where they stated that despite the prohibition of sex outside marriage, study participants reported that there are some conditions when a woman may engage in extra marital sex, including economic need ($p < 0.05$); desire for greater sexual satisfaction ($p < 0.01$).

According to Figure 4, majority of 53.28% of respondents said the main difficulty faced by HIV patients was poverty. They patients complained that they faced the difficulties of transporting themselves on monthly basis from their various villages to the treatment centers to take their routine drugs. This may lead to missed appointments and non-compliance with HAART, viral load increment and drug resistance, declining health and increasing transmission rate. Other primary challenges faced were stigmatization (20.44%), daily drug intake (18.98%) and drug compliance (7.299%).

Conclusion

The survey based research in the health district has identified traditional practices; and sexual behaviors in the community as well as; challenges and support HIV patients receive. It can be concluded that wife inheritance, wife sharing, extramarital sex for pregnancy are practiced in the community. A greater majority of the patients do not use condoms because of the refusals by their partners while almost all the patients agreed that men have more sexual partners in the community. A few patients confided that men exchange their wives like kolanuts with other men for sexual exploration and satisfaction. There is also the

practice of postpartum abstinence in the health district. It is forbidden for men to have intercourse with their wives during breast feeding because it is believed that woman during this period are weak and this leads men to engage in extra marital sex with other women thereby exposing themselves to HIV infection.

The main problem faced by HIV patients is poverty. They find it difficult to transport themselves on monthly basis from their various villages for appointments at the treatment centers. Due to this difficulty in transportation, most of them do not have access to constant HAART leading to an increase in viral load and high rate of transmission of the virus. The relevance of this study is to uncover harmful cultural practices and create awareness to national and international bodies for prompt interventions in rural Africa to curb the spread of HIV.

Recommendations

1. Sensitization campaigns should be held in African villages with the traditional leaders and community members, focusing on the dangers of harmful cultural practices like wife inheritance and wife sharing.
2. International organizations should organize seminars for health personnel working in the treatment centres in the district to enable them to acquire skills to carry out proper health education to HIV patients on harmful socio-cultural practices in the community.
3. Non-governmental organizations should empower the women economically through loans and other means to promote financial autonomy and to mitigate the health effects of poverty.
4. Various social groups for men should be targeted to sensitize them on the importance of condoms use since men hold the power to decide on its use.
5. The campaign of abstinence, proper condom use and fidelity should be reinforced in the community by all health personnel working in different units in the district. Posters should be in place in strategic places and in all drinking spots for awareness creation.
6. Men with sexual weakness should seek proper medical attention for help. There should be sexual communication between married couples. This will improve their sexual life and increase greater sexual satisfaction in order to prevent extra marital sex by women as revealed from the study.
7. The divisional and regional delegations of social affairs and women empowerment should collaborate to lobby with traditional leaders on harmful cultural practices which portray women to be objects of sex.
8. African parliaments should send bills to be enacted into law prohibiting forceful wife inheritance.
9. Empowerment and education of the girl child is pivotal in the prevention of HIV transmission.

Abbreviations

PEPFAR: United States President's Emergency Plan for AIDS Relief

PLHIV: People living with HIV

GRC: Government of Cameroon

ART: Anti-Retroviral treatment

PMTCT: Prevention of Mother to child Transmission

HIV: Human Immunodeficiency Virus

AIDS: Acquired Immune Deficiency Syndrome

NWR: North West Region

FHD: Fundong Health District

UNAIDS: Joint United Nations Programme on HIV/AIDS

DHS-MICS: Demographic Health Survey and Multiple Indicators Cluster Survey

HAART: Highly Active Anti-Retroviral Treatment

PLWHA: People living with HIV and AIDS

UNTH: University of Nigeria Teaching Hospital

NACC: National AIDS Control Committee

Declarations

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Tables

Table 1 Distribution of respondents according to Gender, Occupation, Type of marriage and Religion

Variables	Frequency	Percentage
Gender		
Male	70	24.3
Female	218	75.7
Total	288	100.0
Occupation		
Farming	158	54.9
Retired	4	1.4
Unemployed	24	8.3
Employed	48	16.7
Business	42	14.6
No response	12	4.2
Total	288	100.0
Type of marriage		
Monogamy	136	47.2
Polygamy	72	25.0
No response	80	27.8
Total	288	100.0
Religion		
Catholic	66	45.8
Presbyterian	17	11.8
Pentecostal	8	5.6
Baptist	47	32.6
Islam	2	1.4
No response	4	2.8

More than three-quarters of the respondents were females (75.7%) who were mostly farmers (54.9%), practiced monogamy (47.2%) and were Catholics (45.8%).

Marital status	Age range						Total (%)	P-Value
	15-19	20-24	25-29	30-39	40-44	45-49		
Single	4(1.3%)	18(6.3%)	10(3.5%)	20(6.9%)	14(4.9%)	14(4.9%)	80(27.8)	0.01*
Married	4(1.3%)	2(0.7%)	28(9.7%)	36(12.5%)	28(9.7%)	38(13.2%)	136(47.2)	
Widow/widower	0(0%)	0(0%)	2(0.7%)	14(4.9%)	10(3.5%)	18(6.3%)	44(15.3)	
Divorced	0(0%)	0(0%)	0(0%)	4(1.3%)	6(2.1%)	2(0.7%)	12(4.2)	
Total	8(2.8%)	20(6.9%)	40(13.9%)	74(25.7%)	58(20.1%)	72(25%)	272(94.4)	

*Relationship is significant at level of $p < 0.05$

Mean age is 39 SD \pm 1.4

A majority of respondents were married (47.2%) and belong to the age group 30-39 (25.7%). A total majority of those who were singles (9.8%) were above 40 years.

Place of residence of your spouse	How many sexual partners do you have?				Total (%)	P-Value
	1	2	3 or more	0		
South West region	14(4.9%)	2(0.7%)	0(0%)	12(2.1%)	22(7.6)	0.99
Littoral region	2(0.7%)	0(0%)	0(0%)	0(0%)	2(0.7)	
Central region	4(1.4%)	2(0.7%)	0(0%)	0(0%)	6(2.1)	
Boyo division	130(45.1%)	18(6.3%)	4(0.7%)	68(11.8%)	184(63.9)	
Others	20(6.9%)	4(1.4%)	0(0%)	8(1.4%)	28(9.7)	
Total	170(59%)	26(9%)	4(0.7%)	88(15.3%)	242(84)	

From the table above, majority of the respondents (63.9%) had their spouses living with them in Boyo division (Fundong health district) and had only one sexual partner (59%). Even though they are HIV positive a cumulative majority of 30 patients (9.7%) have 2 sexual partners and more.

Table 4. Distribution of respondents according to frequency of use of condoms and reasons for the non-use						
How often do you use condom during sex	What reasons would you give for the non-use of condoms				Total (%)	P-value
	My partner always refuse the use of condom	It's against my belief	Condom makes sex un-enjoyable	I am married		
Very often	22(7.6%)	12(4.2%)	42(14.6%)	10(3.5%)	86(29.9)	0.000*
Sometimes	36(12.5%)	14(4.9%)	10(3.5%)	10(3.5%)	70(24.3)	
I don't use condom	14(4.9%)	40(13.9%)	12(4.2%)	16(5.6%)	82(28.5)	
Total	72(25%)	66(22.9%)	64(22.2%)	36(12.5%)	238(82.7)	

*Relationship is significant at level of $p < 0.05$

A total majority of respondents (52.8% do not use condoms consistently and their main reason for the non-use was refusal by their partners (25%).

Table 5 Distribution of respondents according to some harmful cultural practices

Variables	Frequency	Percentage
When a man dies his wife is inherited by his relative in the family		
Yes		
No	224	77.8
It's not done in secret	26	9.0
It's done in some other villages in Boyo	10	3.5
No response	26	9.0
	2	.7
Married women have extra marital sex to bear children if the husband cannot impregnate them		
Yes		
No its not done		
It is done in secret		
It is done in some other villages in Boyo	52	18.1
No response	130	45.1
	88	30.6
A man does not have sex with his wife within 6 months after she puts to birth	10	3.5
Yes	8	2.8
No		
I am not aware		
No response	170	59.0
	68	23.6
	42	14.6
	8	2.8

Most of the respondents with a cumulative percentage of 90.3% said there is a practice of wife inheritance in the health district; married women have extra marital sex to get pregnant as reported by a cumulative percentage of 52.2% and they practiced post-partum abstinence (59%).

Table 6. Distribution of respondents according to Awareness of HIV status and Reasons married women indulged in extra marital sex.

Variables	Frequency	Percentage
Is your partner aware of your HIV status?		
Yes		
No	168	58.3
I do not have a partner	74	25.7
	46	16.0
Reasons married women have extra marital sex in this community		
Sexual satisfaction		
Loneliness		
Poverty	86	29.9
No response	32	11.1
	146	50.7
	24	8.3

More than half of the respondents (58.3%) said their partners are aware of their HIV status while a minority of 25.7% did not disclose their status to their partners. The main reason for women engaging in extra marital sex is due to poverty as reported by half of respondents (50.7%).

Table 7 Distribution of respondents according to Drugs intake and Intercourse through the anus.

Do you take any drugs to stimulate yourself?	Have you ever had intercourse through the anus with your partner?		Total	P-Value
	Yes	No		
Yes	14(5.8%)	4(1.7%)	18(7.5%)	0.04*
No	10(4.2%)	208(86.7%)	218(90.8%)	
It's done in secret	0(0%)	4(1.7%)	4(1.7%)	
Total	24(8.3%)	216(75%)	240(100%)	

*Relationship is significant at level of $p < 0.05$

90.8% of respondents do not take drugs and have never had anal intercourse (75%). A majority of 5.8% who takes drugs also had anal intercourse with their partner.

Figures

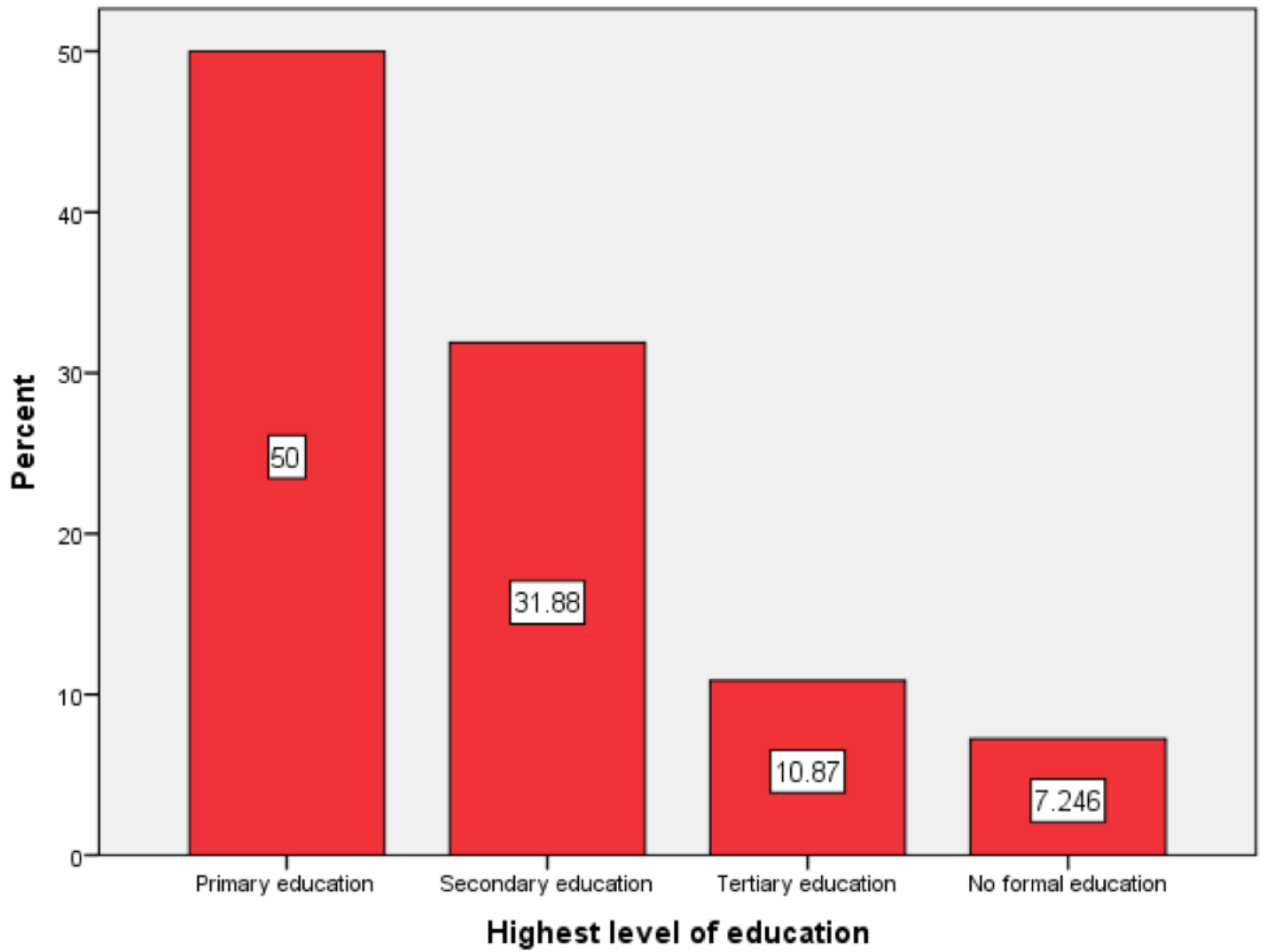


Figure 1

Distribution of respondents according to Educational level

From the figure above half of the respondents (50%) had primary education as their highest educational level.

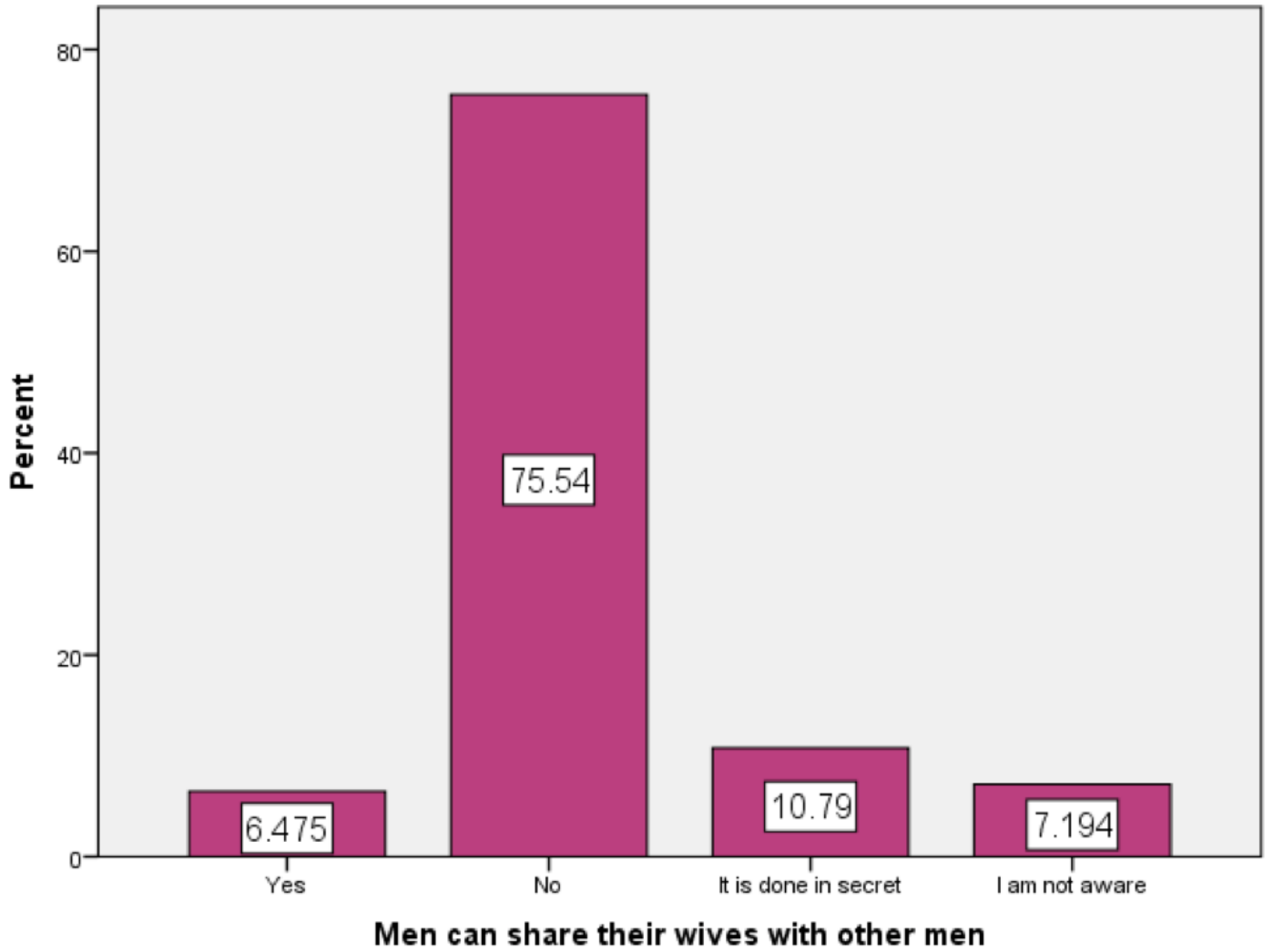


Figure 2

Distribution of respondents according to Wife sharing

Majority of the respondents (75.54%) said wife sharing is not done while a cumulative minority of 17.27% confirmed frankly that the practice exists.

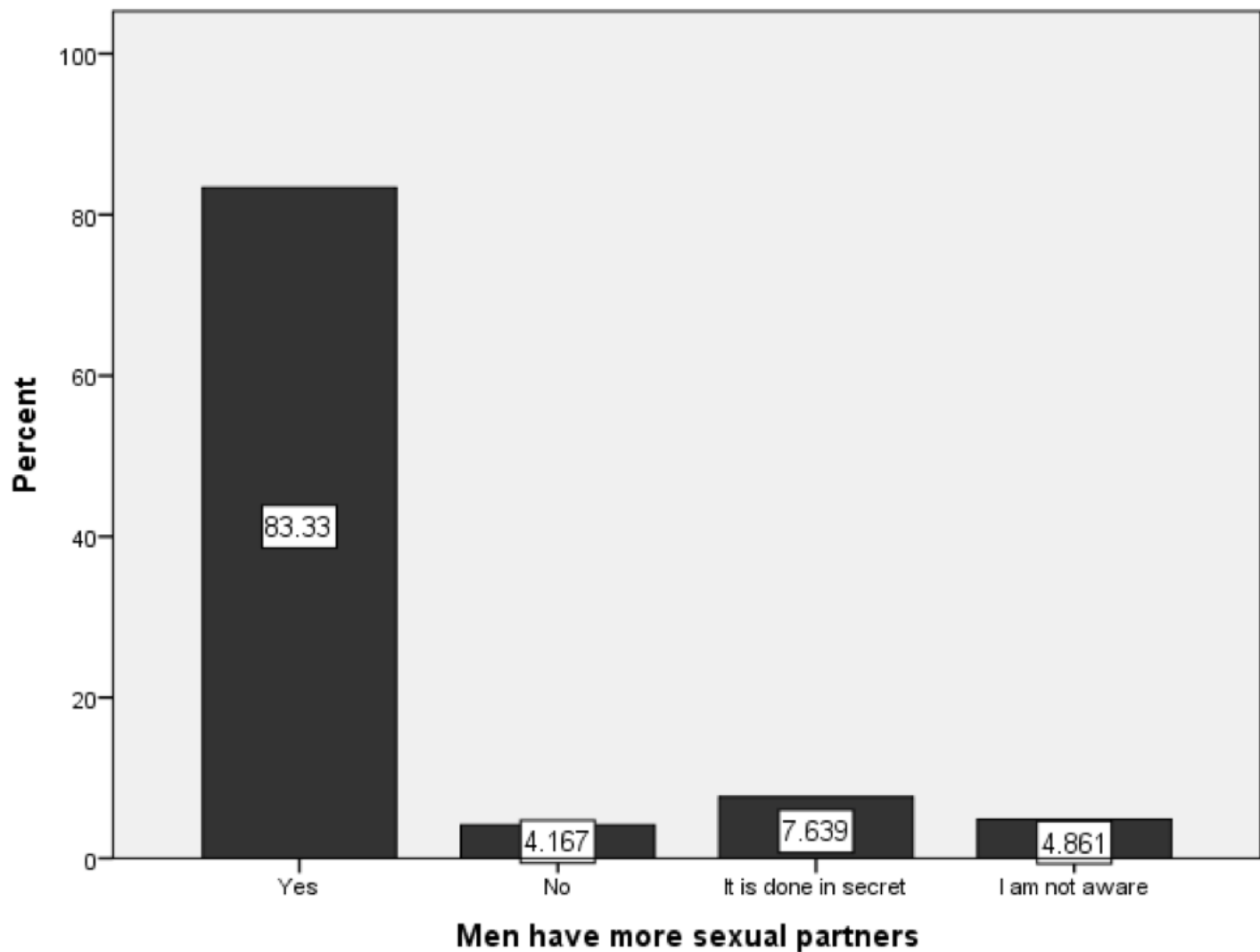


Figure 3

Distribution of respondents according to number of sexual partners by men

According to the figure a total overwhelming majority of 90.97% said men have more sexual partners in the health district.

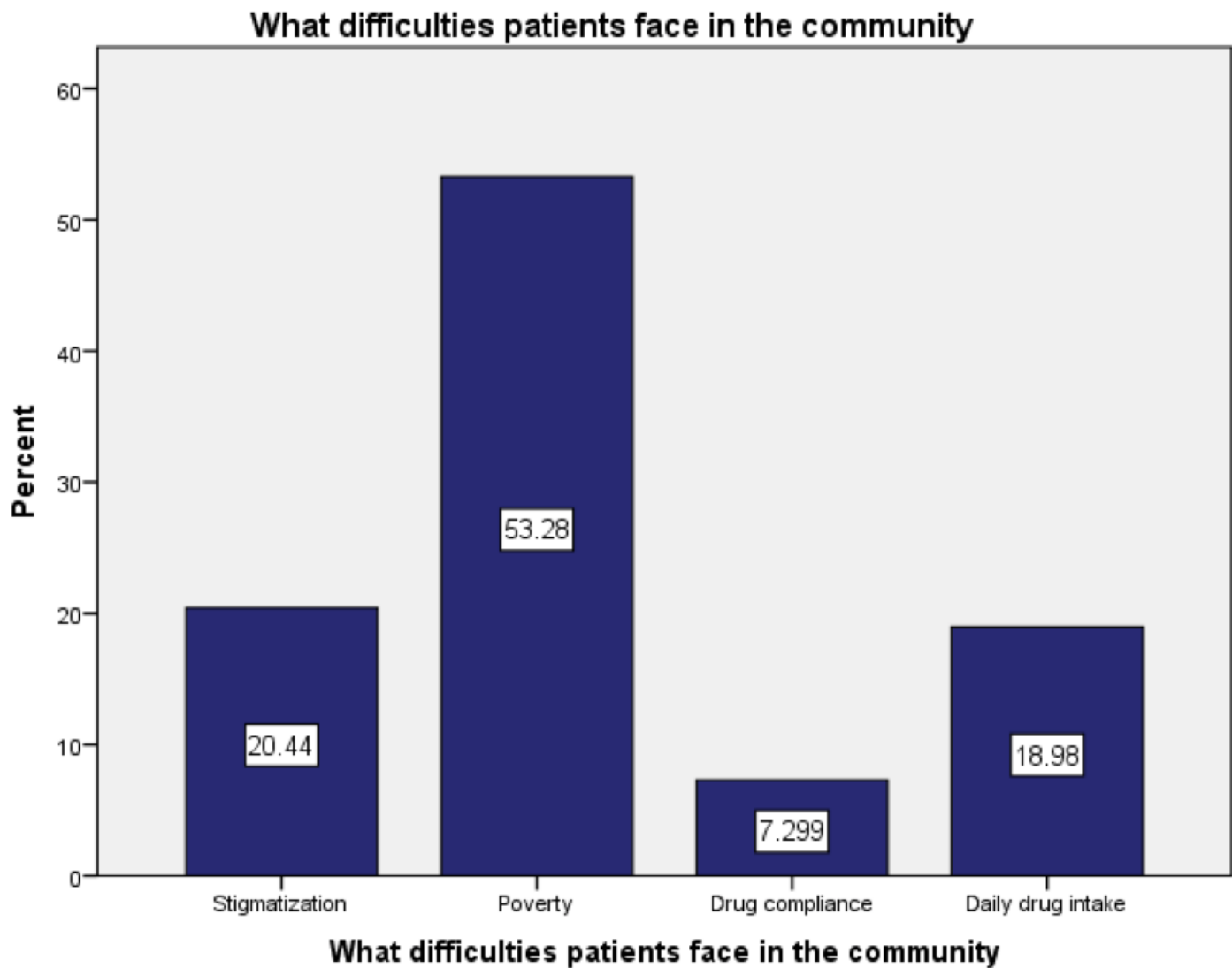


Figure 4

Distribution of respondents according to difficulties faced by patients

A majority of 53.28% of respondents faced the problem of poverty.