



An Analysis of HIV Risk Practices Amongst Women of Child Bearing Age in Aba Municipal of Abia State

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Abstract: *The study analyzed the HIV risk practices amongst women of child bearing age in Aba municipal of Abia State. To guide the study, specific objective with corresponding research questions were posed and hypotheses postulated. The descriptive survey design used a sample of 343 or 10% of the population selected through random sampling by balloting without replacement. A self designed researcher made questionnaire served as the research instrument while data generated were analyzed using t-test and ANOVA statistics. The findings show that the independent variables of age, level of education had significant difference on the knowledge of all dimensions of HIV risk while level of education had significant differences in attitude to one dimension of HIV risk. Conclusions and relevant recommendations were made to checkmate the ugly trend in Aba municipal of Abia State.*

Keywords: *Age, HIV risk practices, women of childbearing*

Introduction

In the developing countries, there has been a changing pattern of male and female HIV infections. Early cases in many countries were concentrated in male homosexuals and intravenous drug users. But as the epidemic increases to spread, there has been a progressive shift towards heterosexual transmission and increasing infection rates among females. Globally today more women than male are dying of HIV/AIDS and the age practices of infections are significantly different for the two sexes.

Globally, over 80% of adolescent girls and young women aged 15-24years living with HIV are in sub-Saharan Africa. The number is also true of the new HIV infections among adolescent girls and young women remains exceptional with about 45,000 (380,000, 530,000) new infections estimated in 2015 (Joint United Nations Program on HIV/AIDS, (UNAIDS, 2016). Some of the adolescents and young women acquire HIV petinatally while many are infected through heterosexual intercourse.

The situation in Nigeria is not different from the global trend that One Million, Twenty three thousand and seventy-three (1,023,073) reported in 1994 are cumulative AIDS cases in both adults and children represented 20% increase (World Health Organization, (WHO,2005). The fact that thousands of teenagers might be carrying AIDS virus without full manifestations is

another dimension to this pandemic. The situation became worse and frightening when WHO projected that 30-40 million people would be carrying HIV infection by the year 2000.

Sexual transmission is widely reported as a singular most important mode of transmission especially productive age bracket of 15-49 years of both gender (Doyle, Mavedzenge, Plummer and Ross, 2012). The youths who are more sexually active are more susceptible to the disease since casual and multiple partners' sexual habit is one of the major causes.

The modes of transmission of all sexual transmitted diseases (STDs) is through close contacts and sexual intercourse while AIDS is both through sexual intercourse, blood product or transmission and from mother to infant (Pettifor, Macphail, Ross and Cohen, 2008). Other type include explosive behaviours such as sharing needles or having sex without condom. Some explosives to HIV carry a much higher risk transmission than other explosives. However, while transmission is biologically possible, the risk is so low that it is not possible to put a precise number on it. But risks do add up overtime and lead to a higher lifetime of getting HIV (Pettifor, Macphail, Ross and Cohen, 2008).

Analyzing the current HIV situation and trends in Nigeria, Federal Ministry of Health (FMOH, 2008) reported that women aged 15-49years and men aged 15-64years has a national prevalence of 36% risk. The report said the prevalence was higher among females compared to males in each of the geo-political zones with the exception of the North West zone. The age-disaggregated data from 2007 FMOH, shows that females have higher HIV zero prevalence at all ages except in the youngest and oldest age groups (15-19 and 45-49). The highest HIV prevalence among the general population for both sexes is the forth decade of life (age 30-39 years that is, 5.7%) for females and 5.1% for males. Among females the next highest level is in the age group of 25-29years (4.7%) (FMOH, 2008).

The HIV trends among pregnant women show the result of the antenatal care (ANC) Sero-Surveillance Surveys of an increase from 1.8% in 1991 to 5.8% in 2001, followed by a decline to 5.0% in 2003 and to 4.4% in 2005. The 2005 survey showed a slight increase to 4.6% (FMOH, 2009). Women of childbearing age refer to women between 15-49 years. World Health Organization (WHO, 1988) asserted that some groups of childbearing women are more at risk than others. WHO reports that teenage girls under the age of 15 or in mid or late forties have the high risk of pregnancy related complication.

Health risks of teenage childbearing for both mother and baby are serious including pre-eclampsia or eclampsia toxemia, obstetric, fistulae, obstructed labour, anaemia, malnutrition, low birth weight and prenatal mortality. The social costs of teenage pregnancies are high. Teenage pregnant girls are threatened with school expulsion and ostracism by their families and often seek to terminate their pregnancies (unsafe abortion), leading to obstetric complications or death (Population Reference Bureau, 1992).

Childbearing is hazardous for older women and obstetric risks associated with this age include uterine atomy, obstetrics hemorrhage and Sepsis (Myles, 2003). However, among the child-

bearing women in Sub-Saharan Africa, one out of every five new HIV infections happens among adolescent girls and young women. In the worst affected countries, 80% of the new HIV infections who are up to eight times are more likely to be living with HIV than adolescent boys (Wilson, Wright, Safrit and Rudy, 2010). It is estimated that around 50 adolescent girls die every day from AIDS related illness (Harrison, Colvin, Kuo, Swartz and Lurie, 2015).

HIV disproportionately affects women and girls because of their unequal cultural, social and economic status in society (Rodrigo and Rajapakseb, 2010). Intimate partner violence, inequitable laws and harmful traditional practices reinforce unequal power dynamics between men and women with young women particularly disadvantaged. HIV is not only driven by gender inequality but also entrenches gender inequality, leaving women more vulnerable to its impact (Rodrigo *et al*, 2010).

In some countries, women face significant barriers to accessing healthcare services. These barriers occur at the individual interpersonal, community and societal levels (Pettifor, Rees, Kleinshmidt, Steffenson, Macphail, Hlongwa-Madikizela, 2005). Barriers take many forms including denial of access to services that only women require, discrimination from service providers that stems from views around female sexuality and poor quality services. Procedures relating to a woman's sexual and reproductive health (SRH), performed without consent, including forced sterilization, forced virginity examinations and forced abortions also deter women from accessing services (Pettifor *et al* 2005; Pettifor, Macphail, Rees and Cohen, 2008). In some cases, health care providers do not fully understand laws around childbirth and HIV. This can lead to HIV-positive women choosing to have an abortion because they are misinformed about their options and how to protect their health as well as their children (Stockl, Kalva, Jacobi and Watts, 2013).

Additionally, in 29 countries women require the consent of a spouse or partner to access sexual and reproductive health services. A lack of access to comprehensive HIV and sexual reproductive health services means that women are less able to look after their sexual and reproductive health and rights (SRHR) and therefore reduce their risk of HIV infection.

A review of evidence from Latin America and Caribbean relating to HIV-positive women's use of and access to sexual reproductive health services found women living with HIV experiences more unplanned pregnancies, more included abortions, a higher risk of immediate sterilization after birth and higher exposure to and institutional violence, compared to HIV-negative women (Rodrigo and Rajapakseb, 2010).

In 45 countries, organizations cannot legally provide sexual reproductive health and HIV services to people under 18 years without parental consent (Harrison, Colvin, Kuo, Swartz and Lurie, 2015). For others in some countries, doing this is an offence linked to encouraging prostitution or the trafficking of minor (Pettifor, *et al*, 2005).

Closely related to this is the finding taken from evidence gathered in 28 Sub-Saharan African Countries, that 52% of adolescent girls and young women in rural areas and 47% in urban areas

are unable to make decisions about their own health. Research into attitudes towards sexual and reproductive health among adolescent girls in Ghana found varying degrees of negative social and community norms, attitudes and beliefs about adolescent girls' sexuality. The study found that adolescent girls tended to endorse these stigmatizing attitudes, and also observed or experienced sexual reproductive health services related stigma regularly (UNAIDS, 2015).

Adolescent girls and young women belonging to groups most affected by HIV are also negatively affected by laws that criminalize injecting drug use, sex work and homo-sexuality (Chama, 2004). Studies have shown that increasing educational achievement among women and girls is linked to better sexual reproductive health services out-comes include delayed childbearing, safer abortions, lower rates of sexually transmitted infections (STIs) and unintended pregnancies (UNAIDS, 2015).

Women with more education tend to marry later, bear children later and exercise greater control over their fertility (Clark, 2002). Despite this, in the least developed countries in the world, 60% of girls do not attend secondary school. Research has shown the direct correlation between girls' educational attainment and HIV risk; uneducated girls are twice as likely to acquire HIV as those who have attended school (Abdulkarim and Mohammed, 2008).

Poverty is an over arching factor that increases vulnerability to and the impact of HIV. The poorest women may have little but to adopt behaviours that may put them at risk of infection including transactional and intergenerational sex, early marriage and relationships that expose them to violence and abuse. Poorer and less-educated women may be less knowledgeable about risks and therefore less able to adopt HIV-risk-reducing behaviours (Anandalaskshary, Talwar, Buckeshee and Hingorani, 2002).

The risk of trafficking and sexual exploitation is also higher for young women and adolescent girls especially those living in poverty. At some point in life time, one in three women will experience physical or sexual violence from a partner or sexual violence from a non-partner or sexual abuse. In conflict settings and among refugee populations, seven out of ten women will experience sexual violence and or gender-based violence (Leclerc-Mahlala, 2008). Violence prevents young women from protecting themselves against HIV. In some regions, it has been estimated that women who experience intimate partner violence are as much as 1.5 times more likely to acquire HIV (Jenkes, Dunkle, Nduna and Shair, 2010).

Age desperate sexual relationships between young women and older men are common in many parts of the world, with particularly high levels in both East, South, West and Central Africa. For instance, these relationships are transactional in nature, in that they are non-commercial, non-marital sexual relationship motivated by the implicit assumption that sex will be exchanged for material support or other benefits. This assumption arises from harmful gendered expectations of intimate relationships, namely that men are responsible for providing sexual and domestic services. Many of these relationships include shared emotional intimacy, with people referring to themselves as boyfriends, girlfriends or lovers (Leclerc-Mahlala, 2008). Research indicates

that in sub-Saharan Africa, transactional sex is one of the key factors in women's heightened vulnerability to HIV and other STIs. Growing evidence suggests transactional relationships are likely to involve high risk sex and low condom use (Audu and Ekele, 2002).

A long term study of age-desperate sex and HIV risk for young women took place between 2002 and 2012 in South Africa. It is estimated that in South Africa a third of sexually active adolescent girls will experience a relationship with a man at least five years older. The study found that a cycle of transmission whereby high HIV prevalence in young women was driven by sex with older men (on average of 8.7years older) who themselves had female partners with HIV, many of whom had acquired HIV as young women (Audu and Ekele, 2002).

To demonstrate a link between the sizes of the age gap in age desperate relationships with HIV, researchers working in Zimbabwe found that when a young woman is in a relationship with a man that is older than her, she is more at risk of acquiring HIV if the age gap is 10years or more. Researchers found that older men had consistently higher HIV prevalence than younger men, thus exposing young women to an increased risk of HIV infection-particularly given the generally low levels of condom use which were also associated with this difference (Leclerc-Mahlala, 2008).

Goal

Specifically, the goal of the study was to determine the knowledge, cause and attitude of childbearing women and adolescents to HIV risk in Aba Municipal.

Research Questions

1. What are the levels of knowledge of causes of HIV risk practices among women of childbearing age in Aba Municipal?
2. What are the levels of knowledge of HIV risk practices among childbearing women according to location/age in Aba Municipal?
3. What are the differences in the level of knowledge of HIV risk practice by the women according to their educational level?

Research Hypotheses

1. There is no significant difference in the level of causes of HIV risk practices among women of childbearing age in Aba Municipal.
2. There is no significant difference in the level of knowledge of HIV risk practices among childbearing women according to age/location.
3. There is no significant difference in the level of knowledge of HIV risk practices among childbearing women according to educational level.

Method

To achieve the goal of the study, descriptive survey design was employed. The population consists of women of childbearing age totaling 3600 from all the hospitals in Aba Municipality. The procedure for sample selection involved two stages. The first stage was stratified random sampling used to stratify the health facilities located in the area of the study. The second involved the use of simple random sampling procedure of balloting without replacement to select all the health facilities in the municipality. A researcher made questionnaire served as the research instrument. The respondents were required to indicate the degree of agreement or disagreement as follows: Strongly Agree (SA), Agree (A), Disagree (D), and Strongly Disagree (SD) with assigned values of 4, 3, 2, and 1 for positive items and 1, 2, 3, and 4 for negative items respectively. The data generated were analyzed using T-test and ANOVA statistics

Results

The results of the study was organized and presented in two parts thus: data answering the research questions and data testing the null hypothesis.

Question One

What are the levels of knowledge of causes of HIV risk practices among women of childbearing age?

Table 1: Level of knowledge of causes of HIV risk practices (KCHIVRP) among women of childbearing age (n = 343)

	n	x	%
KCHIVRP	343	65.48	

Data in table 1 shows a mean score of 65.48% which fell between 60-80%. This implies that the level of knowledge of causes of HIV risk practice (KCHIVRP) among women of childbearing age was high.

Question Two

What are the levels of knowledge of HIV risk practices by the childbearing women according to age?

Table 2: level of knowledge of HIV risk practices according to age and location (n = 343)

Age groups					
S/N	Dimensions of MM	15-23yrs	24-32yrs	33-41yrs	42-49yrs
		% <u>n</u> x = 89	% <u>n</u> x = 180	% <u>n</u> x = 64	% <u>n</u> x = 10
1	Knowledge of Concept of HIV(KCOHIV)	Decision 60.90	Decision 67.44	Decision 61.88	Decision 44.00
2	Knowledge of causes of HIV risk practices (KCHIVRP)	64.27	66.56	67.19	46.00
3	Knowledge of HIV risk practices by women according age (KPHIVR)	61.80	70.00	74.06	52.00

Table two shows that the mean score of women of childbearing age 24-32years (x=67.44%) was slightly higher than aged 33-41years (x=61.88%) and 15-23years (x=60.90%). This implies that women of these age groups possessed high level of knowledge regarding concept of HIV risk. The table further shows that women aged 42-49years had mean score of 44% indicating that they possess average level of knowledge regarding concept of HIV risk.

The table also shows that mean score of women of childbearing aged 33-41years (x=67.19%) was slightly higher than those aged 24-41years (x=66.56%) and 15-23years (x=64.27%). This implies that women of these age groups possessed high level of knowledge regarding causes of HIV risk. In addition, women aged 42-49years had a mean score of 46% indicating that the average level of knowledge regarding causes of HIV risk is not high.

The table further shows that the mean score of women aged 33-41years (x=74.06%) was slightly higher than those aged 24-32years (70%) and those aged 15-23years (x=61.80%). This implies that women of these age brackets possessed high level of knowledge regarding prevention of HIV risk. This also implies that there was difference in the level of various dimensions of HIV risk by women of childbearing age according to age.

Question 3: What is the difference in the level of knowledge of HIV risk practices by the women according to level of education?

Level of education					
S/N	Dimensions of MM	No Formal education (N=5)x	Primary education (n=61)x	Secondary education(n=144)x	Tertiary education (n=133)x
1	KCOHIVR	36.00	47.21	65.83	70.83
2	KCAHIVRP	28.00	49.09	65.14	74.44
3	KPHIVR	48.00	20.59	65.28	77.44

Table 3 shows that the mean of women of childbearing age with tertiary education ($x=70.83\%$) was slightly higher than those with secondary education ($x=65.83\%$). This implies that women with tertiary and secondary education possessed high level of knowledge regarding concept of HIV risk. The table also shows that the mean score of women with primary education ($x=47.21\%$) was slightly higher than those without formal education ($x=36\%$). This implies that women with primary education had average level of knowledge while those without formal education had low level of knowledge regarding concept of HIV risk.

Table 3 further shows that the mean score of women with tertiary education (77.44%) was higher than those with secondary education ($x=65.28\%$). This reveals that women with tertiary and secondary education possessed high level of knowledge of prevention of HIV risk. The table also reveals that the mean score for women with no formal education ($x=48\%$) was higher than those with primary education ($x=20.59\%$). This implies that women without formal education had average level of knowledge of prevention of HIV risk. This implies that there were differences in the levels of knowledge of various dimensions of maternal morality by women of childbearing age to the level of education.

Hypothesis

There is no significant difference in the level of knowledge of HIV risk practices by the women according to concept, education, age and location.

Table 4: Result of one-way analysis of variance (ANOVA) testing the null hypothesis of no significant difference in the level of knowledge of HIV risk practices by the women of age bearing.

Dimensions of mm	sum of b/w groups	Squares within groups	DF	Mean b/w groups	Squares within groups	F	P. value
KCOHIVR	7280.279	166767.334	3	2426.760	491.940	4.933	.002*
KCHIVRP	4319.904	182979.723	3	1439.968	539.751	2.688	.048*
KPHIVR	204016.110	204016.110	3	3017.371	601.817	5.014	.0028*

*Significant

*Not significant

Table 3 shows that the F-values and their corresponding P-values for KCOHIVR (F=4.933, P-value= .002 < .05), KCAHIVR (F=2.668, P= .048 < .05) and KPHIVR (F =5.014, P = .002 < .05) were less than 105 level of significance at 3 and 339 degrees of freedom. The null hypothesis of no significant different is therefore rejected. This implies that women of childbearing age differed in their knowledge of various dimensions of HIV risk according to age.

Conclusion

Based on the result findings and discussions, the following conclusions were attained. That women of childbearing age overall level of causes of HIV risk practices was high. The overall level of knowledge of women of child bearing age in different age groups for the various dimensions of HIV risk practices also was high.

Recommendations

Since women of childbearing age in Aba Municipal had low level knowledge in various dimensions of HIV risk practices, the Ministry of Health in conjunction with Ministry of Women Affairs should mount health seminars and workshops in health facilities, churches and town halls to enlighten women on the causes of HIV risk and maternal death. This may help the women of childbearing age awareness on reproductive age and pregnancy related problems arising from early and late delivery.

-Cost of utilization of maternal health services should not be expensive, especially for pregnant and nursing mothers. Government should subsidize the cost of hospital bills, antenatal and delivery services.

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Appendix

Section A:

Respondents bio- data: You are expected to tick (✓) only in one option as it applies to you in any of the statements below:

1. To which of the following age brackets do you belong
 - 15-23yrs
 - 24-32yrs
 - 33-41yrs
 - 42-49yrs
2. What is your highest educational attainment?
 - No formal education
 - Primary school education
 - Secondary school education
 - Tertiary education
3. Place of residence
 - Urban
 - Rural

Section B: Knowledge of HIV risk practices

In this section, you are expected to choose from options A-D the one that correctly describes the statement or answers the question.

4. HIV risk practices can occur in women at the age of
 - 10yrs
 - 50yrs
 - 15-49yrs
 - 55yrs only
5. HIV risk practices among women of child bearing age is said to occur when a woman is:
 - Giving birth Giving birth and pregnant
 - Menstruating
 - Pregnant
6. When AIDS kills a pregnant woman, the death is referred to as
 - Direct maternal death
 - Indirect maternal death
 - None of the above
7. The death of a pregnant woman can be associated with
 - Shortage of water
 - Bad accommodation
 - Comfortable living
 - Short of blood
 - HIV

Section C: Attitude of HIV risk practices

For each of the statement indicate your degree of agreement or disagreement as it applies to you by ticking (✓) in the spaces provided. Very great extent (VGE), Great extent (GE), very low extent (VLE), Low extent (LE).

S/N	Attributes of knowledge of maternal HIV risk practices	VGE	GE	VLE	LE
9	It is not painful for a woman to die in the process of child bearing				
10	It is annoying when maternal HIV risk is caused by mismanagement of pregnancy cases				
11	It is mere superstition to attribute maternal HIV to evil spirits or witchcraft.				
12	It is negligence on the part of health workers for a woman with HIV to die during delivery				
13	It is annoying when the death of a woman in labor is due to convulsion (eclamptic fit)				
14	It is negligence on the part of health worker if maternal mortality is caused by HIV				
15	It is sad when a pregnant woman dies during child birth as a result of obstructed access to HIV knowledge				
16	It is worrisome when HIV after delivery leads to maternal death				
17	Abortion performed by unqualified health personnel cannot lead to HIV risk.				