

**KNOWLEDGE, PERCEPTIONS AND RISK OF CONTRACTING HIV
FROM SPOUSES AMONG MARRIED WOMEN IN OMI-ADIO
COMMUNITY, IDO LOCAL GOVERNMENT AREA,
OYO STATE.**

BY

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ABSTRACT

Anecdotal evidence has shown that for many women around the world, the primary means of contracting HIV is marital sex. In Nigeria, the perceived vulnerability of married women to HIV infection through sex with their spouses has not been adequately studied. This study was therefore carried out in Omi-Adio, Oyo State, Nigeria to assess married women's knowledge, perception and risk of contracting HIV from spouses.

The study was a cross-sectional survey involving the use of a four-stage random sampling technique in selecting 390 married women aged 16-45 years from 143 workplaces and 55 households. Respondents were classified into three categories based on age: younger women (16-25), middle-aged women (26-35) and older women (36-45). The instrument for data collection was a semi-structured questionnaire which contained questions for eliciting the following information: socio-demographic characteristics, perceptions of HIV transmission and associated risk factors. The instrument included a 14-point knowledge scale on HIV transmission and its prevention. Respondents' scores of 1-5, 6-10 and 11-14 points were classified as poor, fair and good respectively. Data were analyzed using descriptive, chi-square and ANOVA with level of significance set at 0.05.

The mean age of respondents was 30.2 ± 2.9 years with middle-aged, older and younger women constituting 46.2%, 30.8% and 23.0% respectively. Respondents in monogamous unions were 67.2%, 71.0% were traders and 43.0% had primary education. Respondents' mean knowledge score was 7.3 ± 2.9 with the scores for middle-aged women (7.5 ± 2.9) and older women (7.4 ± 2.9) being significantly higher than that of younger women (6.7 ± 2.9). Mean knowledge score for those with tertiary education was significantly higher (8.8 ± 2.9) compared with those with senior secondary (8.0 ± 2.9), junior secondary (6.9 ± 2.9), primary education (6.7 ± 2.6) and no formal education 6.7 ± 2.3 . Most respondents (99.05%) had fair HIV-related knowledge. There was no significant association between knowledge of HIV and type of marriage. Respondents' perceived vulnerability to HIV infection from spouses was not significantly different by age, education and religion. Eighty-five percent of respondents perceived HIV to be serious. Unprotected sex was perceived by most (96.9%) to

be the major route of infection. Ninety-five percent of respondents believed that women could get HIV from their spouses and of these only 10.0% perceived themselves to be at risk of contracting it from their spouses. Although, a majority (80.0%) believed that HIV could be prevented, only 11.3% were of the view that married women could protect themselves from getting infected by their spouses. Fifty-five percent reported ever discussing sexual matters with their spouses. Measures listed by respondents for preventing infection from spouses included mutual faithfulness (82.0%), use of condom (8.5%), use of charms (6.7%), spousal communication (5.9%) and prayers (1.2%). The reported risk factors for HIV infection from spouses included infidelity of spouses (51.5%) and risky traditional practices such as polygyny (77.2%) and wife inheritance (2.3%).

Respondents' knowledge about HIV transmission, prevention and associated risk factors was fair but most of them did not perceive themselves to be vulnerable to infection from their spouses. Health education programmes to increase their knowledge and modify their perceptions relating to vulnerability are advocated.

Keywords: Married women, HIV infection, HIV knowledge, HIV risk, Vulnerability to infection.

Word Count: 489

DEDICATION

This work is dedicated to the Almighty God, to Him be glory forever

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CERTIFICATION

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OPERATIONAL DEFINITION OF TERMS

Knowledge: It is the general awareness or possession of information, facts, ideas and truths about a subject matter.

Marital Sex: Sexual intercourse between spouses

Perceptions: One's attitude or understanding based on what one observes or based on one's thoughts.

Preventive Strategies: A carefully devised plan of action to avoid undesirable harmful outcomes.

Risks: the possibility of coming to harm

Risk Factors: predisposing influences

Spousal communication: Effective dialogue between couples

Spouse sharing: a cultural practice of sharing one's wife with others

Widow cleansing: a cultural and ritualistic practice among particular ethnic groups Africa in which widows are made to have sexual intercourse with cleansers as part of rites recommended for widows before being released from mourning.

Widow inheritance: a cultural practice in some ethnic groups in Africa which involves the passing of a widow to a family member as an inheritance.

ABBREVIATIONS

AIDS: Acquired Immune Deficiency Syndrome

AMREF: African Medical and Research Foundation

HIV: Human Immune Deficiency Virus

NACA: National Agency for the Control of AIDS

NDHS: National Demographic Health Survey

PAHO: Pan American Health Association

STI: Sexually Transmitted Infections

UNAIDS: United Nations Program on HIV/AIDS

UNICEF: United Nations Children Fund

UNDAW: United Nations Division for the Advancement of Women

UNDP: United Nations Development Program

UNIFEM: United Nations Development Fund for Women

UNFPA: United Nations Population Fund

USAID: United States Agency for International Development

WHO: World Health Organization

CHAPTER ONE

1.0

INTRODUCTION

1.1 Background to study

AIDS, the acquired immune deficiency syndrome is a fatal illness caused by a retrovirus known as the human immune deficiency virus (HIV), which breaks down the body's immune system, leaving the victim vulnerable to a host of life threatening opportunistic infections, neurological disorders, or unusual malignancies (Parveco and Clark, 1994). The virus is passed from person to person through sexual fluids, blood and breast milk. Worldwide the majority of HIV infections are transmitted through sex between men and women, and nearly half of all adults living with HIV are women (UNAIDS, 2003).

HIV infects vital cells in the human immune system such as helper T cells (specifically CD4⁺ T cells), macrophages, and dendritic cells (D). HIV infection leads to low levels of CD4⁺ T cells through three main mechanisms: First, direct viral killing of infected cells; second, increased rates of apoptosis in infected cells; and third, killing of infected CD4⁺ T cells by CD8 cytotoxic lymphocytes that recognize infected cells. When CD4⁺ T cell numbers decline below a critical level, cell-mediated immunity is lost, and the body becomes progressively more susceptible to opportunistic infections.

Most untreated people infected with HIV-1 eventually develop AIDS. These individuals mostly die from opportunistic infections or malignancies associated with the progressive failure of the immune system. HIV progresses to AIDS at a variable rate affected by viral, host, and environmental factors; most will progress to AIDS within 10 years of HIV infection; some will have progressed much sooner, and some will take much longer. Treatment with anti-retrovirals increases the life expectancy of people infected with HIV. Even after HIV has progressed to diagnosable AIDS, the average survival time, with antiretroviral therapy was estimated to be more than 5 years as of 2005 (Kaiser, 2007). Without antiretroviral therapy, someone who has AIDS typically dies within a year.

The global AIDS epidemic has become one of the greatest threat human health and development. Statistics at the end of 2009 indicate that around 33.3 million people are living with HIV and each year around 2.6 million more people become infected with HIV with about 1.8 million dying from AIDS(Global health council,). Although HIV and AIDS are found in all parts of the world, some areas are more afflicted than others. The worst affected region is sub-Saharan Africa, where in a few countries more than one in five adults is infected with HIV (UNAIDS, 2010).

Passage of HIV appears to be more efficient from men to women than vice-versa. In recent times, the AIDS epidemic has been found to have increasing prevalence among married women. A number of factors combine to put married women at risk; these include an inability to negotiate safe sex and a lack of communication between spouses, other factors include gender discrimination, gender based violence, abuse of human right, lack of economic empowerment, harmful cultural practices, a lack of sufficient knowledge about HIV/AIDS and low educational status (Underwood and Kopunigio, 2006).

The prevalence of HIV is higher in countries of sub-Saharan Africa than in other parts of the world (USAID, 2003). In 2009, an estimated 2.6 million people were infected, of which 69 percent occurred in sub-Saharan Africa (UNAIDS, 2010). UNAIDS in its 2008 global report stated that although HIV prevalence is much lower in Nigeria than in many countries such as South Africa and Zambia, the large size of Nigeria's population meant that by the end of 2007, there were an estimated 2,600,000 people infected with HIV in Nigeria and approximately 170,000 people died from AIDS in 2007 alone (UNAIDS, 2008). In recent years, life expectancy in Nigeria has declined partially as a result of the effects of HIV and AIDS. In 1991, the average life expectancy was 53.8 years for women and 52.6 years for men (UNFPA, 2005). The 2007 estimate had fallen to 50 for women and 48 for men (WHO, 2009).

In Nigeria, the sero-prevalence rates of 4.4% in 2005 translated to 2.9 million people living with the virus. This placed Nigeria as having third greatest burden of people infected with HIV in the world. Over the last few decades, the HIV epidemic in Nigeria has gone from

affecting only a few populations with high-risk behaviour within a "concentrated" epidemic in a few States to a "generalized" epidemic in many States (NACA, 2008).

1.2 Problem statement

Worldwide heterosexual intercourse accounts for majority of HIV infections, and co-existent sexually transmitted disease (STDs) especially those causing genital ulceration. United Nations program on HIV/AIDS (UNAIDS)/World Health Organization (WHO) epidemic update in November, 2006 reported that worldwide a total of 39.5 million people were living with HIV/AIDS, 37.5 million were adults of which 17.7 million were women (WHO, 2006).

Evidence shows that marriage is not a protective factor against HIV infection for women and girls. Trends in current data on new infections suggest that the incidence of HIV is rising among married women and girls worldwide. This challenges the logic of preventive strategies that are based on messages of abstinence-until-marriage and monogamy for women and girls (Sippel, 2007). Some of the reasons for the high rates of HIV infection among married women are linked to the very reasons that some people marry; they want to have children and with no way to conceive and protect themselves from HIV at the same time and they frequently put themselves at risk of HIV infection (UNAIDS, 2004). The majority of infected women are of child bearing age, opening the way for perinatal HIV transmission to their children on a large scale. United Nations Development Program (UNDP) has estimated that over 85% of the cases of paediatric infections in Africa have resulted from perinatal transmission (UNDP, 1990).

Globally, HIV/AIDS is the leading cause of death among women of reproductive age (UNAIDS, 2004). The percentage of women living with HIV and AIDS varies significantly between different regions of the world. In areas such as Western and Central Europe, Eastern Europe and Oceania, women account for a relatively low percentage of HIV infected people. However, in regions such as sub-Saharan Africa and the Caribbean, the percentage is significantly higher (WHO, 2009).

In 1985 in sub-Saharan Africa there were as many infected men as there were women. However as the infection rate has increased over the years, the number of women living with HIV and AIDS has overtaken and remained higher than the number of infected men. In 2009 there were around 12 million women living with HIV and AIDS, compared to about 8.2 million men. UNAIDS have estimated that around three quarters of all women with HIV live in sub-Saharan Africa (UNAIDS, 2009).

Sub-Saharan Africa is one region of the world where majority of HIV transmissions occur during heterosexual contact. As women are twice as likely to acquire HIV from an infected partner during unprotected heterosexual intercourse than men, women are disproportionately infected in this region (UNAIDS, UNFPA, UNIFEM, 2004). Like many other countries in Africa, HIV is most prevalent among the most productive members of society (age 25-29) with young women, in particular affected. The epidemic also had a disproportionate impact on women and girls in their reproductive years with 4.9% of pregnant women age 25-29 infected, followed by women age 20- 24, with 4.7%. More alarming, 3.6% of women age 15-19 were infected as well (NACA, 2008).

1.3 Justification

Sex is traditionally a very private subject in Nigeria for cultural and religious reasons, thus there is a lack of accurate information about information about sexual health and this has meant that there are many myths and misconceptions about and HIV (Nigeria Federal Ministry of Health, 2002).

Most HIV/AIDS awareness programs organized by health educators fail to address the needs of married women hence the high incidence of HIV among married women in recent times. Preventive strategies that focus on abstinence and faithfulness in lieu of comprehensive evidence based prevention programs are not adequate to protect a woman whose husband is unfaithful (Mishra, 2007). Also such strategies cannot protect a woman who does not perceive herself to be at risk of contracting HIV from her spouse.

1.4. Research questions

1. What is the study group's level of awareness and knowledge about HIV/AIDS?
2. What socio-cultural factors can predispose married women to HIV infection?
3. What is the study group's perception towards the risk of contracting HIV from their spouses?
4. What preventive strategies can be adopted by married women?

1.5 Objectives of the study

1.5.1 General objectives

The general objective of the study was to assess HIV/AIDS knowledge and perception of risk towards contracting HIV from spouses among married women in Omi-Adio community of Ido LGA, Oyo State.

1.5.2 Specific objectives

1. To assess HIV/AIDS knowledge among married women in Omi-Adio.
2. To identify socio-cultural factors that can facilitate spousal transmission of HIV
3. To describe the perception of risk of married women towards contracting HIV from their spouses
4. To identify preventive strategies that can be considered by women within marriage

1.6 Research hypothesis

1. There is no difference in knowledge of HIV/AIDS among younger married women (16-25), middle-aged women (26-35), and older married women (36-45)
2. There is no association between knowledge of HIV/AIDS and level of education.
3. There is no association between knowledge of HIV/AIDS and religion.
4. There is no association between knowledge of HIV/AIDS and type of education.
5. There is no association between knowledge of HIV/AIDS and perceived vulnerability to infection.
6. There is no difference in perceived vulnerability to HIV infection among younger married women, middle-aged women and older married women

7. There is no association between perceived vulnerability to HIV infection and educational level.
8. There is no association between perceived vulnerability to HIV infection and type of marriage.

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CHAPTER TWO

2.0

LITERATURE REVIEW

Literature reviewed under this chapter is presented under the following subheadings: Epidemiology of HIV and AIDS, Gender dimensions of HIV and AIDS, Women's knowledge about HIV and AIDS, Perception of HIV risk among married women and Factors predisposing married women to HIV infection.

2.1 Epidemiology of HIV and AIDS

The Human immune deficiency virus (HIV) is a retrovirus and belongs to the family of lentiviruses. Infections with lentiviruses typically have a chronic course of disease, a long period of clinical latency and persistent viral replication. There are two types of HIV - types 1 and 2. Both have been documented as the causative agents of the acquired immune deficiency syndrome (AIDS) (Clinical Guidelines for Anti-retroviral Therapy in Nigeria, 2003). Over the past 25 years, nearly 25 million people have died from AIDS (). HIV/AIDS causes debilitating illness and premature death in people during their prime years of life and has devastated families and communities. Further, HIV/AIDS has complicated efforts to fight poverty, improve health, and promote development by:

1. Diminishing a person's ability to support, work and provide for his or her family. At the same time, treatment and health-care costs related to HIV/AIDS consume household incomes. The combined effect of reduced income and increased costs impoverishes individuals and households.
2. Deepening socioeconomic and gender disparities. Women are at high risk of infection and have few options for providing for their families. Children affected by HIV/AIDS, due to their own infection or parental illness or death, are less likely to receive an education, as they leave school to care for ailing parents and younger siblings.
3. Straining the resources of communities - hospitals, social services, schools and businesses. Health care workers, teachers, business and government leaders have been lost to HIV/AIDS. The impact of diminished productivity is felt on a national scale (Kaiser Family Foundation, 2007)

Through unprecedented global attention and intervention efforts, the rate of new HIV infections has slowed and prevalence rates have levelled off globally and in many regions. However, despite the progress seen in some countries and regions, the total number of people living HIV continues to rise (Global Health Council, 2009).

In 2008, globally, about 2 million people died of AIDS 33.4 million were living with HIV and 2.7 million were newly infected with the virus. HIV infections and AIDS death are unevenly distributed geographically and the nature of the epidemics vary by regions. Epidemics are abating in some countries and burgeoning in others. More than 90 percent of people with HIV are living in developing countries (UNICEF, 2007). Globally there are 34 million people living with HIV. While HIV infections have declined by nearly 25 percent between 2001 and 2009, the epidemic continues to outpace the response. Two people were newly infected for each person who started antiretroviral therapy in 2009 (UNDP, 2009).

AIDS was first reported in Nigeria in 1986. The epidemic in Nigeria has since extended beyond the high-risk groups to the general population. Some parts of the country are worse affected than others, but no State or community is unaffected. All the States of Nigeria have a generalized epidemic. The epidemic in the country can be described as heterogeneous, with various communities in different stages, some declining while others are still rising. AIDS cases are becoming more visible in communities, although AIDS case reporting has been characterized by under-recognition, under-reporting and delayed reporting, the number of reported cases has been on the increase since 1996 (Federal Ministry of Health, Nigeria, 2005).

The impact of HIV/AIDS on girls and women has been particularly devastating. Women and girls now comprise 50 percent of those aged 15 and older living with HIV (UNAIDS/WHO, 2009). Key statistics on HIV in Nigeria has shown that:

- HIV is the leading cause of death and diseases among women of reproductive age (15-49 years).
- In sub-Saharan Africa, 60% of the people living HIV are female (while women make up 50% of the global epidemic).

- In Nigeria, prevalence among young women age 15-24 years is estimated to be three times higher than among men of the same age.
- Females constitute 58% (about 1.72 million) of persons living with HIV in Nigeria.
- Each year 55% of AIDS deaths occur among women and girls (NACA, 2011).

2.2 Gender dimensions of HIV/AIDS

Women and girls now comprise 48 percent or 17.7 million of the nearly 40 million people living with HIV/AIDS. Especially vulnerable are young women and girls, who make up 75 percent of all new cases in sub-Saharan Africa and a growing population of those infected in Asia, Eastern Europe and Latin America (UNAIDS, 2006). Three-quarters of all women and girls with HIV/AIDS live in sub-Saharan Africa (UNAIDS, UNEPA, UNIFEM, 2004). No other region in the world approaches its HIV prevalence rates or displays such a disproportionate impact on women and girls. In sub-Saharan Africa, about 23 million adults aged 15-49 are infected with 57 percent of them being women (UNAIDS/WHO, 2004).

HIV is no longer striking primarily men. Today, more than 20 years into the epidemic, women account for nearly half of the 40 million people living with HIV worldwide. Despite this alarming trend, women know less than men about how HIV/AIDS is transmitted and how to prevent infection and what little they know is rendered useless by the discrimination and violence they face (Thomson and Heyzer, 2004). Eighty-percent of young women (age 15-24) in low and middle income countries cannot correctly identify ways of preventing HIV transmission (UNAIDS, 2006).

The feminization of the epidemic is particularly acute in sub-Saharan Africa because heterosexual transmission has been the mode of transmission for some time. In other regions of the world, men are still more likely to be infected with HIV than women, as the main mode of transmission is either homosexual transmission, injecting drug use or commercial sex work (Hargreaves and Boler, 2006).

Recent studies in Africa indicate that young married women are at a higher risk of HIV infection than their married counterparts. A study in Kisumu, Kenya found that 33 percent of married girls were positive compared to 22 percent of sexually active unmarried girls of the

same age. In Ndola, Zambia, 27 percent of married girls were HIV positive compared to 16 percent of unmarried girls. The study also found that adolescent girls who were married to much older men- a common occurrence- were more likely to be HIV positive. Half of the married women whose husbands were ten or more years older were infected with HIV, compared to none of the women whose husbands were up to three years older (Glynn, Carael and Auvert, 2001). Another study as shown that the bond of marriage is not the protection against HIV infection that many assume it to be. Many of the risk factors continue to apply. Marriage- whether in Lusaka or Pretoria- may not be as safe or as sacred as once thought. This is especially true for younger married women. According to a research done in recent years, married adolescent girls in both Kenya and Zambia demonstrate higher rates of HIV infection than their stereotypically more "at risk" single, sexually active female counterparts. The same studies also point out these young girls often have much older husbands who are about three times as likely to be HIV positive than the boyfriends of single girls (Centre for health and gender equity, 2003).

Marriage may be putting sub-Saharan Africa's women in a risky situation when it comes to HIV/AIDS. What makes marriage dangerous for these women? Among other things: more sex, less condom use and virtually a non-existent ability to abstain. Being faithful as a means to prevent HIV only works if both partners are HIV negative when they begin the relationship and if both partners do not have sex outside of it (UNFPA, 2004). A 2003 study found that married adolescent girls in southern and eastern Africa had much more unprotected sex than single girls their age. There are obvious reasons for this. In some instances, married persons may not feel the need to use a condom- convinced of a partner's fidelity and status, or with the goal of having children. In other cases, women lack the negotiating power in a relationship to insist on condom use, even when they know that their partner is unfaithful (Dunkle, 2004).

Reversing the spread of HIV/AIDS must address the critical role that gender relations plays in sexual and reproductive life and how it affects HIV prevention. Indeed, the changing face of the epidemic brings into sharp view the gender and social inequalities that shape people's behaviour and limit their choices (UNFPA, 2004). An overwhelming body of scientific,

medical and public health data now irrefutably confirms the unique biological, social, cultural and economic vulnerability of women and girls to HIV/AIDS (Centre for Health and Gender equity, 2003).]

2.3 Women's knowledge about HIV/AIDS

According to an AIDS reduction model, knowledge of AIDS is a prerequisite to recognizing risky behaviour and taking action to change it (Catania, Kegel, Coates, 1990). In many societies, both the discussion of and education about sexual matters is frowned upon. As a result, millions of people, especially girls and women remain ignorant about HIV/AIDS with potentially deadly consequences (UNAIDS, 2001). Even though girls and women are highly vulnerable to HIV infection, they know less than males about HIV/AIDS and how it is transmitted (Global HIV prevention working program, 2003).

Reports gathered from most countries of the world, especially countries in sub-Saharan Africa and Nigeria in particular show that knowledge about HIV/AIDS among women is low compared to that of men. It is even lower in the rural parts due to a number of factors which include harmful cultural practices, economic disadvantage (due to limited access to economic opportunities) and limited access to health care and diminished social status (USAID, 2003). A study by NACA as shown that in Nigeria only 23 percent of women have comprehensive knowledge of the mode of HIV transmission and prevention (NACA, 2011). Sex is traditionally a very private subject in Nigeria (Odutola, 2006). In some regions of Nigeria women marry relatively young, often too much older men. In North-western Nigeria around half of girls are married by age 15 and four out of five are married by age 18 (The Population Council, 2007). Studies have found that those who are married at a younger age have less knowledge of HIV/AIDS than unmarried women, and are more likely to believe that they are low-risk of becoming infected with HIV (The Population Council, 2007). One of the eight goals of the United Nations Millennium Declaration is to combat HIV/AIDS, malaria and other diseases.

To monitor the success of national programmes to prevent the spread of HIV/AIDS, data are now being collected by a number of developing countries and compiled by UNICEF on

knowledge about HIV/AIDS and use of condoms. The data reported below refer to young women and young men aged 15-24 and were collected between 1998 and 2003. According to data from the surveys, globally, more than 80 percent of the young women did not have sufficient knowledge about HIV/AIDS. Many had no idea of how HIV/AIDS is transmitted and little or no information on protection methods (UNICEF, 2003). In South-east Asia, only 13 percent of young women were able to correctly identify two preventive methods (using condom and limiting sex to one faithful, uninfected partner) and three common misconceptions about HIV/AIDS, in Vietnam almost all young women believed they could get HIV from a mosquito bite, in Cambodia 30 percent of young women believed a healthy looking person could not be infected, in sub-Saharan Africa only 20 percent of women aged 15-24 were able to identify two prevention methods and the common misconceptions about HIV while in Somalia only 26 percent of young women had heard of AIDS and only 2 percent knew how to avoid infection. Many young women did not know that a healthy looking person can be infected with HIV and that a condom can prevent HIV transmission (UNICEF, 2003).

Women's limited knowledge is evident in nearly every country surveyed with sex-disaggregated data for both sexes. In some regions and countries, the gap is substantial. In sub-Saharan Africa 53 percent of young women know that a healthy looking person can be infected, compared to 64 percent of young men (UNIFEM/UNAIDS, 2004). In Burkina Faso the differences are 42 percent of young women, compared to 64 percent of young men (UNIFEM/UNAIDS, 2004). In Ethiopia, 39 percent of young women know that a healthy person may have HIV compared to 54 percent of young men (UNIFEM/UNAIDS, 2004).

Figures of HIV/AIDS knowledge vary among countries and while knowledge among young women has improved between 2000 and 2008 slightly, there remain great challenges. Young men consistently have higher rates of accurate knowledge about HIV/AIDS in all regions of the world (UNICEF, 2010). A survey of 24 sub-Saharan African countries found that two-thirds of young women lacked understanding of HIV transmission and showed that men's knowledge was greater (UNICEF, 2010). A similar study carried out in 2004 also showed women's more limited knowledge evident in nearly every country surveyed with sex-disaggregated data for both sexes. In some regions and countries, the gap is substantial. In

sub-Saharan Africa, 53 percent of young women know that a healthy-looking person can be infected, compared to 64 percent of young men (UNFEM/UNAIDS, 2004).

2.4 Perceptions of HIV/AIDS risk among married women

Sexual health behaviour depends very much on each person's sexual perceptions, thus it is necessary to understand sexual risk perceptions of people as baseline data for determining their sexual status. Sexual risk perception has been defined as an individual's instinctive judgement of both aspects of sexual risk, including the probability of occurrence and the severity of the associated consequence of having unsafe sexual intercourse (Naravage and Oehler, 2008). The relationship between perception of risk and sexual behaviour is complex and poorly understood (Akwaru, Madhise and Hinde, 2003). Studies conducted in different cultures have associated HIV risk perception with a wide range of variables: number of sexual partners, knowledge of sexual partner's past sexual behaviour, fear of AIDS, discussing AIDS at home and religious affiliation. In sub-Saharan Africa, socio-cultural norms and practices are major determinants of sexual risk-taking behaviour (Caldwell, Orubuloye and Caldwell, 1999).

However, a study in Kenya on perception and risk of contracting HIV/AIDS and sexual behaviour has indicated a strongly positive association between perceived risk of HIV/AIDS and risky sexual behaviour (Akwaru, Madhise and Hinde, 2003). Another study on perception carried out among African American women showed that an individual's subjective perception of risk is based on a multiplicity of both internal and external factors, including relationship context and cultural world view. Results from the study went on to show that when partner infidelity was controlled, financial independence and interpersonal control were significant predictors of perceived HIV risk, with lack of power related to elevated levels of perceived risk. When relationship power and HIV knowledge were taken into account, cultural worldview was a significant negative predictor of perceived risk, with high levels of fatalism associated with low perceived risk. These findings suggest that knowledge alone is not enough to explain HIV risk perception (Younge, Salem and Bybee, 2010).

A study in Thailand has revealed that marital status is an important factor in sexual risk perception since sexual activities would be accepted among married women but not for single women (Gray and Punpuing, 1999). Recent studies also in Thailand showed that women felt they were not at risk because they knew their men and their history and therefore trusted them not to be infected. Women tended to link sexual intercourse with love and romance and this perception resulted in unsafe sexual intercourse. This proves that knowledge did not relate to actual perception and behaviour. The study went on to show that even though some women understood the concept of risk they still believed that they stood a minimal chance of contracting the disease compared to others (Naravage, Oehler, 2008). Individuals may perceive their risk of getting AIDS to be high or low depending on their previous sexual behaviour or that of their partners. In this case, risky sexual behaviour is the influencing factor on perception of risk. In some cases, a person's perception of risk may be passive, and not necessarily based on his or her previous sexual behaviour. A high perception of risk might lead to a modification of sexual behaviour, for example refusal to have sexual intercourse with a partner (Akwara, Madaise, Hinde, 2003).

The belief that AIDS is a disease for "high risk" groups can influence people's perceptions and behaviour. For a long time in Kenya, AIDS was associated with homosexuals, drug users, prostitutes, truck drivers and tourists. As a result, some people discounted their own risk because they did not identify with these high-risk groups (Kenya et al, 1998; Okeyo et al, 1998). Another belief that may influence the perception of HIV is the way that illness is viewed. Some see AIDS as punishment for immoral behaviour so that those who see their lifestyle as being morally upright may perceive their chance of being infected by HIV to be low (Konde-Lule, 1993; Nzioka, 1996). Studies have indicated that wives of men who engage in high-risk behaviour have inadequate knowledge of their husbands' activities outside marriage and hence do not perceive themselves at risk (Newmann, 2000).

2.5 Factors predisposing married women to HIV infection

While the levels of HIV infection and AIDS among women demonstrate clearly the magnitude of the problem, an understanding of HIV infection in women requires more than just an appreciation of the statistics. The social and cultural determinants of HIV infection in

women are very different from those for men because they relate to the role of women within relationships, families and communities which, in turn, determines the nature and patterns of sexual activity and other factors that place women at risk of HIV infection. An understanding of the epidemic must therefore include not only how women have been affected but also why they have been affected (Hamblin and Reid, 1991).

In a multi-site comparative ethnographic study, five anthropologists returned to their long-term research sites in countries at different stages of the epidemic (nascent: Papua New Guinea; concentrated: Mexico and Vietnam; disseminated: Uganda and Nigeria) to explore how gender inequality combines with social stratification, labour migration, and emerging ideals of romance to shape married women's risk of HIV infection. Using Marital Case Studies, Key Informants Interview, Participant Observation and Archival Research, researchers found that social, cultural and economic factors combine to make men's extramarital sex the exception rather than the rule (American Public Health Association, 2005).

The United Nations Secretary General's task force on women, girls and HIV/AIDS in Southern Africa has identified three key factors that contribute to the greater vulnerability of the sub region's women and girls to HIV infection, each of which must be addressed:

- The culture of silence surrounding sexuality
- Exploitative transactional and intergenerational sex and
- Violence within relationships

Gender-based violence is now one of the leading factors for HIV infection. Unless the link between the two is broken, it will be hard to reverse the epidemic. While the challenges are daunting, there are many models already in place that use a variety of approaches: utilizing the health care system, human rights protection, education, legal reform and working with community groups. When the rule of law has been eroded or has disappeared, as in conflict situations, efforts are being made to offer protection and prophylaxis through humanitarian agencies (Maman, 2002). Violence against women is both a cause and a consequence of HIV/AIDS.

It is a fact of life for too many women in all countries, whether in peacetime, during conflict or post-conflict periods. The true extent of violence against women is unknown, but current research indicates that intimate partner violence ranges anywhere from 10 to 69 per cent, and one in four women may experience sexual violence by an intimate partner in her life (USAID, 2002).

According to a recent study, one of the first to show a firm link between violence and HIV, women who are beaten or dominated by their partners are much more likely to become infected by HIV than women who live in non-violent households. The research was carried out among 1,366 South African women who attended health centers in Soweto and agreed to be tested for HIV and interviewed about their home lives. After being adjusted for factors that could skew the outcome, such as whether interviewees had engaged in casual sex or sex work, the figures showed that women who were beaten by their husbands or boyfriends were 48 per cent more likely to become infected by HIV than those who were not. Those who were emotionally or financially dominated by their partner were 52 per cent more likely to be infected than those who were not dominated (Dunkle, 2004).

Customary practices that seemed immutable when women rights activists began targeting them a few decades ago are now being called into question by leaders and policy makers. In many cases, the link to HIV/AIDS only makes the need to change practices such as early marriage, female genital cutting, spouse sharing and widow cleansing more urgent. The value of early marriage is being debated. In many countries, it is common to marry young people especially girls at an early age. Even with the threat of HIV, many parents are marrying their daughters still younger in the mistaken belief that this might protect them from infection. Since the men who are financially able to marry are generally older and are more sexually experienced, many are unwillingly bringing HIV and STIs to their marriage (Glynn, 2003). "Widow cleansing" practiced in some communities in Africa and Asia, is also being targeted. Such "cleansing" generally involves a widow having sexual relations either with a designated village cleanser or with a relative of her late husband. It has been a way to break with the past and move forward as well as an attempt to establish a family's ownership of the husband's property, including his wife. In cases where a husband died of AIDS, this is just as risky for

the men who are chosen to "cleansed" as the women who are "cleansed". It also prevents women from inheriting property that has been their family's main source of support (Saibi, 2003).

In a small village in Western Kenya, a group of widows are challenging the practice of "widow cleansing" with help from AMREF (African Medical and Research Foundation), an NGO based in Nairobi. They have refused to sleep with a cleanser and have borrowed funds to create a brick making business so they do not have to rely on men in the village for support. They talk to anyone who will listen about the problems associated with "cleansing" and have won converts among the men (Global Coalition on Women and AIDS, 2004).

Ultimately, much of the discrepancy between what girls and women know they should do and what they actually have the power to do is rooted in gender inequality. As one recent study noted, "deeply entrenched beliefs about female and male sexuality mean that women generally have less power than men to decide with whom, how and when they have sex. These beliefs are reinforced by a number of factors, including poverty, age or disability, but may still affect women who are financially independent or middle or upper class. Discrimination against women is a fact of life in all regions of the world to varying degrees, and manifested in varying ways. In many countries, women find difficulty finding and keeping paid work or earning a wage that is equivalent to men's. In some regions they are not allowed to inherit or own property or are discouraged from doing so, meaning that a woman without male protection has very little ways to support herself or her children (www.tuw.org/campaign/women/property/aidsfactsheet.htm). The abuses of human rights that women deal with on a daily basis can become nearly insurmountable obstacles when HIV/AIDS is involved. One of the most serious economic effects of HIV for women has been loss of property (Global coalition on women and AIDS, 2004).

In Zimbabwe, one project works with 200 women to reduce poverty and economic dependence on men, thus increasing their bargaining power for safer sexual relations. The women have received grants and training to start income generating projects such as grinding mills, horticulture, poultry farming, soap making, juice making, butchery and tailoring. During the entire process women also receive technical support and education on human

rights, reproductive and sexual health and on how to deal with domestic violence and HIV/AIDS. The campaign is led by women and other trained community resource persons (www.vso.org.uk/advocacy/gendering-aids.pdf).

Poverty and economic dependence are not the only reasons it is difficult for many girls and women to insist on protection. In some cases, they are not comfortable speaking about sexual issues. In other cases women—especially girls—may acquiesce to unsafe sexual practices in order to preserve a relationship ultimately much of the discrepancies between what girls and women know they should do and what they actually have the power to do is rooted in gender inequality. As one recent study noted, *deeply entrenched beliefs about female and male sexuality means that women generally have less power than men to decide with whom, how and when they have sex. These beliefs are reinforced by a number of factors, including poverty, age or disability but may still affect women who are financially independent, or "middle" or "upper class"* (Bala, 2000).

With less ability to control sexual encounters, and increased physiological susceptibility to HIV, many women are finding that commonly accepted methods of prevention are insufficient. For example, abstinence is meaningless to girls and women who are coerced or forced into sexual activity. Faithfulness offers little protection to wives whose husbands have several partners or who were infected before they were married. Condoms require the cooperation of men, who may refuse to use them. Furthermore, married couples frequently do not use condoms either because they want to have children or because condoms would indicate a lack of trust (UNAIDS/UNFPA/UNIFEM, 2002).

Some other studies too have supported the fact that these factors affect the spread of the infection among women—factors affecting the spread of HIV/AIDS among women and girls in the region are poverty, early marriage, trafficking, sex work, migration, a lack of education, and gender discrimination and violence. Breaking the culture of silence is critical. As in many regions, both industrialized and developing, complex social and cultural barriers have made talking about sexuality or insisting on protection from HIV so difficult that even educated middle class women say they are unable to protect themselves, while poor women have even less power to do so (UNAIDS, UNFPA, UNIFEM, 2004). The patterns of social

and economic dependency that render women vulnerable to HIV infection are manifested in many different ways. First and foremost, they lead to women being deprived of the power to determine the basis upon which their sexual relationships with men take place. For many women, sexual intercourse is not a question of choice but rather a question of survival. Cultural attitudes and norms leave no place for unmarried or childless women. A woman's fertility and her relationship to her husband will often be the source of her social identity. Moreover, for many women, marriage provides forms of economic and social support that would not be available to them if they were to remain single (Sabatier, 1990).

Harmful marriage practices violate women's right and contribute to increasing HIV rates in women and girls. In Nigeria, there is no legal minimum age for marriage, and early marriage is still the norm in some areas. Parents see it as a way of protecting young girls from the outside world and maintaining chastity. Young married girls are at a risk of contracting HIV from their husbands as it is acceptable for men to have sexual partners outside marriage, and some men have more than one wife (polygyny). As a result of their age, lack of education and low status, young married girls are not able to negotiate condom use to protect themselves against HIV and STIs. In countries of this region, social and cultural norms limit the discussion of sexuality and reproductive and sexual health issues, and many countries have not developed prevention programmes. Part of the challenge facing the region is the need to defuse the stigma and blame that are so often attached to vulnerable groups, and to widen the general public's knowledge and understanding of the epidemic (UNAIDS, UNFPA, UNIFEM, 2004).

2.6 Preventive strategies

Current HIV/AIDS prevention strategies commonly promote monogamy, fidelity and condom use, in connection with morality and religion (such as the ABC strategy which stands for Abstinence, Be faithful and Use Condoms). Since these strategies have failed to address the underlying concepts of masculinity and high-risk or even violent practices of sexuality, they have proven to be insufficient and even harmful. Due to systemic gender inequality and women's powerlessness, women have not been able to enforce these strategies vis-à-vis their male partners. Often, they have added to the existing burden on women's lives,

as safe sex negotiation has become the exclusive responsibility of women. These prevention strategies have victimized and further marginalized infected women (Sommerfeldt, 2001).

For many girls and women, knowledge is not enough. They need to learn not only how HIV is transmitted but also how to negotiate abstinence, "If you want me to have sex with a condom, I won't give you any money for food." The response a South African woman received when she asked her husband to use a condom. (www.icw.org).

2.7 Conceptual framework

Two conceptual models relevant to the study have been selected. These are the Health Belief model and the Ecological model. A conceptual framework describes the relationship of a problem to some concepts. The Health Belief model and the Ecological model have been used in highlighting the linkages among a set of concepts believed to be related to the problem under investigation in the study.

2.7.1 The Health Belief Model

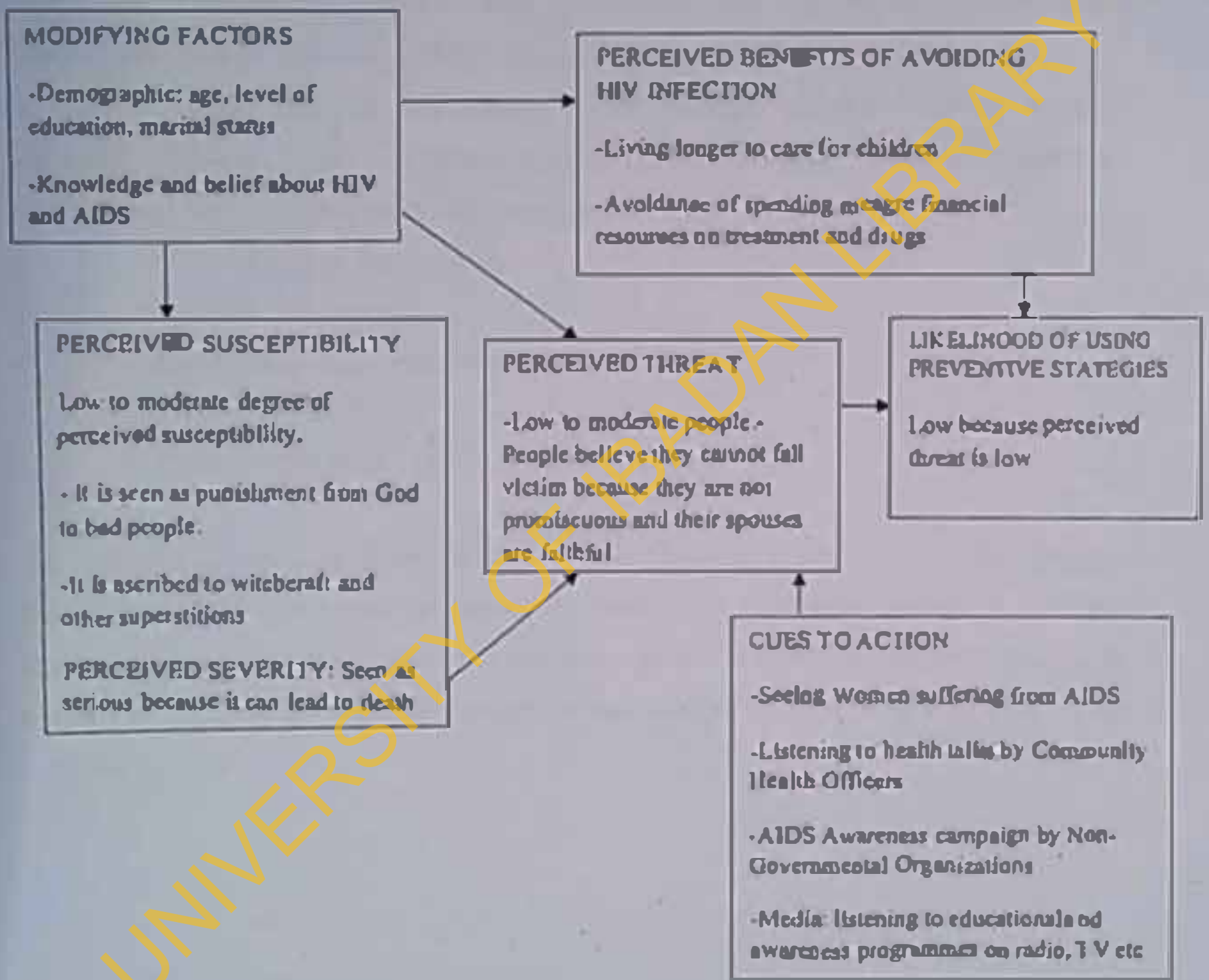
The Health Belief Model (Rosenstock, Hochbaum et al. 1974) was developed to explain preventive health behaviour. In this study, the model is used to describe the factors that are useful in understanding the relationship between the study group's perceived seriousness of HIV infection, their perceived vulnerability to contracting HIV from their spouses and their likelihood of adopting preventive strategies. The model is interactive as each step influences the others. The model has 4 major components:

- **Perceived susceptibility:** this refers to the subjective perception of risk or vulnerability to health threat.
- **Perceived severity:** this consists of an individual's perception of the seriousness of the health threat.
- **Perceived benefits:** this consists of the efficiency of an action designed to prevent or reduce the threat of illness.
- **Perceived barriers:** this refers to the assessment of the negative consequences that might be associated with the preventive or ameliorate behaviour (inconvenience, uncomfotability, side effects etc)

Fig. 2.1 shows that an individual is mobilized to act through the susceptibility and severity components, which together create a sense of disease threat. For example, results from studies have shown that perceived susceptibility to sexually transmitted infections including HIV infection is a significant predictor of condom use (Adib and Alexander, 1999). Perception of increased susceptibility or risk is linked to the adoption of healthier behaviour, and decreased susceptibility to unhealthy behaviour. However, this is not always the case. For example although college students consider themselves at risk of HIV because of unsafe sexual behaviours, they still do not practice safer sex (Lewis and Malow, 1997). Perception of susceptibility explains behaviour in some situations but not in all situations. Despite threats to a person's health however, behaviour will not occur unless a cue to action is present. Those cues may be internal or external (mass media etc) (Prentice and Rogers, 1986). Reports have shown that countries with high prevalence of HIV will often see this eventually stabilize and even decline because people are beginning to change risky behaviour patterns having seen someone die from AIDS (www.avert.org, 2011). Meanwhile, it is also believed that psychological or demographic variables (age, education, marriage etc) may indirectly affect the likelihood of a self protective act (use of condom before sexual intercourse through the influence of one or more of the model's components (Janz and Becker, 1984). Reports from 2008 demographic health survey in Nigeria shows a positive association between educational attainment and increased awareness of HIV preventive methods (NDHS, 2008). The same report showed that married women and unmarried women who have never had sexual intercourse are least likely to know that using condom and limiting sexual intercourse to one HIV- negative partner reduces the risk of HIV transmission. The last phase of this model is the likelihood of taking action which may be positive if the barriers that prevent action are less than the perceived benefits.

Fig 2.1. Conceptual framework

HEALTH BELIEF MODEL (Rosenstock, Hochbaum et al. 1974) APPLIED TO KNOWLEDGE, PERCEPTION AND THE RISK OF CONTRACTING HIV/AIDS FROM SPOUSES BY MARRIED WOMEN AND THE ADOPTION OF PREVENTIVE STRATEGIES



2.7.2 The ecological model

The ecological model emphasizes the interaction between, and the interdependence of, factors within and across all levels of a health problem. It highlights people's interactions with their physical and socio-cultural environments. Two key concepts of the ecological model help to identify intervention points for promoting health. The first is that behavior affects, and is affected by multiple levels of influence while the second is that individual behavior both shapes, and is shaped by, the social environment (reciprocal causation).

In order to explain the first key concept of the ecological model, (multiple levels of influence), McLeroy, Bibeau, Steckler and Glanz (1988) identified 5 levels of influence for health-related behaviors and conditions. These levels include:

- Interpersonal or individual factors
- Intrapersonal factors
- Institutional and organizational factors
- Community factors
- Public policy factors (NIH, 2005).

An ecological perspective shows the advantage of multilevel interventions that combine behavioral and environmental components. Clearly, the ecological stresses a wholistic approach to problem identification and resolution. Figure 2 shows the ecological model as adapted to facilitate the study of perceptions and risks of married women relating to the contraction of HIV.

Fig2.2: The Ecological model

The Ecological model adapted to explain Knowledge, perceptions and risks of contracting HIV from spouses by married women

POLICY - Ineffective or non-existent policies protecting the rights of women
- Policy makers not giving needed attention to the vulnerability of married women to HIV infection

COMMUNITY - Taboos, myths and cultural beliefs about HIV/AIDS
- Community norms regarding the place of the woman in society

ORGANIZATION - HIV preventive and education programs not tailored to meet the needs of married women.

INTERPERSONAL - Views of peers about HIV
- Views of family members about use of protective strategies in marriage.

INTRAPERSONAL
- Beliefs & Perceptions about HIV/AIDS
- Attitudinal disposition towards disease
- Married women's limited knowledge about HIV

Even though the Health Belief Model (HBM) was originally developed to help explain certain health related behaviours, it has also helped to guide the search for "why" these behaviours occur and to identify points for possible change. Using this framework, change strategies can be designed. The HBM has been used to help in developing messages that are likely to persuade an individual to make healthy decision (Campbell, 2001).

However, there are two main weaknesses which have been noted about the HBM. First, health beliefs compete with an individual's other beliefs and attitudes (outside of those described in modifying factors) which can also influence behaviour (Campbell, 2001). For example an educated individual who is aware of the dangers of indulging in risky sexual behaviour may still indulge in it just to fit into his circle of friends. Secondly, in decades of research in the social psychology of behavioural change, it has not been shown that belief formation always precedes behavioural change. In fact, the formation of a belief may actually follow a behaviour change (Campbell, 2001).

The interaction between the two models helps to downplay the weaknesses of each framework. For instance relationships with family, friends, neighbours, co-workers and acquaintances (interpersonal relationships) are important influences on the health behaviour of individuals. An individual can belong to one or more social networks. Through these ties in social networks, people acquire norms (Campbell, 2001), this may account for the other non-health beliefs that an individual may have. Ecological models for health education focus attention on the individual and the social environmental factors as the targets for any interventions. Some health education professionals maintain that using such terms as "lifestyle" and "health behaviour" may direct attention towards changing individuals (as seen in the HBM), rather than changing the social and physical environment, which can serve to reinforce unhealthy behaviours. Within the ecological framework, organizational characteristics can be used to support behavioural change. Organizations, such as school, work, church, professional or neighbourhood groups, may have positive or negative effects on the health of their members. Since they are important sources and transmitters of social norms and values, organizations can provide the opportunity to build social support for a

desirable behaviour change (Campbell, 2001) Organizational changes are needed to support long-term behavioural changes among individuals, for example, they can serve as cues to action.

An ecological model should focus attention on the environmental causes of behaviour (rather than be individually focused) and should also identify environmental interventions for enhancing health (Campbell, 2001).

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CHAPTER THREE

3.0 METHODOLOGY

3.1 Study design

This study was a cross sectional descriptive survey designed to determine and document the knowledge, perceptions and risks of contracting HIV from spouses among married women in Omi-Adio community of Ido Local Government Area of Oyo State.

3.1.2 Description of study area

The research was carried out in Omi-Adio, a ward in Ido LGA of Oyo state. Ido LGA came into existence in May, 1989 with its headquarters at Ido. It shares boundaries with Oluyole, Ibarapa, Akinyele, Ibadan North West, Ibadan South West in Oyo state and Odeda LGA of Ogun state. The populace is predominantly Yoruba. The LGA is blessed with fertile land and the main occupation of the people is farming and trading. Food crops and cash crops such as cassava, cocoa, palm oil and kola nut are produced and then sold in the market. Many industries are located within the LGA. Some of them are; The Nigerian National Petroleum Corporation, Nigerian Wire and Cable Industry, Nigerian Mining Corporation, NIPOL (manufacturer of plastics). The LGA consists of 10 wards with Omi-Adio being one of them. Omi-Adio itself consists of 34 communities. The only major industry in Omi-Adio is the Nigerian Mining Corporation. However several small scale industries like concrete block making industries and furniture making industries are also present there. There are 2 public secondary schools and several primary schools. There is one government owned health facility- a primary health care centre and several private health centres.

The total population of Omi-Adio community according to 1991 census is 11,094 with males numbering 5,418 and female numbering 5,676 (According to the National Population Commission, current figures are yet to be published).

3.1.3 Study variables

The dependent variables are married women's knowledge and perceptions, while the independent variables are the socio-demographic characteristics such as age, religion, educational status and occupation.

3.1.4 Study population

The study population consisted of married women between the ages of 15 and 45 years. These are women in their most productive and reproductive stage of life.

3.2 Sampling procedure

A multistage random sampling technique was used for the selection of respondents for the questionnaire.

Stage I: The selection of Omi-Adio community was purposive based on the fact that it is a busy sub-urban community located on the outskirts of Ibadan city hence there is a lot of migration to and from the city especially by the men.

Stage II: Nineteen out of about thirty-six streets were randomly selected using ballots.

Stage III: A total of 143 households out of about 350 and 55 workplaces were systematically selected (alternate households and workplaces).

Stage IV: Convenience sampling (All available subjects were picked until the required number was reached) was used to select respondents until the required sample size was obtained. Participants for the focus group discussions were recruited from the market place and from their residences respectively.

3.2.1 Sample size estimation

The sample size was determined using the formula:

$$n = \frac{z^2 p q}{d^2}$$

Where,

n= desired sample size

z= the standard normal deviate set at 1.96 confidence interval

p= proportion estimated to be obtainable in target population

q= proportion that does not have the characteristic being investigated

i.e. $q=1-p$

d= degree of accuracy required=0.05

Therefore,

$$n = \frac{(1.962)^2(0.5)(0.5)}{(0.05)^2} = 384$$

The calculated sample size was however increased to 400 to make up for possible cases of attrition or incomplete response.

3.3 Instruments for data collection

Data collection employed both qualitative and quantitative methods. A focus group discussion guide (qualitative) and a semi-structured questionnaire (quantitative) were used for data collection.

3.3.1 Data collection process.

The focus group discussion guide (see appendix I) was used as a tool for exploring the topic. The questionnaire was designed using information gathered from reviewing literature. Six focus group discussions (FGD) were conducted two each for the three age groups [younger married women (ages 16-25), middle-aged women (26-35) and older married women (ages 36-45).] The researcher served as moderator for all the sessions while the research assistants complemented by taking notes and audio-taping the responses after verbal consent was obtained from the participants. A Yoruba version of the guide was used for the discussion since the populace was Yoruba speaking. Participants for the FGDs were recruited from the market place and from their places of residence. Each session consisted of 6 married women and lasted for about 55 minutes. Information gathered from the FGDs was then used to fine tune the questionnaire (see appendix II) which was administered by the researcher and research assistants. The questionnaire was divided into 4 sections (Sections A-D).

Section A focused on respondents' demographic information, section B focused on knowledge about HIV and AIDS; section C focused on HIV prevention while section D focused on risk perceptions and preventive strategies. Respondents were selected at random

from the market, shops and from places of residence. Before the respondents were interviewed, they were assured of confidentiality and that the information obtained from them would be used only for the study and that they would not be required to supply their names and addresses in the interview. With this assurance and feeling secure in their anonymity, the women opened up and shared their experiences with the interviewers without fear of any reprisals. Women who had never been married, who were not within the age bracket of 16-45 or who had never heard about HIV and AIDS were excluded from the interview. It took a period of 4 weeks to conclude data collection. About a hundred questionnaires were administered per week.

3.3.2 Data validity

To ensure validity of the quantitative study, the following steps were taken.

- The instruments were reviewed by co-researchers, lecturers and necessary corrections were made by my supervisor.
- Questions in the questionnaire were fine tuned using the qualitative information gathered during the FGD.
- The questionnaire was translated into Yoruba language ensuring that it was well understood.

The questionnaire was pre-tested on a neutral population having similar characteristics with the proposed study population. Thus ensuring that: Errors (systematic or otherwise) in the structure of the questionnaire that were discovered were corrected before being employed for the research. After the pre-test the questionnaire had to be redesigned to make it more exploratory.

3.3.3 Data reliability

To ensure the reliability of the instrument, the following steps were taken:

First the questionnaire was administered to 40 respondents outside the study site (Apete community) to ensure reproducibility. Analysis was then carried out using Cronbach's Alpha correlation coefficient of the SPSS (Statistical Package for Social Sciences). Alpha (Cronbach's) is a model of internal consistency, based on the average inter-item correlation

(<http://www.spss.com>). According to this approach, a result showing a correlation coefficient greater than or equal to 0.5 is said to be reliable. Analysis of the data obtained from the pre-test yielded a correlation coefficient of 0.533 which confirmed the reliability of the instrument.

3.3.4 Data management, analysis and presentation

The researcher ensured that a daily review of completed questionnaire was carried out on the field and also at the end of each day. This was to correct mistakes and to detect omissions. A coding guide was developed for the questionnaire to aid uniform and correct entry of data for analysis. Data collected were coded accordingly. They were then entered into the computer for statistical analysis using the SPSS package. Both descriptive and inferential tools were used to facilitate the analysis of the data. The results are presented in tables and graphs.

3.5 Limitations of the study

The major limitation of this study is the sole reliance on the respondents' reports and the assumption that the questions were well understood by the respondents. This means that the correctness of the claims may not be totally reliable. Also the trained field assistants were assumed to have understood the purpose and the usefulness of the study, they were therefore also assumed to have been able to make respondents cooperate and give reliable information with the use of the instruments for data collection. It was also assumed that they administered it appropriately. To reduce the effect of these limitations the following was done:

- Some questions were included in the questionnaire to serve as trackers to answers already given such that if they were contradictory the research assistants went back to the question and inquired for clarification.
- Only experienced field assistants were employed to administer the questionnaire.
- A training session was conducted for the field assistants for a period of 2 days by the researcher to enable them understand the content and the context of the questions to facilitate good quality data collection. The field assistants were briefed on the objectives of the research and they were lectured on how to conduct themselves on the field. Their training took place in a class within the Faculty.

- Efforts were made to maintain privacy during interviews since the questionnaire contained some sensitive and personal questions.
- The services of an expert in Yoruba language was employed because the researcher was not vast in Yoruba language and in order to have the exact meaning of items in the questionnaire thus ensuring standardization and consistency of the instrument.
- The questionnaire started with less personal questions so the respondent was allowed time to warm up to the interview before being asked more personal questions.
- The questionnaires were administered by 4 female field assistants to ensure that respondents were free to express themselves.

3.6 Ethical consideration

The confidentiality of the respondents was ensured and protected as there was no request for names, personal addresses or any other type of identifier. Research assistants were of good conduct, morally upright and did not act coercively, or in any unethically unacceptable manner. Records were also kept and stored in a safe place. The researcher did not require any formal letter of introduction to the study site due to the fact that the LGA is one of the field sites of the department but informed consent was obtained from respondents before administering the questionnaire.

CHAPTER FOUR

4.0

RESULTS

The findings from the study are presented in this section. They are organized into the following sub-sections: socio-demographic characteristics, knowledge about HIV and AIDS, perception of risk towards contracting HIV, socio-cultural factors that can facilitate the transmission of HIV between spouses and appropriate preventive measures that can be recommended within marriage.

4.1 Socio-demographic factors

A total of 398 respondents were interviewed. However, eight of the respondents reported that they had never heard about HIV, for these eight the interview was terminated and as a result only 390 questionnaires were used for the analysis. The women were met and interviewed at their workplaces and at their places of residence. The age of respondents ranged from 16 to 45 years with a mean age of 30.2 ± 2.9 years. The middle-aged married women were more 180(46.2%) than the older married women 120(30.8%) and the younger married women 90(23.0%). This is shown in figure 4.1. Five (1.3%) of the women were widowed while eight (2.1%) were either separated. Majority of respondents were of Yoruba origin. Most respondents 166(42.6%) had primary education as the highest level of education, followed by senior secondary school education 126(32.3%), junior secondary 55(15.1%); higher education (university/polytechnic/NCE) 23(5.9%) and those with no formal education 20(5.1%). (See figure 4.2). Other socio-demographic characteristics of respondents can be seen in table 4.1.

About a third of respondents were in polygynous marriages 128 (32.8%) while the remaining 262 (67.2%) were in monogamous marriages. A total of 217 (55.6%) and a total of 173 (44.4%) of respondents were Moslems and Christians respectively. A large percentage of respondents were traders 276 (70.8%). A large percentage of respondents 379 (97.2%) reported having a radio, followed by television 369 (94.6%) and video 343 (87.6%). See table 4.1 below.

Table 4.1. Socio-Demographic Characteristics of Respondents

N=390

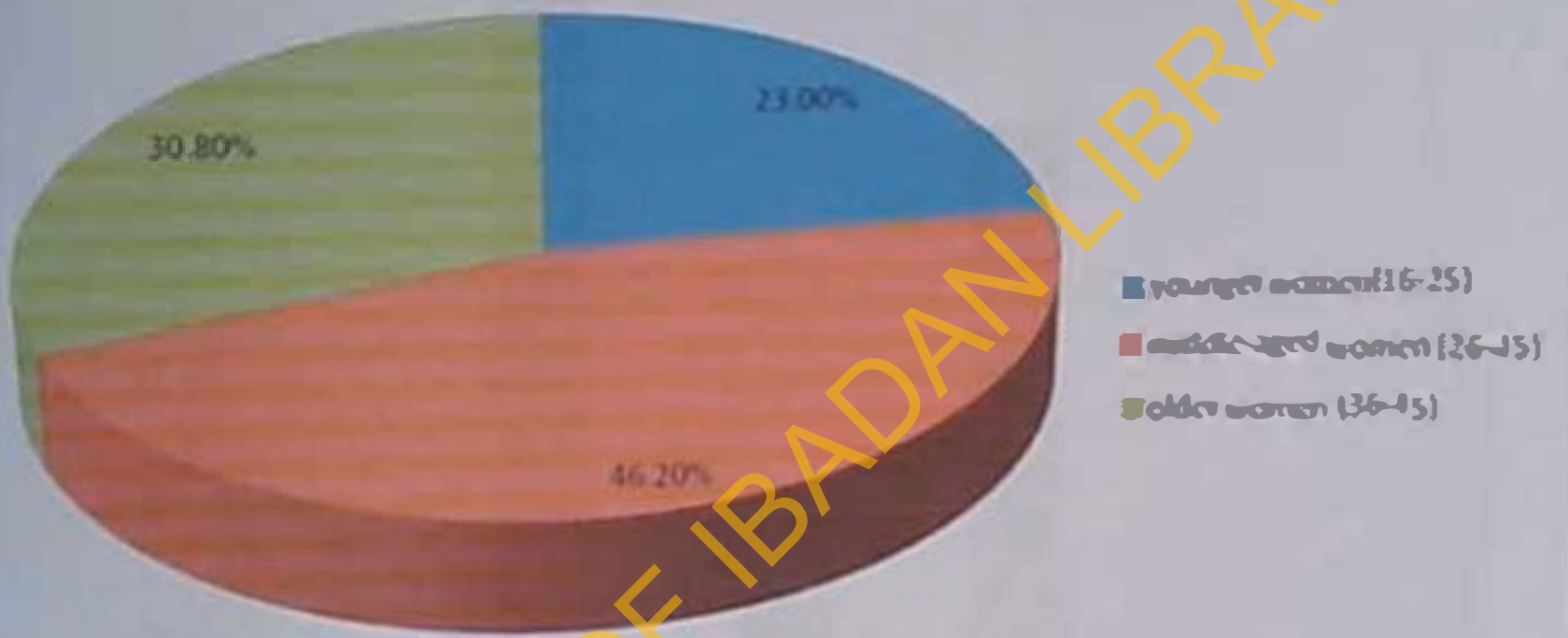
Socio-demographic Characteristics of respondents	Frequency	Percent (%)
Religion:		
Christianity	173	44.4
Islam	217	55.6
Total	390	100.0
Type of marriage:		
Monogamous	262	67.2
Polygynous	128	32.8
Total	390	100.0
Ethnic group:		
I-Iousa	1	0.3
Ibo	4	1.0
Yoruba	379	97.2
Others*	5	1.3
No response	1	0.3
Total	390	100.0
Occupation:		
Trader	276	70.8
Arisan	80	20.5
Teacher	14	3.6
Farmer	4	1.0
Housewife	1	1.0
Others**	10	2.6
No response	2	0.5
Total	390	100.0
Ownership of*** electronic media:		
Television	369	94.6
Video	343	87.9
Radio	379	97.2

*Togolise, Edo, Idoma

** Nurses, Public Servants

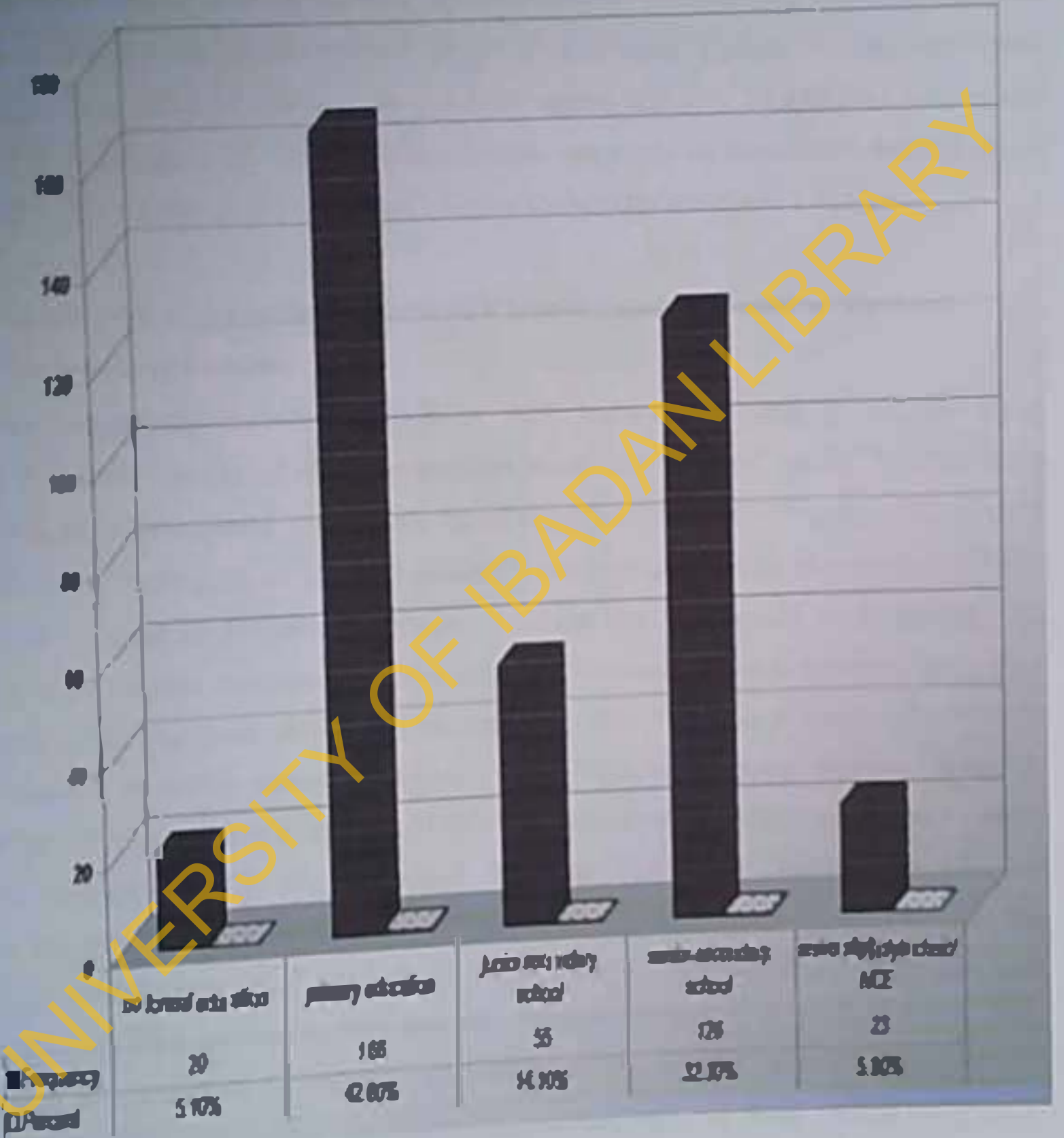
*** Multiple Responses

Fig 4.1. respondents' age group



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FIGURE 4.2: DISTRIBUTION OF RESPONDENTS BY LEVEL OF EDUCATION



4.2 Respondents' awareness about HIV and AIDS

None of the respondents mentioned HIV in particular as a common health problem of women. However a large percentage mentioned malaria as a common health problem of women. (See table 4.2). All 390(100%) respondents had heard about HIV and AIDS. Sources of information about HIV mentioned by respondents included the radio 336(86.2%); television 269(69.0%); health worker 201(51.5%); friends 126(32.3%) and newspaper 51(14.6%) (See table 4.3 below). Respondents agreed that HIV 383(98.2%); Gonorrhoea 322(82.6%) and Malaria 247(63.3%) were diseases that could be transmitted through sexual intercourse. The overall mean score on a 14-point knowledge scale was 7.31 ± 2.6 .

4.3 Knowledge of respondents about HIV transmission, prevention, Signs and symptoms prevention

The most commonly mentioned mode of HIV transmission was sexual intercourse 383(98.2%). Other means of HIV transmission mentioned included sharing of unsterilized sharp objects or instruments 320(82.1%), blood transfusion 182(46.7%) and mother to child transmission 117(30%) others included sharing of cutlery and sharing of toilet 6(1.5%) (see table 4.3). A total of 312(80%) respondents agreed that HIV could be prevented. The methods of prevention mentioned included mutual faithfulness between spouses 278(71.3%), avoidance of sharing sharp objects and instruments 239(61.3%), use of condom 161(42.1%) and avoidance of taking unsterilized blood 147(37.7%). Loss of body weight 274(70.3%) topped the list of signs and symptoms of HIV infection mentioned by respondents followed by skin infections 116(29.7%), prolonged diarrhoea 57(14.6%), tuberculosis 49(12.6%). Twenty six percent of respondents did not know any signs or symptoms of infection (see table 4.3). Sixteen percent of respondents were of the opinion that AIDS could be cured medically 34(8.7%); spiritually 22(5.6%) and through the use of herbs 1(0.3%). A large percentage of respondents 237(60.8%) believed that the worst thing that could happen to a person with HIV was death, 101(25.9%) mentioned loss of body weight, 92(23.6%) mentioned ill health, 15(3.8%) mentioned stigmatization while 20(5.1%) did not know the worst that could happen to a person with HIV. Findings from the focus group discussions revealed that there were some misconceptions about HIV transmission as some women said

HIV could be contracted through sharing of toilets and eating utensils such as plates and spoons while some others were of the opinion that having sexual intercourse with a woman during her menstrual period could put a man at risk of HIV infection.

Some symptoms of HIV infection mentioned during the discussion in addition to those mentioned in the interviews included malaria, constant severe headaches, wounds that refuse to heal and resistance of infections to drugs.

4.4 Perception of risk towards contracting HIV

This section presents details of respondents' perceptions, their perceived vulnerability to HIV infection and their perceived seriousness of the disease condition. A total of 331(84.9%) perceived HIV infection as very serious; 31(7.9%) perceived it to be somewhat serious; 13(3.3%) were not certain about the seriousness of the infection; 6(1.5%) were of the perception that it was not at all serious and 9(2.4%) did not respond. Ninety one percent of respondents were of the opinion that commercial sex workers were at risk of contracting HIV others mentioned are as follows: single men 325(83.3%); married men 321(82.3%); Single women 320(82.1%); married women 320(79.5%); drivers 308(79.0%); health workers 282(72.3%) and young children 251(64.4%).

A majority of respondents 372(95.4%) were of the opinion that married women were at risk of HIV infection but only forty-four percent believed that women's primary risk were their spouses, could get it from their spouses. Of the 95.4% who felt married women were at risk only 37(10.0%) perceived themselves to be at a high personal risk of contracting HIV from their spouses (those who reported that they were very likely to get the infection from their spouses). A majority 264(70.9%) however felt that they were not at all likely to be infected by their spouses. (See details in table 4.4). Those who perceived themselves to be at risk (those who reported "very likely") gave reasons such as their spouses' unfaithfulness and polygamy for perceiving themselves at risk (See details in table 4.4). Findings from the Focus group discussion sessions revealed some of the women felt that married women's greatest risk of contracting HIV was through engaging in extra-marital affairs and although, most were of the opinion that a married woman greatest risk of infection was a promiscuous spouse, very few felt they were at a personal risk of getting it from their spouses.

Table 4.2: Respondents common health problems and treatment options

N=390

COMMON HEALTH PROBLEMS AND TREATMENT OPTIONS		Number	%
COMMON HEALTH PROBLEMS:	Malaria	288	73.8
	Stomach pain	63	16.2
	Typhoid	30	7.7
	Sexually transmitted diseases	24	6.2
	Fibroids	19	4.9
TREATMENT OPTIONS:	Go to a chemist	181	47.9
	Visit a clinic	105	26.9
	Go to the health centre	105	26.9
	Use herbs or other medications at home	90	23.1
	Visit a traditional practitioner	5	1.3
	Visit faith healers	14	3.6
	Patronize drug hawkers	10	2.6

• Multiple responses

Table 4.3: Respondents' sources of information about HIV/AIDS and knowledge about HIV transmission, prevention, signs and symptoms.

N=390

Sources of Information about HIV*	Frequency	Percent (%)
Radio	336	86.2
Television	269	69.0
Health workers	201	51.5
Friends	126	32.3
Newspaper	51	14.7
Mode of HIV transmission*		
Sexual intercourse	383	98.2
Sharing of unsterilized sharp instrument	320	82.1
Blood transfusion	182	46.7
Mother to child transmission	117	30.0
Sharing of cutleries and toilets	6	1.5
Methods of HIV prevention*		
Mutual faithfulness	278	71.3
Avoidance of sharing sharp objects	239	61.3
Use of condom	164	42.1
Avoiding unscreened blood	147	37.7
Signs and symptoms of HIV*		
Loss of body weight	274	70.3
Skin infections	116	29.7
Prolonged diarrhoea	57	14.6
Tuberculosis	49	12.6
Don't know	101	26.0

*multiple responses

Table 4.4: Perceived vulnerability and reasons for perception

Perceived vulnerability n=372	Number	%
Very likely	37	10.0
Somewhat likely	51	13.7
Not certain	20	5.4
Not at all likely	264	70.9
Total	372	100
Reasons for perceived vulnerability n=37	Number	%
Spouses' unfaithfulness	24	64.9
Polygyny	10	27.0
Others*	3	8.1
Total	37	100

* Spouses indiscriminate sharing of barbing clippers and other sharp objects.

4.5 Socio-Cultural factors that can facilitate transmission of HIV between spouses

This section gives details of socio-cultural factors mentioned by respondents which can predispose married women to HIV infection from their spouses. Factors mentioned by respondents included the following: cultural beliefs and norms [which include polygamy 301(72.2%); spouse-sharing 150(38.5%); widow-cleansing 98(25.1%) widow-inheritance 9(2.3%); early marriage 8(2.0%) and female circumcision 4(1.0%)], a culture of infidelity as a show of sexual prowess among men 201 (51.5%) and religious beliefs [negative disposition to divorce and negative disposition to protected sexual intercourse within marriage 29(7.4%)]. Other factors mentioned by respondents include low economic status of women due to their relegated position in the society. Findings from the Focus group discussion sessions showed that some women blamed the culture of making men abstain from sexual intercourse with their wives after child-birth and until they wear the baby on increased promiscuity among men while others blamed it on the fact that culture does not allow a woman to discuss sexual issues with her spouse and this makes it difficult for a woman to express her concern about getting HIV infection to her spouse.

4.6 Preventive strategies mentioned by respondents

A total of 44(11.2%) of respondents felt they could protect themselves from getting HIV infection from their spouses while 22(5.6%) felt they could not protect themselves. For those who reported that they could protect themselves, use of condom 30(68.2%) topped the list of protective measures mentioned followed by abstinence. Details of this can be seen in table 4.5. Mutual faithfulness followed by prayers topped the list of preventive strategies which are considered to be acceptable within marriage by respondents. Details are presented in table 4.5. Fifty five percent of respondents reported ever having discussed sexual issues with their spouses. Of this percentage 181(46.4%) had ever discussed issues relating to HIV and AIDS. A total of 146(37%) reported that their spouses had expressed a willingness to discuss such issues (See table 4.6). Only 132(33.8%) reported that their spouses had ever initiated discussion on issues relating to HIV and AIDS with them. Some women at the focus group discussion felt the best method of preventing HIV was satisfying one's spouse sexually so he doesn't have any reason to indulge in extra-marital affairs; others were of the view that the best method was to provide one's spouse with condoms that he can use when indulging in

extra-marital affairs. Quite a number agreed that engaging one's spouse in communication pertaining to sexual matters could help in preventing HIV infection.

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Table 4.5: Preventive strategies mentioned by respondents

n=390	Number	%
Preventive strategies acceptable within marriage: *		
Mutual faithfulness	320	82.0
Prayers	4	1.0
Use of condom	33	8.5
Use of charms	26	6.7
Spousal communication	23	5.9
Voluntary counselling and testing	8	2.1
How do you think you can protect yourself? n=44		
Methods of personal protection employed by respondents*:		
Use of condom	30	68.2
Abstinence	22	50.0
Separation	9	20.5
Spousal communication	8	18.2
Use of charms	2	4.5

*multiple responses

Table 4.6: Spousal communication and reaction of spouses to issues relating to HIV and AIDS

Spousal Reaction to discussions on sexual issues	Number	%	
Do you ever discuss sexual issues with your spouse?	Yes	214	55.5
	No	171	44.5
	Total	385	100
Have you ever discussed sexual issues relating to HIV and AIDS with your spouse?	Yes	181	84.6
	No	33	15.4
	Total	214	100
What was your spouse's reaction?	Willingness	146	81.1
	Anger	22	12.2
	Violence	6	3.3
	Silence	6	3.3
	Total	180	100

4.7 TEST OF HYPOTHESES

In this study the following hypotheses were tested:

1. There is no difference in knowledge of HIV/AIDS among younger married women, middle-aged married women and older married women.
2. There is no association between educational level and knowledge of HIV/AIDS
3. There is no association between knowledge of HIV/AIDS and religion.
4. There is no association between knowledge of HIV and perceived vulnerability to HIV.
5. There is no association between perceived vulnerability to HIV infection and level of education.
6. There is no difference in perceived vulnerability to HIV infection and type of marriage
7. There is no association between perceived vulnerability to HIV infection and age group.
8. There is no association between age and discussion about HIV-related issues with spouse.
9. There is no association between level of education and discussion about HIV-related issue with spouse.
10. There is no association between type of marriage and discussion about HIV-related issues with spouses

Hypothesis 1

H0: There is no difference in knowledge of HIV/AIDS among younger married women, middle-aged married women and older married women

Results show a significant difference in knowledge of HIV/AIDS among younger married women, middle-aged married women and older married women since p-value is less than 0.05 (see tab 4.7 below). This implies that the older a woman's age the better her knowledge about HIV/AIDS.

Table 4.7: Comparison of mean knowledge score of respondents by age group.

Age group	Mean	N	Std. Deviation	Median
Younger married women	6.70	90	2.889	7.00
Middle-aged married women	7.54	180	2.987	7.00
Older married women	7.42	120	2.984	7.00
Total	7.31	390	2.964	7.00

ANOVA	SS	df	MS	F	p-value*
variation					
Between	36.860	1	36.860	4.231	0.040
Within	3380.216	388			

CODE: SS=Sum of Squares, df=degree of freedom, F= Variance ratio

MS= Mean Square, p-value = Probability value * Significant at ≤ 0.05

Hypothesis 2

H₀: There is no association between educational level and knowledge of HIV/AIDS

From the result of the test as shown in table 4.8. There is a significant association between educational level and knowledge about HIV/AIDS. This implies that the higher the educational level of a woman the better her knowledge about HIV/AIDS.

Table 4.8: Comparison of mean knowledge score of respondents by educational status

Highest level of education	Mean	N	Std. Deviation	Median
No formal education	6.7	20	2.296	6.00
Primary education	6.7	166	2.693	6.00
junior secondary school	6.9	55	2.965	7.00
senior secondary school	8.0	126	2.989	8.00
university/polytechnic/ NCE	8.8	23	2.984	9.00
Total	7.3	390	2.964	7.00

ANOVA variation	SS	df	MS	F	p-value*
Between	161.592	4	40.398	4.778	0.001
Within	3255.485	385	8.456		

CODE: SS=Sum of Squares

df= degree of freedom

MS= Mean Square

p-value= Probability value

F= Variance ratio • Significant at $\alpha \leq 0.05$

Hypothesis 3

H0: There is no association between knowledge of HIV/AIDS and religion.

As shown in table 4.9 below p-value obtained from the test of this hypothesis is less than 0.05, the null hypothesis H0 is therefore rejected. This implies that the religion of a woman does not affect her knowledge about HIV/AIDS.

Table 4.9: Comparison of the mean knowledge score by respondents' religion

Religion	Mean	N	Std. Deviation	Median
Christianity	7.67	173	2.884	7.00
Islam	7.02	217	3.001	7.00
Total	7.31	390	2.964	7.00

ANOVA variation	SS	df	MS	F	p-value*
Between	40.931	1	40.931	4.704	0.031
Within	3376.146	388	8.701		

CODE: SS=Sum of Square df= degree of freedom

MS= Mean Square F= Variance ratio

p-value= Probability value *Significant at ≤ 0.05

Hypothesis 4

H0: There is no association between knowledge and perceived vulnerability to HIV infection

The null hypothesis is not rejected because the result as seen in table 4.10 below show p-values greater than 0.05. This can be interpreted to mean that knowledge about HIV does not affect perceived vulnerability to infection.

Table 4.10: Comparison of knowledge with perceived vulnerability

Do you think you are at risk of contracting HIV from your spouse?

n=372

Knowledge scale	Very likely	Somewhat likely	Not certain	Not all likely	X ²	p-value
Poor (1-5)	12 (3.2%)	14 (3.8%)	6 (1.6%)	72 (19.4%)	4.069	3.32
Fair (6-10)	13 (3.5%)	17 (4.6%)	5 (1.3%)	111 (29.8%)	6.820	4.02
Good(11-14)	12 (3.2%)	20 (5.4%)	9 (2.4%)	81 (21.8%)	3.052	2.88
Total	37	51	20	164		

p-value significant $\alpha \leq 0.05$

Hypothesis 5

H0 There is no association between perceived vulnerability to HIV infection and level of education.

The null hypothesis is not rejected, the test result shows no significant association between perceived vulnerability to HIV infection and level of education since p-value is greater than 0.05 (see tab 4.11). This implies that level of education does not affect perceived vulnerability to infection.

Table 4.11: Comparison of perceived vulnerability with level of education Do you think you are at risk of contracting HIV from your spouse?

n= 368

Level of education	Very likely	Somewhat likely	Not certain	Not at all likely	Total
No formal education	2(10.0%)	1(5.0%)	2(10.0%)	14 (70.0%)	19
Primary education	16(9.6%)	25(15.1%)	8(4.8%)	107 (61.5%)	156
Junior secondary education	4(7.8%)	11(21.6%)	3(5.9%)	29 (56.9%)	47
Senior secondary education	10(7.9%)	11(8.7%)	6(4.8%)	97 (77.0%)	124
University/Polytechnic/NCE	4(17.4%)	(8.7%)	1 (4.3%)	15 (65.2%)	22
Total	36	50	20	262	368

$\chi^2 = 23.019$ $p = 1.539$ Significant at ≤ 0.05

Hypothesis 6

H0: There is no association between perceived vulnerability to HIV infection and type of marriage.

Since the p-value is greater than 0.05 it indicates no significant association between perceived vulnerability to HIV infection and type of marriage. This is shown in table 4.12 below. The implication of this is that the type of marriage to which a woman belongs does not affect her perception of vulnerability to HIV/AIDS.

Table 4.12: Comparison of perceived vulnerability with kind of marriage

Do you think you are at risk of contracting HIV from your spouse?

Type of marriage	Very likely	Somewhat likely	Not certain	Not at all likely	Total
Monogamous	7 (4.9%)	12 (9.4%)	12 (9.4%)	97 (68.3%)	128
Polygynous	15 (6.0%)	10 (4.3%)	18 (7.8%)	189 (76.2%)	232
Total	22	22	30	286	360

$\chi^2=6.206$ $p=3.976$ Significant at ≤ 0.05

Hypothesis 7

H0: There is no association between perceived vulnerability to HIV infection and age group. Since the p-value is greater than 0.05 it indicates no significant association between perceived vulnerability to HIV infection and age. This is shown in table 4.13 below. The implication of this is that the age of married women has no impact on perceived vulnerability to HIV/AIDS. This is shown in table 4.13 below.

Table 4.13: Comparison of perceived vulnerability with age group

Do you think you are at risk of contracting HIV from your spouse?

n=372

Age group	Very likely	Somewhat Likely	Not certain	Not at all likely	Total
Younger married women	12 (12.9%)	17 (18.3%)	4 (4.3%)	66 (70.9%)	99
Middle-aged married women	14 (13.6%)	13 (12.6%)	8 (7.8%)	68 (66.0%)	103
Older married women	11 (6.5%)	21 (20.4%)	8 (4.7%)	130 (76.5%)	170
Total	37	51	20	264	372

$\chi^2 = 10.853$ $p = 0.788$ Significant at ≤ 0.05

Hypothesis 8

H0: There is no association between age and discussion on HIV-related issues with spouse

Since the p-value is less than 0.05 it indicates a significant association between age of married women and discussion on HIV-related issues with their spouses. This is shown in table 4.14 below. It therefore implies that the older a married woman the more the likelihood that she would engage in HIV-related issues discussions with her spouse.

Table 4.14: Comparison of discussion on HIV-related issues with age group

Have you ever discussed issues relating to HIV with your spouse?

Age group	Yes	No	Total
Younger married Women	26 (74.3%)	9 (25.7%)	35
Middle-aged Women	62 (74.7%)	21 (25.3%)	83
Older married women	93 (80.2%)	23 (19.8%)	116
TOTAL	181	53	234

$\chi^2=1.177$ $p=0.001$ Significant at ≤ 0.05

Hypothesis 9

H0: There is no association between educational level and discussion on HIV-related issues with spouse.

Since the p-value is greater than 0.05 it indicates no significant association between educational level and discussion on HIV-related issues with their spouses. This is shown in table 4.15 below. It therefore implies that educational level does not improve the ability of a married woman to engage in HIV-related issues discussions with her spouse.

Table 4.15: Comparison of discussion on HIV-related issues with educational level

n=234

Educational level	Yes	No	Total
No formal education	4 (20.0%)	2 (10.0%)	6
Primary education	70 (42.2%)	24 (14.5%)	94
Junior secondary school	31 (86.1%)	5 (13.9%)	36
Senior secondary school	61 (48.4%)	19 (15.1%)	80
University/Polytechnic/NCE	15 (65.2%)	3 (13.0%)	18
Total	181	53	234

$\chi^2=26.264$

p-value=9.999 Significant at ≤ 0.05

Hypothesis 10

H10: There is no association between type of marriage and discussion on HIV-related issues with spouse.

Since the p-value is less than 0.05 indicating a significant association between type of marriage and discussion on HIV-related issues with their spouses. This is shown in table 4.15 below. It therefore implies that women in monogamous unions are more likely to engage in HIV-related discussions with their spouses than those in polygynous marriages.

Table 4.15: Comparison of discussion on HIV-related issues with type of marriage
n=234

Type of marriage	Yes	No	Total
Monogamous	115 (77.2%)	34 (22.9%)	149
Polygynous	66 (77.6%)	19 (22.4%)	85
Total	181	53	234

$$\chi^2=5.476$$

p-value= 0.025 significant at ≤ 0.05

CHAPTER FIVE

5.0 DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

This chapter discusses the findings of this study. It is organized into 5 sub-sections as follows: socio-demographic characteristics, knowledge about HIV and AIDS, perceptions on risk of contracting HIV, socio-cultural factors that can predispose married women to infection and appropriate preventive measures that can be considered within marriage. The chapter ends with the conclusions and recommendations.

5.1 Socio-demographic characteristics of respondents

A larger percentage: (46.2%) of respondents are middle-aged women followed by older married women: 30.8% while younger married constituted the smallest percentage, 23.0%. This difference in the number of respondents from each of the groups is probably related to the stage of life of the middle-aged women and the older women. Compared to their younger counterparts, the older and middle-aged women are more independent and have more free time to socialize and interact outside the home since their children are likely to be grown ups who have either left home or require less attention than children of younger married women. It may also be that the study community has a higher population of middle-aged and older married than younger married women, the community being located in South-western Nigeria where early marriage is not as common as in the northern part of the country. From the FGDs held with the women, it was evident that older married women were more willing and open to discussions about sex and HIV than were younger married women. This is probably due to their maturity and their life experiences.

It is not strange that an overwhelming majority of respondents 379(97.2%) were Yoruba because the populace is predominantly Yoruba, the community being located in Oyo State, a state in South western Nigeria. There were however a few women from other ethnic groups who are either married to Yoruba spouses or are immigrants from neighbouring states and countries, Omi-Adio being both a farming and a trading community.

(HIV)/acquired immunodeficiency syndrome (AIDS) epidemic in developing countries since its onset in the early 1980s (Liskin, 1990).

One would expect younger married women to have a higher mean knowledge score being young and supposedly dynamic, but interestingly the middle-aged and the older married women have a higher mean knowledge score. Earlier studies have linked the soaring HIV rates among younger married women partly to a lack of adequate knowledge about HIV and AIDS resulting from the false notion that being ignorant about sex and sexuality until marriage is an asset (Sadik, 2008) a fact that has been confirmed by this study. This may also be related to the fact that older women, because of their stage in life, have more opportunities to interact with people outside of their family, hence they have more access to information about HIV and AIDS. They are also more likely to ask questions and discuss issues relating to sex and HIV more freely than their younger counterparts because of their wider experiences.

Education leads to the acquisition of information and increases the extent to which such information is processed, used and passed on to individuals or members of a social network (Isiugo-Abanihe, 1994). This statement agrees with the findings of this present study. The 2008 National Demographic Health Survey also showed a positive association between educational attainment and increased awareness of HIV preventive methods report is consistent with the report of a study carried out by Olawoyin, in 2007 which also showed an association between educational level and knowledge of HIV/AIDS and sexual health. The study observed that there was a faster rate of response to questions among relatively older women in tertiary institutions than those of secondary institutions, and discussions on topics relating to sexual health and HIV/AIDS were better engaged by the older women as well. The observation is consistent with the findings of this present study as evident in the results obtained in chapter four.

As would be expected mean knowledge score appeared to increase with increase in the level of education except for those with primary education and those with no formal education. This anomaly can be attributed in part to the fact that formal education is not the only source of knowledge even though it may enhance aptitude (ability to reason, process and use

information). It could also mean that too little education can be counterproductive which agrees with a common saying that goes thus, "Insufficient education is worse than no education at all." This situation might however be addressed by the recent plan of to incorporate junior secondary education into the Universal Basic Education program by the Federal Government of Nigeria thus improving the standard of primary education.

Other studies have shown that formal education can influence vulnerability to HIV in five different ways:

- 1) Expose girls to HIV and AIDS education, which helps prevent HIV.
- 2) Provide psychosocial benefits for young women, helping them to build their self-esteem and capacity to act on HIV prevention messages.
- 3) Lead to better economic prospects, which in turn lead to lifestyle changes that can influence HIV vulnerability.
- 4) Influence the level of power within sexual relationships.
- 5) Affect the social and sexual networks of the girl child (Hargreaves and Boler, 2006).

Since there was no significant difference in mean knowledge score between women in polygamous marriages and those in monogamous marriages, it may be assumed that the type of marriage to which a woman belongs may not be a contributory factor to her knowledge about HIV and AIDS.

The difference in the mean knowledge score between Christian women and Muslim women is perhaps due to the fact that in Islam women are expected to be at the background asking no questions, "being seen but not heard", hence they may not have access to adequate knowledge about HIV and AIDS like their Christian counterparts who are freer to express their opinions and ask questions. Also the impact of western education appears to be greater among Christians than Muslims. A confirmation to this finding is this comment by Islamic leader Shah Dawood in Pakistan where various girls schools have been labelled offensive and destroyed by Islamic fundamentalists, "Female education is against Islamic teachings, it spreads vulgarity in the society" (Dawood, 2003).

As would be expected, there was a significant difference between mean knowledge score and type of occupation of respondents. Respondents whose occupation require a higher level of formal education like teachers, health workers and public officers have a higher mean knowledge score than those whose occupation require less formal education like traders, artisans and farmers. Overall, mean knowledge score of respondents was average as measured on 14-point scale, being (7.3 ± 2.9) . However it has been reported that people's overall knowledge about the nature of HIV and AIDS is often low despite their high level of awareness of the disease condition (Isibor and Ajuwon, 2004).

5.3 Respondents' perceptions on HIV infection

Sexual risk perception is defined as an individuals' instinctive judgment of both aspects of sexual risk, including the probability of occurrence and the severity of the associated consequence of having unsafe sexual intercourse (Naravoge and Oehler, 2008). Health behaviour depends very much on each person's health perception, therefore understanding and measuring sexual perceptions of people can provide baseline data for determining their sexual health status (Edlin, Golunty and Brown, 1996).

The perceived risk of getting AIDS may have important implications for health if the perceptions are rational and lead to a willingness to avoid risky behaviour. In addition, an understanding of the association between perception of risk and sexual behaviour may facilitate the design of AIDS-preventive measures necessary to check the spread of the disease among different population subgroups (Akpan, Madise and Ilindé, 2003).

The relationship between perception of risk and sexual behaviour is complex and poorly understood (Ndola et al, 2006). Studies conducted on the influence of knowledge on perception of risk and adoption of safer sexual practices has reported mixed results. Some have reported that an individual's knowledge of HIV and accurate assessment of their own risk seem to be among the key factors in the adoption of safer sexual practices (UNAIDS, 2001). Other studies have reported a lack of association between HIV knowledge and sexual behaviours (Lindan, 1991). Findings in this study do not show any significant association between risk perception and knowledge about HIV. This is contrary to the AIDS risk

reduction model that states that knowledge is a prerequisite to recognizing risky behaviour and taking action to change it (Catania et al, 1990).

However some studies have reported that a possible reason for this discrepancy is that women may not apply their knowledge of disease transmission to assess their risk level every time they engage in sexual activity and that women are more reluctant than men to report their self-assessment of risk (Nyoni, 2008). This report lends support to the findings of this present study. Perception on the severity of the disease condition was high as majority of respondents saw AIDS as being very severe. A possible explanation for this is the increased awareness being created through various health education programs citing AIDS as "the disease that has no cure." Also the possibility of having seen or heard of someone who died of the disease is a probable reason.

Earlier studies conducted in different cultures have associated HIV risk perception with a wide variety of variables which include: number of sexual partners, knowledge of sexual partner's past sexual behaviour, fear of AIDS, shame associated with having AIDS, community perceptions of AIDS risk, knowing someone with AIDS, discussing AIDS at home, closeness to parent child relationships and religious affiliation (Macintyre et al, 1990). In this study, the majority of respondents are of the opinion that married women are at risk of contracting HIV. However, only 44% agreed that married women could contract the infection from their spouses. Extramarital affairs topped the list of reported routes of HIV transmission. Even though a majority of respondents are of the opinion that married women are at risk of HIV infection, only 9.5% perceived themselves to be at a personal risk of contracting it. This perception may be due to the fact that many of them see marriage as a safe haven from the infection because they believe their husbands are faithful. This opinion is consistent with those of women in Thailand in a study carried out in 2008 which revealed that some women felt that they were not at risk because they knew the men and their history and therefore trusted them not be infected. This finding proves that knowledge did not relate to actual perception and behaviour (Navaroge and Oehler, 2008).

However some others believed they could not get infected because they felt that being "positive minded" or simply believing that they could never become victims of the infection

was enough guard against the infection. Studies have indicated that wives of men who engage in high risk behaviours often have inadequate knowledge of their husband's sexual activities outside marriage and hence, do not perceive themselves at risk (Newmann, Sarin and Kumarasamy, 2000).

Even respondents in polygynous marriages believe they are safe from the infection judging that their husbands could not be unfaithful since they have enough women at home to satisfy them. This state of mind was evident from the focus group discussions held with the women. Some others are of the opinion that HIV is a curse or a reward for evil deeds, and God can not be so unkind as to afflict them with it being innocent. This line of thought is consistent with that obtained in a study in Kenya where some women see AIDS as punishment for unimoral behaviour so that those who see their lifestyle as being morally upright may perceive their chance of being infected by HIV to be low (Konde-Lule, 1993; Nzioka, 1996).

On the other hand however, a study has shown marital sex to be the single greatest risk for HIV infection for a growing number of women around the world because marital infidelity by men is so deeply ingrained across many cultures (Hirsch, 2007). The same study further reveals that in some parts of the world, including Nigeria, married men routinely have extramarital sex, get infected with HIV, then come home and infect their wives. The study agrees with these findings since, spousal unfaithfulness followed by polygyny are the major reasons reported by respondents who perceived themselves to be at risk of infection from their spouses. This view is in line with the general understanding that the most prevalent route of HIV transmission is through heterosexual intercourse. Also it has been reported that certain faith-based and governmental bodies continue to propagate the myth of marriage as safe (Gonzalez, 2008).

5.4 Predisposing socio-cultural factors

In sub-Saharan Africa, socio-cultural norms and practices are major determinants of sexual risk-taking behaviour (Caldwell, Oribuloye and Caldwell, 1999). In this study, polygyny topped the list of reported practices that can predispose a married woman to HIV. It is however interesting to note that respondents who are in polygynous marriages and who had

earlier reported a low perception on self vulnerability to HIV infection also mentioned polygamy as a predisposing cultural factor to HIV transmission between spouses. This may be attributed to the misconception by so ~~some~~ other people may be susceptible to HIV but not themselves. Polygynous behaviour has been considered one of the major factors promoting the spread of HIV in Africa, where higher rates of HIV infection often are found in areas with high rates of polygamy. However, the evidence supporting this notion is inconsistent. In Ghana, the prevalence of HIV infection was lowest in the north, where 44% of marriages are polygynous. Polygyny may provide a closed sexual network, with a lower chance of the introduction of HIV (HIV and AIDS, the issues for Africa).

Other socio-cultural factors include spouse-sharing. Only, 39% of respondents mentioned this factor, perhaps because it is not a common practice among the Yoruba ethnic group. Also only 25% of respondents mentioned widow cleansing which is also not a common practice in Nigeria although it has been reported that it is commonly practiced in some other sub-Saharan African countries such as Kenya (Saidi, 2003). Surprisingly only about three percent of respondents mentioned widow inheritance which is an age-long practice among the Yoruba ethnic group.

"Cultural prescriptions in various ethnic settings condone male infidelity but expect women to stay faithful to their partners. As a result it is found that women sometimes contract HIV straight on their matrimonial beds." This statement by (Nyoni, 2008) agrees with the findings of this present study because over 50% of respondents mentioned the culture of male infidelity as a predisposing socio-cultural factor to HIV infection from spouses. Further studies by Nyoni (2008), have reported that the majority of women stay faithful to their husbands and partners according to cultural prescriptions and roles, while their husbands do not comply.

Other socio-cultural factors that were mentioned by respondents included religious beliefs, low economic status of women, early marriage and female circumcision. The Bible and Koran both teach submission for women, but this has been erroneously taken to mean that women are inferior to men and hence are not in the position to dictate the premise upon

which sex with their spouses takes place. According to a report by the Zimbabwean ministry of Health and Child welfare (2000), the submissive role of women disempowers them and makes them unable to question issues pertaining to their health and sexuality. This inability to question pertinent issues regarding their health makes women susceptible to HIV/AIDS and STIs.

Studies have shown that there are socio-economic inequities such as great gaps between women and men in education, income, status and other factors which allow individuals to be self-supporting and autonomous. As a result, many poor women who are alone, uneducated and powerless, must depend on a man to support them and their children (Langen, 2005). Studies have shown female circumcision to also be a risk factor for women in HIV transmission. Traditional practices involving female circumcision and mutilation can result in infection during and after the cutting, including HIV infection through sexual activity prior to the healing of the wounds. In countries such as Mali, Senegal and others, legal measures have been taken to abolish this harmful traditional practice (HIV and AIDS, the issues for Africa). A study on early marriage by Clark, Bruce et al (2006) has revealed that for many adolescents - particularly the youngest brides - marriage greatly increases their potential exposure to the virus, because marriage results in a transition from virginity to frequent unprotected sex. Even among adolescents who are already sexually active, marriage generally leads to a dramatic rise in the frequency of unprotected intercourse, especially when pregnancy is desired. Secondly, the partners of married female adolescents are typically older and, by virtue of their age more likely to be HIV positive than the boyfriends of unmarried female adolescents. In addition, in polygynous societies, child and adolescent brides are more likely than older brides to be second or third wives. Thirdly, women who marry as adolescents receive less formal education and have less exposure to the media than their unmarried peers, greatly reducing their opportunities to receive information about HIV/AIDS via these channels and potentially undermining their ability to negotiate safer sexual practices. This foregoing argument agrees too well with the findings in this study.

5.5 Preventive strategies

When asked what preventive measures they considered appropriate for use within marriage, the majority of respondents mentioned mutual faithfulness between spouses. Other mentioned players, use of condom, spousal communication and voluntary counselling and testing.

A study has shown that many HIV preventive strategies assume an idealized world in which everyone is equal and free to make empowered choices, and can opt to abstain from sex, stay faithful to one's partner or use condoms consistently (UNAIDS/WHO, 2004). However in this study, only 25% of respondents mentioned a way by which they thought they could protect themselves from getting HIV from their spouses. The remaining 75% either did not think they could protect themselves or did not respond. The majority of respondents did not respond perhaps because they had never given it a thought or because they thought being married has left them with no choice. For those who responded, the use of condom topped the list of methods of protection that were mentioned, followed by abstinence. This is consistent with FOD findings. This is perhaps due to the publicity that such protective methods have received in recent times rather than because respondents believed them to be methods that are applicable within marital context.

A study has however shown that although condom use seems to be the best strategy to reduce HIV transmission, there are socio-cultural barriers that prevent discussions about safer sex behaviours between husband and wife (Steinbrook, 2001). For example, it is socially inappropriate for a wife to discuss her husband's whereabouts or attempt to negotiate condom use with him. Such attempts could be misinterpreted as an allegation of infidelity and could lead to violence, consequently many women remain in high-risk relationships (Go, Johnson, Bentley et al, 2003). Another study has also shown that the inability of women to control the factors that place them at a risk for HIV infection is compounded by the fact that many societies define the social and cultural identity of women primarily through their role as child-bearers and child rears. HIV barrier preventive measures such as the use of condoms which inhibit women's ability to fulfil their reproductive role are therefore not acceptable. The experience with family planning programmes in the past has highlighted the

extent to which the cultural value placed upon reproduction has been an obstacle to change and has demonstrated that women rarely have control over the reproductive process (Hamblin and Reid, 1991). A study carried out in India has shown that a majority of women reported their inability to negotiate safer sex behaviours, such as condom use. Those who were aware that condom use protects against HIV infection had a hard time convincing their spouse to use condoms because of the fear of such requests being interpreted as a lack of trust between them (Varma, Chandra, Callahan et al, 2010).

A study carried out in a province of South Africa showed that men are more likely to refuse to use the condom when the age difference between them and their female partners is wide, if they are in a married relationship; and where there is no communication about HIV/AIDS between them and their partners (Langen, 2005). The study lends support to the fact that there is a relationship between spousal communication and condom use. Another study has also shown a relationship between spousal closeness (a result of spousal communication) and faithfulness of spouse (Isiugo, 1994). According to the study, emotional bonding between spouses, or spousal closeness, clearly shows a negative relationship with the incidence of extramarital relations. For instance, men who share a strong emotional bond with their partners are about 58 per cent less likely to have extramarital relations as those with a weak bond.

Findings in this study suggests that most husband's expressed willingness to discuss HIV-related issues with their wives contrary to the opinion expressed at the FGD that it is seen as indecent for a woman to discuss such issues with their husbands. These findings may be an indicator to the need to develop culturally relevant HIV prevention programs directly targeted to wives to equip them with effective skills to negotiate safer sex behaviours with their spouses.

Surprisingly there was no significant association between educational level and discussion of HIV-related issues with spouses. The study revealed that older married women from monogamous unions were more likely to discuss HIV-related issues with their spouses. It is expected that education should make it easier for a woman to discuss such issues with her

spouse this is not so perhaps because the influence of culture is still somewhat greater than the influence of education when it comes to gender issues. It is however not surprising that older women find it easier to discuss such issues with their spouses being wiser and more experienced. It is also not strange that women in monogamous unions found it easier to discuss HIV-related issues with their spouses than their counterparts in polygynous unions. This is because the husband in polygynous marriages may not spend quality time with each wife since they are many and he has to spend some time with each of them.

Health Education implications of findings

There is no doubt that the results of this study will have far reaching implications for planning, designing, implementing and evaluating HIV preventive and educative programs for married women in the study area and in Nigeria at large. Health education is a combination of learning experiences designed to facilitate voluntary adaptation of behavior conducive to health (Green, Kruter et al, 1980). It is concerned with reinforcing and changing knowledge, attitudes and behaviour of people through effective communication of factual information, with the aim of helping them to ensure an optimum well-being. Health education can therefore be used to bridge the gap between health information and health practices within the context of HIV and AIDS. The findings of this study have revealed gaps in the knowledge and perception of self vulnerability of married women to HIV infection from spouses. This should be addressed with appropriate HIV and AIDS education strategies among married women.

As far as HIV and AIDS control and prevention in married women is concerned, the goal of health education using factual information is to improve the knowledge of married women about HIV transmission and prevention and to enlighten them about the risk that comes from marital sex. Effective education can contribute to the knowledge of married women and protect them against HIV infection. Preventive programs for married women should be developed with their active involvement. Also preventive programs should be tailored to suit age, gender and the cultural peculiarities of the study population.

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Health education activities organized for married women must be capable of improving their perception towards self vulnerability. Such activities should aim at achieving set goals of reducing the incidence of HIV transmission through marital sex.

According to a technical report by the Federal Ministry of Health (2004), "data from around the world, including Nigeria, suggest that married women's greatest risk of contracting HIV is through having sex with their husbands." Thus HIV preventive programs for married women must be based on scientifically proven, evidence-based strategies that are culturally acceptable and judged to be appropriate, effective and usable within the marriage context.

The core elements of preventive HIV and AIDS related programs should include the following: information about HIV and AIDS and how it is transmitted; educational programs to enhance understanding of personal risk and promote enabling strategies and practical prevention measures which encourage and support behavioral change. Such programs should also involve the men.

Conclusion

The results obtained from this study have revealed that many married women do not consider themselves vulnerable to HIV infection from their spouses hence the need for public enlightenment to raise their awareness on vulnerability to infection. Also most HIV prevention programs focus on strategies like abstinence, mutual fidelity and use of condom. These are strategies that are difficult for women to implement within marriage. Since marriage and motherhood are important in the Nigerian cultural context, new evidence-based strategies that can make intercourse within marriage safer for women should be promoted. One of such strategies is spousal communication. There is a need to sensitize women in marital relationships on the importance of spousal communication as a means of keeping the risk of HIV transmission among spouses at the lowest ebb. Women should be trained in the art of culturally acceptable communication skills. It is also important to involve the men in sensitization programmes so that they are carried along.

Recommendations

Based on the findings of this study, the following recommendations are made:

- Preventive messages need to emphasize that marriage is not a guarantee of safety from HIV infection.
- There is a need to conduct public enlightenment programmes to increase married women's awareness on vulnerability to HIV infection.
- New policies and interventions tailored to the sexual and behavioral profile of women are needed to address the vulnerabilities of married women.
- There is a need for increased enlightenment and sensitization for both men and women in the marital relationship on the need for spousal communication.
- Projects must continue to explore effective, evidence-based strategies for preventing HIV infection in married women.

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APPENDIX I

GUIDE FOR FOCUS GROUP DISCUSSION

INTRODUCTION

My names are Popoola Olabisi and my colleagues are _____. I am pursuing a Master in Public Health degree (specializing in Health Promotion and Education) in the Faculty of Public Health at the University of Ibadan, Ibadan.

The topic of my project is "KNOWLEDGE, PERCEPTION AND RISK OF CONTRACTING HIV FROM SPOUSES AMONG MARRIED WOMEN IN OMI-ADIO COMMUNITY OF IDO LOCAL GOVERNMENT AREA OF OYO STATE."

We would like to inform you that in this discussion we are interested in your opinion about issues we would introduce so everyone should feel free to participate in this discussion. Your participation would enable us to generate useful data and give insight into the study. Absolute confidentiality of your involvement and response in this study would be maintained. However, we appeal to you to allow us use a tape recorder so that we would not forget all the important things that you would tell us, you should please not mention your name so that it would not be recorded.

GENERAL

1. In your own understanding what is HIV and AIDS?
2. What do you know about its cause, symptoms and prevention?

PERCEPTIONS OF RISK

3. Which kind of women in your opinion are at risk of contracting HIV?
4. How do you think married women can contract HIV from their spouses?
5. How do you think married women can discuss sexual issues with their husbands?
6. What kind of lifestyles in your opinion can predispose married women or their spouses to HIV infection?

PREVENTIVE STRATEGIES

7. How do you think ~~that~~ married women can help prevent their spouses from contracting HIV?
8. What factors or practices in your opinion can promote or hinder the adoption of safe sexual practices between married women and their spouses?
9. How do you think married women can protect themselves from contracting HIV from their spouses considering these factors?

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ILANA FUN IJIRORO EGBE LORI ORO AFOJUSUN.

ISIWAJU:

Ẹkú ojumo, oruko temi ní POPOOLA OLABISI, awon elegbe mi oje

Mo n ko eko fun oye giga ninu imo ilera ara ilu (Paraki julo nipa igbega ilera an imo) ni eka ilera ara ilu ti ile-iwe giga University of Ibadan.

Akori akanse ise mi ni: IMO NIPA IFURA SI ATI EWU ATI KO ARUN HIV/AIDS LARA TI IPINLE OYO.

Afe lati so fun yin wipe ninu ijiroto yi a nfe ero okan yin nipa awon isele ti a ma so nipa awon idi eyi, ki olukuluku fi gbogbo okan darapo mo wa ninu ijiroto na. Ijiroto yin pelu wa yio fun wa ni imo ti yoo wulo lati ni oye kikun nipa iwadi yi. A ti da yin loju pe ohun gbogbo ti e ba so yio wa laarin awa ati eyin aikan. Sibe, a o be yin ki e gbawa laaye lati lo ero imohun lati gba ohun yin sile ki a ma ba gbagbe ohun patiki ti e ba so. E ma daruko yin, ki a ma gba sile pelu.

IMO NIPA HIV/AIDS

1. Kini oye titi yin ni pa arun ko gbogun eyi ti a npe ni arun AIDS?
2. Kini emo ni pa okunfa, itona ni idiwo arun aidi?

IFURA SI EWU ATI KO ARUN AIDS

3. Iru awon obirin wo ni eyin ni ero pe ewu ni ko arun aidi wa fun?
4. Bawo ni e se ro pe awon abileko se le ko arun aidi lati ara oko won?
5. Bawo ni e se ro pe a won abileko se le ba awon oko won jiroro lori ibalopo oko ni aya?
6. Iru igbe aye wo ni o le fi aye sile fun ewu kiko arun aidi laarin awon abileko.

ILANA IDIWO FUN ARUN AIDS

7. Bawo ni ero pe awon abileko se le se iran lowo lati mu ki awon oko won mase ko arun aidi?
8. Iru ohun wo tabi asa wo ni ero pe o le se igbega tabi idiwo fun yijan ibalopo oko ati aya ti ko mu ewu dari laarin awon abileko ati awon oko won?
9. Lehin awon ohun won yin ti eti daruko, bawo ni e se ro pe awon abileko se le da abo bo ara won lati ma ko arun aidi lati ara awon oko won?

APPENDIX II

QUESTIONNAIRE

KNOWLEDGE, PERCEPTIONS AND RISK OF CONTRACTING HIV FROM SPOUSES AMONG MARRIED WOMEN IN OMI-ADIO COMMUNITY OF IDO LOCAL GOVERNMENT AREA OF OYO STATE.

INTRODUCTION: Good day, my name is POPOOLA OLABISI. I am a postgraduate student of the department of Health Promotion and Education, Faculty of Public Health, College of Medicine, University College Hospital, Ibadan.

I am carrying out a research on the knowledge, perception and risk of contracting HIV from spouses among married women. Information obtained from this questionnaire will be helpful in planning appropriate HIV prevention programs for married women.

I want to make sure that all the information you give me is kept confidential, therefore I will not write your name on this form. Your most open and sincere answers are needed to make this study successful, so I would like you to answer all questions as completely as you can. The result of your responses will be used for academic and research purposes only.

I wish to ask whether you are willing to participate in the survey. (If "No" thank respondent and terminate interview).

Thank you.

SECTION A: SOCIO-DEMOGRAPHIC CHARACTERISTICS

- 1) Age (as at last birthday)
- 2) Marital status: 1. Married 2. Divorced 3. Widowed 4. Separated
- 3) Religion
1. Christianity 2. Islam 3. Traditional 4. Others (specify)
- 4) Ethnic group: 1. Yoruba 2. Hausa 3. Ibo 4. Others (Specify)
- 5) Highest level of education: 1. No formal education 2. Primary education
3. Junior secondary school 4. Senior secondary school
5. University/Polytechnic/ NCE education 6. Others (Specify):

6) What kind of marriage are you into? 1. Monogamous 2. Polygamous
3. Others (Specify).....

7) What is your profession?.....

8) Do you own any of the following? (Tick yes or No)

	1. Yes	2. No
Radio	<input type="checkbox"/>	<input type="checkbox"/>
Television	<input type="checkbox"/>	<input type="checkbox"/>
Video player	<input type="checkbox"/>	<input type="checkbox"/>

SECTION B: KNOWLEDGE OF HIV/AIDS

9) What common health problems of married women do you know? List some of them

1.....

2.....

3.....

4.....

10) What do you usually do for treatment if you have health problems?

1. Use of herbs at home 2. Visit to a chemist 3. Go to the health centre

4. Visit a private clinic 5. Visit a traditional healer

6. Others (specify)..... 1. Yes 2. No

11) List all the diseases that you know can be transmitted through sexual intercourse
(Tick Yes or No)

	1. Yes	2. No
Gonorrhoea	<input type="checkbox"/>	<input type="checkbox"/>
Mogun	<input type="checkbox"/>	<input type="checkbox"/>
AIDS	<input type="checkbox"/>	<input type="checkbox"/>

Others (specify).....

12) Have you heard of HIV and AIDS? 1. Yes 2.No

[If "No", please stop the interview. Thank you]

[If yes, how did you get to know about it? Through; (Tick Yes or No)

	Yes	No
Television	<input type="checkbox"/>	<input type="checkbox"/>
Radio	<input type="checkbox"/>	<input type="checkbox"/>
Health workers	<input type="checkbox"/>	<input type="checkbox"/>
Friends	<input type="checkbox"/>	<input type="checkbox"/>
Newspaper	<input type="checkbox"/>	<input type="checkbox"/>
Others (specify).....		

14) Mention the ways by which HIV can be transmitted (Tick all that apply)
1. Through sexual intercourse 2. Sharing of unsterilized sharp objects 3. Through blood transfusion 4. From mother-to-child 5. Don't know

15) What are the signs and symptoms of AIDS? (Tick all that apply)

SECTION C: HIV PREVENTION

16) Do you think HIV can be prevented? 1. Yes 2. No 3. Don't know

[If "No" or "Don't know", go to question number 18].

17) If "Yes", how do you think it can be prevented? (Tick only those mentioned)

1. Faithfulness to one's partner
2. Avoid sharing sharp objects
3. Avoid taking unscreened blood
4. Use of condom during sex
5. Others
6. Don't know

18) Do you think AIDS can be cured? 1. Yes 2. 3. Don't know

[If "No" or "Don't know" go to question 20]

19) If "Yes", how do you think it can be cured?.....

SECTION D: RISK PERCEPTION

20) Which of the following group of people do you perceive to be at risk of contracting HIV?

(Tick all that apply)

1. Young children
2. Single men
3. Single women
4. Married men
5. Married women
6. Driver
7. Commercial sex workers
8. Health workers

9. All of the above 10. Others (specify)

21) How serious do you perceive HIV to be? 1. Very serious 2. Somewhat serious 3. Not certain 4. Not at all serious

22) What do you think can happen to a person that gets infected with HIV? (List all)

1. _____

2. _____

3. _____

4. _____

23) Do you think married women are at risk of contracting HIV?

1. Yes 2. No 3. Don't know

[If "No" or "Don't know" go to question 25]

24) If "Yes", how do you think married women can contract it? List all

1. _____

2. _____

3. _____

4. _____

25) Do you ever discuss sexual issues with your spouse? 1. Yes 2. No

[If "No", go to question number 28]

26) If "Yes", have you ever discussed sexual issues relating to HIV/AIDS with your spouse?

1. Yes 2. No [If "No", go to question number 28]

27) If "Yes", what was his reaction?

1. Anger 2. Violence 3. Willingness to communicate 4. Silence

5. Others (specify)

28) Has your spouse ever initiated or raised sexual issues relating to HIV/AIDS with you?

1. Yes 2. No

29) If "yes", what was your reaction? _____

30) What kind of work does your spouse do?

1. Artist 2. Trader 3. Driver 4. Public servant 5. Clergy

6. Others (specify)

31) Do you think his work puts him at risk of HIV? 1. Yes 2. No

32) Do you think you are at risk of ever contracting HIV infection from your spouse?

1. Very likely 2. Somewhat likely 3. Not certain 4. Not at all likely

[If "Not at all likely", go to question number 35].

33) Why do you perceive yourself at risk? _____

34) How do you think you can protect yourself?

1. Abstinence 2. Use of condom 3. Charms 4. Separation 5. Divorce

6. Don't know 7. Others (specify)

35) Do you know any cultural practices that can lead to married women contracting HIV from their spouses? Mention them. (Tick only those mentioned).

1. Polygamy 2. Widow cleansing 3. Spouse sharing

4. Others (specify)

36) What other practices do you know can predispose a married woman to HIV infection?

List all.

1. _____

2. _____

3. _____

4. _____

37) What appropriate preventive measures can you recommend for HIV prevention among married women? _____

CONCLUSION

What appropriate preventive measures can you recommend for HIV prevention among married women?

The 14-point knowledge scale on HIV

Mention the ways by which HIV can be transmitted? Maximum of 4 points for up to 4 correct answers.

What are the signs and symptoms of AIDS? Maximum of 4 points for up to 4 correct answers.

Do you think HIV can be prevented? Maximum of 1 point for correct answer.

If "Yes", how do you think it can be prevented? Maximum of 4 points for up to 4 correct answers.

Do you think AIDS can be cured? Maximum of 1 point for correct answer.

TOTAL marks =14 points

GRADING

1-5 points= Poor

6-10 points =Fair

10-14 points= Good

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IWE IFORO WANI LENU WO

AKORI: IMO NIPA IFURA SI ATI EWU ATI KO ARUN KOGBO OGUN (AJIDI) LARA OKO LAARN AWON ABILEKO NI ADUGBO OMI-ADIO TI IJOBA IBILE IDO, TI IPINLE OYO.

ISIWAJI: Eku ojumo, oruko temi ni POPOOLA OLABISI. Moje akeko iwe giga oipa igbega ilera ati imo ni ile- iwe giga ti University of Ibadan.

Oro ti a ba gba sile ni pa ese iforo wani lenu wo yi, yio wulo lati se eto idina kiko arun asidi lo peye fun awon abileko.

Mo fe si da yin loju wipe gbogbo ohun ti eba so fun mi yio wa laarin emi ati eyin nikan, nitori eyi, emi ko ni ko oruko yin sinu iwe iwadi yi. Orito la ti inu okan wa ni a nfe lati mu ki iwadi yi kun peye, nitori idi yi mo fe ki e dahun awon ibere wonyi pelu gbogbo okan yin.

Iwadi imo ijinle nikan ni a o lo awon esi ti e ba fun mi fun.

Mo fe beere boya e se tan lati darapo mo wa ninu iwadi yi? (Ti won ba so pa: rara, e dupe lowo won ki e si si opin si iwanu lenu wo).

Ese.

A. ILANA IKANIYAN NI AWUJO

1. Omo odun melo ni eyin je?

2. Ki ni a le so nipa eyin ati oko yin lowoluwo yi?

A. Ejo ngbe po B. Eti ko aru yin C. Oko yin ti se aisi D. Eti ko jade nile oko

3. Esin wo ni e nse?

A. Onigbagbo B. Musulumi C. Ibile D. Awon miran (Se alaye).

4. Abule oko tabi Iletu:

Adugbo Ijoba ibile?

Agbegbe:

5. Eya tabi ede:

A. Yoruba B. Hausa C. Ibo D. Ede miran (Se alaye)

6. Ibo ni e ka iwe de?

A. E o lo ile-iwe rara B. Ile kewu C. Eko agba D. Ile eko Primary E. Ile eko Junior Secondary F. Ile eko Senior Secondary G. Ile eko giga (University/Polytechnic/NCE).

7. Ije eyin ni ikan kan niou awon ero won yi?

1. Bee ni

2. Rara

A. Ero mohun-maworan

B. Ero iworan (Video)

C. Ero asoro magbesi

8. Ise wo ni eyin se?

A. Isowo B. Onise owo C. Agbe D. Ise- ljoba E. Iyawa-ile F. Omiran (Se alaye)

9. Inu igeyawo wo ni eyin wa?

A. Oko kan- nya kan B. Oko oni iyawo pupo C. Awon miran (Se alaye)

B. IDIWO FUN KOKORO HIV

10. Ije eyin ti gbo n pa aarin kogbogun eyi ti a o pe ni aarin AIDS ni cde geesi?

A. Bee ni B. Rara

11. Bi e ba ti gbo, ba wo le se gbo?

A. Ero mohun-maworan B. Ero asoro ma gbesi C. Onise-isegun D. Omiran (Se alaye)

12. Ewo ninu awon eyan yi ni eni ero pe o le ko aarin unidi?

A. Omo de

B. Odo ototo okunrin

C. Odo omo obinrin

D. Balc ile

E. Abileko

F. Awa oko

G. Asewo

H. Onise- isegun

I. Gbogbo awon u ati n daruko

J. Omiran (Se alaye)

13. Nje eyin ni ero pe a le di kiko kokoro aidi lowo?

A. Bee ni B. Rara

14. E daruko ona meta ti a fi le ko kokoro aidi

A.....

B.....

C.....

15. E daruko ona meta ti a fi le di kiko kokoro aidi lowo

A.....

B.....

C.....

C. IFURA SI EWU

16. Nje eyin ti ba oko yin jiroro lori oro ti ojo mo ibalope laarin obinrin ni: okunrin ni

A. Bee ni B. Rara

17. Ti o ba je bee, bawo ni won se da yin lo hun?

A. Ibinu B. Ija C. Tokan tokan D. Odi

18. Iru ise wo ni oko yin ase?

A. Oni se owo B. Onisowo C. Awako D. Oni ise ijoba

19. Nje eni ero pe ise oko yin fi won si ipo ewu fun kiko kokoro aidi?

A. Bee ni B. Rara

20. Nje eyin ni ero pe e le ko kokoro aidi lati odo oko yin?

A. Bee ni B. Rara

21. Ti o ba je bee ni, bawo le se ro wipe e le da aabo bo ara yin?

A. Isera B. Lilo Condom C. Kiko Jade ni ile D. Omiran (Se alaye)

22. Nje eyin mo asa ibi le kan kan ti ofi abileko si ipo ewu fun kiko kokoro aidi?

Da oruko won.

A.....

B.....

C.....

23. Awon asa omiran wo ni eyin mo ti ole fi abileko si ipo ewu fun kiko kokoro aidi?

Da oniko won

.....

IPARI

Awon ona idiwo fun kiko kokoro aidi to peye wo ni e le la si ile fun awon abileko?

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