Attitude towards negotiation for safe sexual practices in sub-Saharan Africa: Does women's decision-making involvement matter?

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EXTENDED ABSTRACT

Introduction

Women's decision-making involvement is considered a key factor affecting their sexual and reproductive behaviour especially in the context of Sexually Transmitted Infections (STIs). Globally, mortality reductions remain higher among women relative to their men counterparts and this gender gap is particularly notable in sub-Saharan Africa, where 56% of people living with HIV are women (UNAIDS, 2018). In addition, couples in stable long-term relationships or marriages in Africa are the largest Human Immunodeficiency Virus (HIV) risk group (Coma, 2013; Mkandawire-Valhmu et al. 2013). Specifically, women are particularly at greater risk of contracting STI considering the interaction of social and political factors with their biological vulnerability (Ostrach & Singer, 2012). However, behaviours that increase the risk of transmission of STIs and HIV continue to be wide spread in sub-Saharan Africa (SSA) and explain why HIV infection is endemic in this region (Chialepeh & Susuman 2017). Studies have established that the view on prevention and risk reduction strategies overlook relationship and dyadic-level factors such as intimacy, trust and commitment, as well as various relationship permutations arising from different social contexts (Darbes, et al., 2014). Previous studies have also shown that men have control over sexual and fertility matters and they extend authority over women who compromise their positions in negotiating safer sex practices as a result of their social positions and culturally prescribed gender roles (Osuafor & Mturi 2014; Haberland, 2015; Imo, Isiugo-Abanihe & Chikezie, 2016).

Therefore, these studies were silent on the role women's decision-making involvement play in negotiating safe sexual practices within the family. Hence, little is known about the extent to which women's decision-making involvement is effective in stimulating strong attitude towards negotiation for safe sexual practices, especially among childbearing women from countries with different degrees of patriarchal norms and HIV infections. This study is timely considering the large proportion of HIV infections in SSA which has about two-thirds of the world's HIV burden are women and could account for the largest burden of babies born with HIV in the world - one in every four babies (CIA, 2018). Therefore, this study filled the above identified gap by examining four SSA countries, namely Nigeria, Zimbabwe, Cameroon and Namibia, with a special focus on childbearing women who are married or living together with partners. The reason is because this group of women have more or less similar experiences on sexual control. The outcomes of this comparative study which have several policy implications for future STIs prevention would help to facilitate the achievement of sustainable development goals of preventing deaths of newborns, ending the epidemic of AIDS and other STI and creating gender equality in SSA and Africa at large.

Data and Research Methods

This study utilised datasets from the latest Demographic and Health Surveys (DHS) conducted as part of the worldwide Measure DHS Program in the selected countries from sub-Saharan Africa on the basis of data availability and geographical differences: Nigeria (West Africa), Zimbabwe (Eastern Africa), Cameroon (Middle Africa) and Namibia (Southern Africa). The study involved analysis of data from nationally representative samples of 27,274 (2013 Nigeria DHS), 6,015 (2015 Zimbabwe DHS), 9,805 (2011 Cameroon DHS) and 3,803 (2013 Namibia DHS) making a total of 46,897 childbearing women aged 15-49 years who are married or living together with their partners using individual recodes.

The outcome variable for this study is 'attitude towards negotiation for safe sexual practices, which was measured among the study population. The composite index of outcome variable was derived from women's responses to the two questions on attitude towards negotiation for safe sexual practices in the datasets. These questions are (i) wife refusing to have sexual intercourse with her husband if she knows he has sex with other women has two categories of 'yes=1' and 'no=0' and wife asking that they use a condom if she knows that her husband has an STI also has two categories of 'yes=1' and 'no=0'. The respondents who expressed the sentiment that a woman is justified to refuse sexual intercourse with her husband if she knows he has sex with other women and ask that they use a condom if she knows that her husband has an STI were classified as having 'strong' negotiation for safe sexual practices – coded as 1, while the others were classified as having 'weak' – coded as 0. The choice of explanatory/independent variables for this study was guided by literature. To make interpretation simpler and more meaningful, some independent variables were regrouped from their original categories in the datasets.

Data analyses for this study were carried out at three levels: univariate, bivariate and multivariate using Stata software (version 14). At the univariate level, percentage distribution of respondents was presented. Pearson chi-square was used at bivariate level to investigate the relationships between the outcome variable (negotiation for safe sexual practices) and each of the selected explanatory variables at $p<0.05$. Also, analysis at the multivariate level was carried out using logistic regression to explore which variables are significantly associated with the outcome variable. Logistic regression model was chosen because the outcome variable is binary (strong attitude towards negotiation for safe sexual practices '1' and weak attitude towards negotiation for safe sexual practices '2'. The regression coefficients of the independent variables are expressed as Odds Ratio (OR). A variable with Odds Ratio greater than 1.00 implied that the variable increases the likelihood of the outcome variable, while it is the opposite when the OR is less than 1.00. Consequently, unadjusted and adjusted regression tables for independent variables were generated for this study.

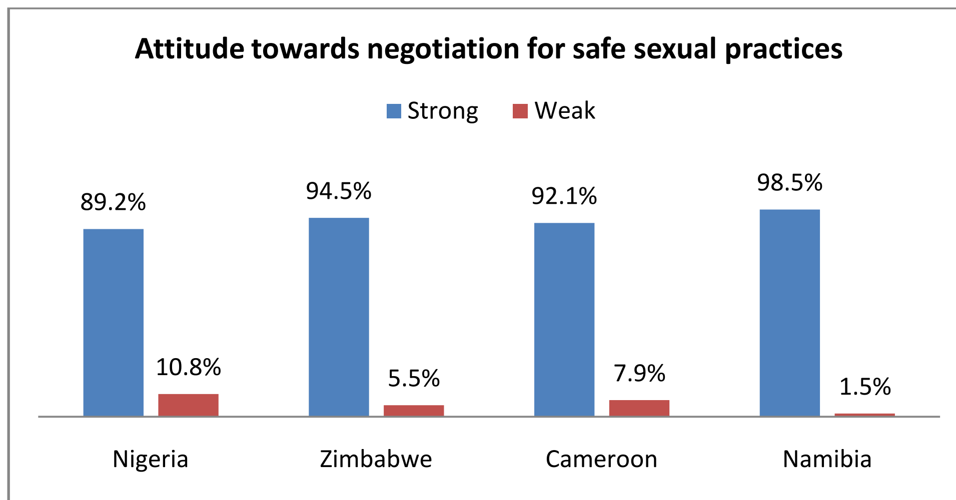
Summary of key findings

Weighted distribution of the study population showed that the average age of the respondents across the four selected countries was 30 years. Our results revealed that about 60% of the decisions on respondents' heath care were independently made by their partners in Nigeria and Cameroon, relative to 51.1% and 43.7% of their counterparts in Zimbabwe and Namibia respectively, who made joint decisions on their health care with partners. Also, the largest proportion of women in Nigeria (70.0%) and Cameroon (66.7%) made independent decisions on how to spend their earnings, while their counterparts in Zimbabwe (62.3%) and Namibia (51.5%) made joint decisions on their earnings. The majority of respondents who had joint decisions with their partners on large household purchase were found in Zimbabwe (60.3%) and Namibia (59.5%), compared to those in Nigeria (52.3%) and Cameroon (40.8%) whose partners made independent decisions on large household purchase.

In addition, a large proportion of the respondents expressed strong attitude towards negotiation for safe sexual practices across the four countries with significant variation. In

addition, the expression of weak attitude towards negotiation for safe sexual practices ranged from 10.8% in Nigeria to 1.5% Namibia (***Figure 1*).**

Figure 1: Percentages of attitude towards negotiation for safe sexual practices in the selected countries



Our findings from the bivariate analysis showed that education, wealth quintile, place of residence and decision on large household purchase were significantly association with strong attitude towards negotiation for safe sexual practices at $p<0.05$ across the four countries, with country-specific determinants such as age, occupation and the respondents' positions in deciding their health care, how to spend their earnings and large household purchase. The logistic regression results revealed that making independent decisions on the respondents' heath care by their partners reduced the likelihood of having strong attitude towards negotiation for safe sexual practices in all the countries, but was found to be significant in Nigeria (OR: 0.67; CI: 0.55-0.81; $p<0.001$) and Zimbabwe (OR: 0.54; CI: 0.34-0.84; $p<0.01$). Surprisingly, the respondents who made joint decision on how to spend their earnings with partners were significantly less likely to have strong attitude towards negotiation for safe sexual practices (OR: 0.50; CI: 0.44-0.58; $p<0.001$), as well as their counterparts whose partners made sole decision on how to spend their earning (OR: 0.20; CI: 0.17-0.23; $p<0.001$) in Nigeria. With respect to decision on large household purchase, the results revealed a significantly less likelihood to have strong attitude towards negotiation for safe sexual practices (OR: 0.57; CI: 0.36-0.89; $p<0.01$) in Namibia.

Discussion, conclusion and recommendations

It is evident from the above preliminary results that childbearing women expressed strong attitude towards negotiation for safe sexual practices in the selected countries with variation. However, the positions of women in decision-making influenced their attitude towards negotiation for safe sexual practices within the family. The implications of this on both maternal and child health in SSA cannot be over emphasised.

The variation experienced is a reflection of how the women's voices influence a range of sexual negotiation and communication across SSA. The plausible explanation could be attributed to the persistence of culturally accepted norms in marital relationships with regards to roles of men that certainly contribute to poor sexual negotiation. This is an indication that childbearing women in the region might continue to bear the brunt of HIV epidemic as a result of the disproportionate gender impact. Therefore, acknowledging and adopting the implications of these findings are essential for future STIs prevention and development strategy towards achieving sustainable development goals of preventing deaths of newborns, ending the epidemic of AIDS and other STI and creating gender in SSA and Africa at large.

In addition, both government and non-government organisations should review existing programmes to intensify efforts of spreading the reach of pooled resources and income generating projects that are geared towards empowering childbearing women to gain a high level of health care control.

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