Texila International Journal of Public Health
ISSN: 2520-3134
DOI: 10.21522/TIJPH.2013.10.03.Art008

Reasons for Victimization and Help-Seeking Behavior of HIV-Positive Men Affected by Intimate Partner Violence in Birnin Kudu, Northern Nigeria

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Abstract

Intimate partner violence (IPV) is traditionally viewed in the context of men as being the perpetrators of violence against women, the victims. Reports of female perpetrated violence against men living with HIV are relatively few in the literature. This is a descriptive cross-sectional study that utilized an interviewer-administered questionnaire to identify the reasons for IPV and help-seeking response to IPV among 322 men living with HIV in Birnin Kudu, Jigawa state, Nigeria. Data were analyzed using SPSS. The prevalence of IPV among men in the study period was 45% (145/322). Out of the 145 respondents that experienced IPV in the year preceding the survey, 72 (49.7%) felt the IPV was related to domestic problems, 70 (48.3%) ascribed it to the disclosure of their HIV status, while 48 (33.1%) attributed it to 'poor upbringing' on the part of their spouse. About a third of the respondents (n= 51; 35.2%) did not report the incident to anyone; out of those that reported the incident, 94 (64.8%) sought help from informal and formal sources, 48 (51.1%) sought help from their in-laws, and 37 (39.4%) sought help from healthcare workers. Domestic problems, disclosure of HIV status, and poor upbringing of the female perpetrators were the commonest reasons for IPV as perceived by the respondents. The majority of the victims sought help from their in-laws and healthcare workers following the episodes of IPV directed at them. Efforts should be made to screen HIV-positive men for IPV during visits to ART clinics.

Keywords*: Help-seeking, HIV, Intimate partner violence, Men, Northern Nigeria, Reasons.*

Introduction

According to World Health Organization (WHO), Intimate partner violence (IPV) is defined as "any behavior within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship'' [1, 2]. IPV is seen as violence in a relationship where the man is traditionally regarded as the perpetrator and the woman is the victim.

In recent times, there has been further appreciation of the nature of IPV within relationships and the changing gender roles [3, 4]. Thus, it may be inappropriate to say perpetration of IPV is male gender specific since women are also now known to perpetrate partner violence against other women as well as men within an intimate relationship [5–8]. There is a growing body of evidence supporting the notion that many women perpetrate IPV [9–11], and these findings may conflict with the prevalent feminist perspective of IPV. Nevertheless, research in this field has shown that women are capable of perpetrating violence just as men do [5, 6, 8, 12, 13]. However, the acknowledgment of men as victims of IPV, persistently challenging especially in most societies where men are supposed to be financially, socially, and politically domineering [14]. IPV against men take place in all communities but to different degrees and

Received: 06.01.2022 ***Accepted: 14.06.2022*** ***Published on: 30.09.2022***
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forms; not with standing it is terribly underreported [15].

Worldwide, most of the literature on female-perpetrated IPV is about its determinants and distribution as evidenced for instance, in the annual publications by several government agencies in developed nations such as the Australian Institute of Health and Welfare [16], the National Center for Injury Prevention and Control (U.S.) [17] and the reports on domestic violence from the records of the police in England and Wales; United Kingdom [18]. Many notable published works have also dwelled on establishing the prevalence, predictors, and correlates of female-perpetrated IPV [19–24]; however, they do not provide information about the reason(s) and factors associated with why women perpetrate IPV.

Though there are some studies that have highlighted the reasons/motivation for this act and how the affected men have responded to it [6, 25–27]. Many scholars have reported that the rates of partner violence and perpetration were similar among men and women [6, 26, 28]. Some studies have identified self-defense and difficulty in communicating negative feelings as common reasons for perpetrating IPV [6, 8, 27]. A review of women arrested for perpetrating violence also found that envy, having control of the partner and wanting the partner to take them seriously or as a way of seeking for attention were other key reasons women perpetrated the act [27].

It is important to note that the motivation or reason for these acts may also influence how men respond to it. Globally, there are conflicting reports on how men have reacted to IPV. A significant number of men who are victims of IPV are noted to shy away from reporting the incident, and most men respond by walking away from their female partners [29–32]. However, some authors have reported several experiences where men have sought for help; they argue that the majority of the victims sought help from informal sources like friends, family, and neighbors [29, 33], while the minority sought assistance from the police, legal representative, and clergy [31, 33]. Local reports on IPV indicate that the pattern is similar as reported in two studies from Nigeria [19, 34].

Female-perpetrated IPV is evolving as societal norms and values are also constantly changing. Globally the relationship between IPV and HIV has been keenly studied among women living with HIV, but only a limited number of studies on men living with HIV have highlighted the magnitude of the problem. It is interesting to note that little or nothing is known about the reasons why HIV-positive men are abused and how they respond to the abuse. Does it differ from other men in the general population? We, therefore, sought to identify the reasons why HIV-positive men are violated by their intimate partners and how they responded to it in this semi-urban community in northern Nigeria.

This study attempts to fill the gap in knowledge regarding what is known about the reasons why HIV-positive men are exposed to IPV and their responses. It will also help in planning strategies and formulating policies on how men who experience IPV should be supported.

Materials and Methods

Study Setting

Birnin Kudu; a semi-urban town in the south of Jigawa state in Northern Nigeria, is the headquarters of the Local Government Area (LGA) and the most populous of the 26 LGAs in the state. It is about 55km from Dutse the capital of Jigawa state, and about 133km from Kano which is the commercial nerve center in northern Nigeria. The town accommodates tertiary, secondary, and many primary healthcare facilities. The majority of the residents are Muslims, and farming is their main occupation [35, 36].

The study was conducted at the specialist clinics of the Federal Medical Centre (FMC) and General Hospital (GH), both in Birnin

Kudu. The FMC is a two hundred and fifty (250) bedded facility; it is a tertiary centre and is owned by the federal government of Nigeria; it is fee-paying. The hospital is designated as prevention of mother-to-child transmission of HIV (PMTCT) centre and it is the main tertiary health facility in the state. The anti-retroviral therapy (ART) clinics are run every day of the week by five medical officers, three consultant physicians and two nurses.

The GH, Birnin Kudu, is a secondary health facility, and it is a public hospital owned by the state government. It is a one hundred and eighty (185) bedded facility and offers general medical services. The costs of obtaining care at the facility are highly subsidized by the state government, and this explains why it is highly attended. The hospital also offers PMTCT and other HIV-related services. The ART clinics of the hospital is run by a medical officer supported by two technicians, and they usually refer clients and patients who require further specialist attention to the FMC, Birnin Kudu.

Study Design, Sample Size Estimation and Sampling Strategy

This is a descriptive cross-sectional study. The sample size for this study was estimated using the Leslie Kish formula for one proportion [37] i.e., $n = z^2pq/d^2$ where z is the standard normal deviate set at 1.96, the confidence level was specified at 95%, while the acceptable error margin (d) was set at 5% and a prevalence of 66.8% was used based on the estimates from a study on intimate partner violence among men in an urban community in Northern Nigeria [19]. After substituting the values into the formula, a sample of 340 was obtained, and this was adjusted upwards to compensate for an estimated non-response rate of 10%. The final estimated minimum sample size obtained was 374, and after proportionately allocated to the two study sites, the sample size for each facility was determined to be 298 and 76 for FMC and GH Birnin Kudu, respectively.

The sampling of respondents was conducted at the two study sites simultaneously, and this lasted 16 weeks. Once the clients arrive at the record office, they are registered and subsequently assigned a number on a consecutive basis. The files of clients are then retrieved, and those whose serial number tally with the systematic sampling process were invited into another room and recruited into the study if they give consent.

The clinic register constituted the sampling frame and based on the average monthly attendance, a sampling interval was determined at each facility. The first respondent for the day was selected by picking a random number between one and the sampling interval for each of the facilities. Consecutive participants were determined by adding the sampling interval to the preceding participant's serial number. This was done until the desired sample size for each facility was realized. Respondents who were exposed to IPV in the previous 12 months prior to the study were regarded as victims, and respondents were asked about the type of abuse that they experienced. Those that were victims of IPV were further asked about their perceived reason(s) for the act and how they responded to it. The possible responses to each item was either 'yes' or 'no', and where the response was positive, the frequency was aggregated. Any respondent that admitted to have been insulted, shouted at, accused of being a lousy lover, called fat, was told something to spite him, had any of his belongings destroyed deliberately or had their partner stomp out of the room during an argument is considered to have experienced psychological violence; any respondent that his partner threw something that could hurt at him, slapped, grabbed, pushed or shoved, punched, hit or kick, slammed against the wall or suffered burn/scald injury from the partner is considered to have experienced physical form of IPV. While if the partner insists on sex when it was not desirable to the respondent, uses threat to have sex, used force to have sex or interfere with the use of a condom or

contraception are regarded as a sexual form of violence. If any of the respondents had experienced one of the above from his female partner, then he was considered to have suffered IPV.

Research Instrument

A structured interviewer-administered questionnaire, adapted from the revised conflict tactic scale (CTS-2) was used. The questionnaire was structured according to the objectives of the study. The questionnaire was designed in English language and translated into Hausa; the main language is spoken in the community. It was translated by a professional translator, and the accuracy of the translation was checked by a back translation done by a different professional translator. The questionnaire was discussed during interviewer-training sessions on a question-by-question basis. Comments and observations made on the questionnaire based on the wording as well as interpretation of the questions were adopted. Although the CTS-2 has an alpha coefficient of 0.79 – 0.95 suggesting a good to excellent internal reliability and consistency [38, 39], it was pretested for comprehensibility, reduction of measurement error and internal validity at Rashid Shekoni Specialist Hospital located in the state capital using 30 questionnaires. The new alpha coefficient that was obtained for the research instrument after conducting the pre-test was 0.80 – 0.90, while the information obtained from the pre-test regarding how to make the questionnaire more comprehensible was incorporated into the main study.

The questionnaires were administered by four male research assistants who were recruited and trained to carry out the fieldwork/data collection. All the research assistants had an ordinary national diploma (OND) qualification in Health Information Management (HIM), were native Hausa speakers and had previously participated in several quantitative research. They primarily worked as contract staffs employed by the management of GH and FMC Birnin Kudu at the HIM department. The research assistants were subsequently trained by the authors for five days on interview techniques, informed consent, and questionnaire administration before the commencement of data collection, and two research assistants were assigned to each hospital for the purpose of data collection, under the supervision of the authors.

Inclusion and Exclusion Criteria

Adult males (≥18 years) with documented evidence of HIV-positive status attending the specialist clinics of either FMC or GH Birnin Kudu; and had experienced at least one form of IPV perpetrated by their spouse were recruited for the study. Men who were too ill to participate were excluded.

Ethical Considerations

The research protocol was reviewed and approved by the Research and Ethics Committee of Jigawa State Ministry of Health. Permission was also obtained from the management of FMC and GH, Birnin Kudu, respectively. In addition, during the recruitment and data collection stages, respondents were informed of the voluntary nature of the study as well as their right to withdraw from participating at any time during the study or not to answer any question if they did not feel like, without needing to give any explanation. A written informed consent form was signed by all the respondents before enrolling into the study and the study questionnaires were anonymized to further ensure confidentiality.

Data Analysis

The information obtained from the filled questionnaires were entered into the Statistical Package for Social Sciences (SPSS) version 25 (IBM Corporation, Armonk, NY, USA) software, then cleaned and analyzed. The quantitative variables were summarized using descriptive statistics such as means and standard deviation, while frequencies and

percentages were used to summarize qualitative variables.

Results

Out of the 374 respondents identified for the survey, only 322 participated, giving a response rate of 86.1%. All the eligible participants from GH participated in the survey, while only 246 (82.6%) from FMC participated in the study.

Of the 322 participants, 145 had experienced at least one form of IPV or the other perpetrated by their partners, giving a prevalence of 45%. The one hundred and forty-five participants were the **s**ubjects for this study. Psychological aggression was the commonest form of violence reported, constituting 143(98.6%) of the violence experienced, physical assault was noted among 75(51.7%), while sexual coercion accounted for 51 (35.2%).

Sample Description

The respondents' ages ranged from 22 – 62 years, with a median and inter-quartile range of 40 and 10 years respectively. Majority of them, were in their third and fourth decade of life.

The majority 126(86.9%), were married, 15(10.3%) were separated while 4(2.8%) were divorced. Out of those that were married, 76(60.4%) were married to one wife; 44 (34.9) to two wives while 6 (4.7%) had three wives. They were mainly Muslims 139 (95.9%) and 94 (64.8%) were of Hausa ethnicity. None of them drank alcohol while 13 (9.0%) smoked cigarette. Most of them 77 (53.1%) had formal education while a third (n= 48; 33.1%) were farmers and about a fifth (n=33; 22.8%) were petty traders. They had fathered between 0 and 21children with a mode of 3 children. The majority, 99(68.3%) were exposed to childhood violence, while 46 (31.7%) did not report experiencing childhood violence. About a – third (n= 49;33.8%) of the respondents earned between 40 000 – 59 000 naira monthly, about a quarter (36;24.8%) received between 20 000 – 39 000 naira while 40 respondents (27.8%) earned 20 000 naira or less every month.

History of IPV

Fifty-one (35.2%) of the husbands admitted that they had previously either psychologically, physically, or sexually assaulted their partners.

Partners' HIV status

The majority of the perpetrators of violence 122 (84.1%) were HIV positive, while 23 (15.9%) were HIV negative.

Reason(s) or Motivation for Violence

The reason identified by the partners of the perpetrators of IPV varied, and many of the factors co-existed. The main reasons were grouped as domestic problems by 72 (49.7%), disclosure of HIV infection in 70 (48.3%) respondents, and poor upbringing by 48 (33.1) respondents. Some other reasons cited include influence of friends noted by 47 (32.7%); being hot-tempered 20 (13.8%) and experiencing childhood violence was noted among 19 (13.1%) respondents, while partner not supporting in household chores was reported by 18 (12.4%) respondents. Others include husband fertility challenge 8 (5.5%), jealousy 8 (5.5%), unemployment, and mental ill health each made up 5 (3.4%) respectively.

Reported the IPV Incident

Out of those that have experienced IPV, the majority of the victims 94 (64.8%) had told someone about their experience, while 51(35.2%) never talked about it.

Where Help was Sought

Out of the 94 victims, many sought help from multiple sources. Majority of them (n=48; 51.1%) sought help from their in-laws, slightly over a third (37; 39.4%) sought help from the healthcare workers and 16 (17%) respondents discussed the issue with their families. Eight (8.5%) of the respondents sought assistance from neighbors when the incident occurred, 6(6.4%) each sought help from their friend and the community leader or Imam (the spiritual

leader in the mosque). None of the victims reported the incident to the police.

Reason(s) for not Seeking Help (Multiple Responses)

Out of the 51 victims that did not seek help from anyone after their experience of IPV, 43(84.3%) did not do so due to fear of disclosure of their HIV status, 18(35.3%) felt it was a challenge to their masculinity, 14(27.5%) refused to talk about it due to their commitment to the relationship while 10 (19.6%) had diminished self-confidence.

Outcome of Help-Seeking

The majority 64 (68.1%) of those that reported the experience to someone, were satisfied with the outcome but 30 (31.9%) were not satisfied with the outcome.

Discussion

About half of the respondents in this study had experienced IPV within the 12 months that preceded the survey. The main reasons for the violence were often attributed to domestic issues, disclosure of HIV status to their partners occurring in about half of the respondents and poor spousal upbringing in about a third of the respondents, respectively. About a third of those that experienced IPV never talked about it or sought for any assistance, while about two–thirds that sought for assistance, mainly reached out to their in-laws and healthcare worker. Majority of those that kept the experience to themselves did so out of fear that their HIV status would become known to everyone by reporting the issue.

It is interesting to note that apart from HIV disclosure, domestic issues (which here refers to challenges faced regarding day-to-day living within the family, such as non-payment of utility bills) is a major concern believed to be responsible for IPV against men living with HIV. It is reasonable that when a wife discovers that her husband has acquired an incurable disease, she gets furious, knowing it's no fault of hers, she may be infected and require life-long medication. This study observed that majority of the perpetrators were possibly infected by their partners. The reported association between HIV disclosure and IPV as seen in this study, has been documented previously by [40] and may be partly responsible for the introduction pre-marital screening for HIV in the state. Unlike before, many intending couples are now aware of their HIV status before marriage. This has also promoted the organization of arranged marriages between those living with HIV. The disclosure of HIV status, however, cannot totally explain the high prevalence of IPV experienced by the victims. However, poverty a known stressor within low-income families [41,42], may explain this as more than half of the victims are petty traders and subsistence farmers who may have challenges with day-to-day living due to their low earnings. It is also possible that for many couples, IPV preceded the detection and disclosure of HIV in the relationship, and acquiring HIV just exacerbated the challenges associated with surviving day to day. Some of the victims who felt that poor spousal upbringing was the reason for their partners' actions may be resorting to the lay or traditionally believed cause of unruly or violent behavior in the society [43]. Since most of the victims gave multiple reasons why they experienced partner violence, may suggest that many of these reasons may co- exist, have some degree of overlap or are more complex than they are reported.

Following the IPV, many of the victims refused to talk about it because of the fear that many more people would get to know about their status, and they may be stigmatized or discriminated at, which may be worse than experiencing IPV. Societal norms and values also do not encourage a man to talk about himself as a victim of IPV, because he would be seen as a weakling who cannot manage his home affairs [44–46]. However, for the majority that have sought help, they preferred to discuss with their in-laws and healthcare

workers who are likely to keep the information about their HIV status and the occurrence of IPV to themselves while still addressing the IPV.

Although this sample size was small, the population studied may be a fair representation of men living with HIV who receive care at these levels of care in the community. This is because participants were recruited from the tertiary and secondary levels of care using a systematic sampling approach. The cost of services in the GH Birnin Kudu is highly subsidized by the state government, and it is well patronized by HIV positive clients without bias. This study has limitations. The non-responders 52 (14.1%) may have been different from the study participants because all were from the tertiary level of care, and the latter may have had recall bias in completing the questionnaire. In addition, since the study was based on self-report, it cannot be completely ascertained that all the victims experienced IPV, especially since their partners were not interviewed to corroborate the report. Finally, the reasons proffered for the act of the IPV was as perceived by the victims, and they may not be the real reason(s) for the act. This is buttressed by the fact that about a third of the victims admitted having also abused their partners in the past prior to the survey.

It must be highlighted that there is a dearth of similar studies locally to make adequate comparison with. Under these circumstances, this study can be compared with studies in the general population. Generally, scholars' have reported various reasons as to the motives for IPV against men [6, 8, 26, 27,28].

These include self-defense, in retaliation, envy and taking control of the partner. The main findings in this study differ from the preceding studies cited above, however, it is partly consistent with the finding from the report by [46], which highlighted poor upbringing as a cause of female-perpetrated IPV.

It has been noted that male victims of IPV do not generally like to report the incident [19, 29,30,32, 44] and that most men respond by walking away from their female partners. This is not consistent with the findings from this study as the majority of the victims sought help, especially from their in-laws. This is like the findings of Ameh and Asekun – Olarinmoye [48, 49].

It is important for clinicians to appreciate that disclosure of HIV status is just one of the major reasons for IPV among men living with HIV and domestic problems are just as important. This implies that the provision of appropriate social support is as important as the provision of counseling support to HIV-positive men to prevent the unwanted consequences of female-perpetrated IPV against men living with HIV. Additionally, over a third of the victims that sought help discussed it with healthcare workers, possibly because about half of the victims were physically assaulted.

It is, therefore important that routine screening for IPV be conducted among men living with HIV by healthcare workers whenever they present to the clinic. This may help in identifying victims who can be counseled and supported appropriately. Policy makers should also appreciate the fact that IPV is not a gendered issue as females can perpetrate IPV just like men too and this should be taken cognizance of when formulating policies for addressing domestic violence. There should also be policies that encourage reporting of incidents of IPV and prompt prosecution of cases by the law enforcement officers without undue delay while protecting the victim.

Conclusion

Domestic problems, disclosure of HIV status and poor spousal upbringing of the women are the commonest perceived reasons for IPV among men living with HIV and majority of the victims sought help from their in-laws and

healthcare workers. Efforts should be made to screen HIV-positive men for IPV.

Acknowledgment

The authors would like to thank Mr. Bashir Murtala, Mubarak Ahmad, Muhammad Sani, and Surajo Bello for administering the questionnaires.

Conflict of Interest

The authors hereby declare no conflict of interest.

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