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Gender differences in sexual behaviour among people living with HIV in Chennai, India

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***Background & objectives*: Risky sexual behaviour is usually the focus of HIV prevention programmes and little attention has been given to sexual behaviour patterns among HIV positive individuals. In order to ensure that people with HIV receive high quality sexual and mental health services, providers must have a comprehensive understanding of the issues and challenges faced by men and women with HIV. This study was conducted to gain insight into the gender differences in sexual behaviour patterns among HIV seropositive men and women in south India.**

***Methods*: This descriptive cross-sectional study on a cohort of 203 seropositive patients (102 women and 101 men) attending outpatient clinics in the Tuberculosis Research Centre and the STD clinic of the Government General Hospital, Chennai, India. A semi-structured interview schedule was administered to collect information from the respondents.**

***Results*: Fifty three per cent of the women were discontented with the sexual relationship with their spouse as compared to 23 per cent of the men ($P<0.001$). Thirty two of the 54 women who refused sex said that their spouses reacted violently to their refusal. More men than women reported to having extramarital relationships most often with a commercial sex worker or a friend, without condoms and usually under the influence of alcohol.**

***Interpretation & conclusions*: There are gender differences in sexual behaviour patterns among men and women. Understanding these differences is important to plan gender based intervention strategies in order to ensure that people living with HIV have a better quality of life, addressing their sexual concerns both within and outside of marriage. The findings will also help in advocacy and prevention programmes aimed at HIV/AIDS control.**

Key words Gender - HIV/AIDS - sexual behaviour

The factors influencing the Indian HIV epidemic are the size, behaviours and disease burdens of high risk groups, their interaction with bridge populations and general population sexual networks[1]. Heterosexual transmission accounts for the majority of cases, with increasing rates of infection in married women contracting HIV from their infected spouse[2-4]. While the biological factors that place women and men at risk of HIV infection are well known, the socio-cultural, psychosocial and sexual factors that compound women and men's biological vulnerability have been often overlooked[5]. Studies in India have shown significant

proportion of men and women report both premarital and extramarital sexual activity[6]. Understanding the social context of risk behaviour including gender dynamics that affects common sexual behaviour patterns and characteristics remains critical to the development of preventive strategies[7,8]. Against this background, this study was envisaged to understand details of marriage and sexual behaviour in the context of premarital, marital and extramarital relationships among HIV seropositive men and women in Chennai, Tamil Nadu, India.

Material & Methods

This is a descriptive cross sectional study done on a cohort of patients attending two out patient clinics at the Tuberculosis Research Centre and the Government General Hospital, Chennai. The study was carried out between March 2000 and July 2003. The study population consisted of 203 of 220 HIV positive patients enrolled in a clinical trial on tuberculosis chemoprophylaxsis during this period. They included 101 sero positive men and 102 sero positive women. Inclusion criteria included documented evidence of HIV seropositive status, ability to be able to speak in Tamil, the local language, willingness to provide consent and willingness to spare time for the interview. A semi structured interview schedule administered by trained medical social workers was used to collect information from the respondents. This questionnaire was developed from experience gained from an earlier study on gender issues in tuberculosis (WHO/TDR multi-centric study on gender differentials in tuberculosis control), focus group discussions, individual interviews with HIV positive patients and discussions with other behavioral researchers. The questionnaire was translated into Tamil, the local language, translated back into English and checked for accuracy and internal consistency to avoid ambiguity. Noting down narratives from the respondents and open-ended questions captured qualitative data. The study was approved by the Institutional ethics committee.

Statistical analysis was done using the SPSS package 10.5 and EpiInfo 6.04D and MAXQDA packages for qualitative data[10,11]. Descriptive statistics was done for all the demographic variables. The gender differentials were compared using the Chi square test. The level of significance was taken as 5 per cent.

Some operational definitions: The reference to a "Satisfactory" and "Unsatisfactory" marriage is a summary statement based on factors such as sharing of ideas, oneness in decision making, parenting, domestic responsibilities, attending social events, and absence of unfair dominance. The description of sexual relationship was based on factors such as openness in sexual discussions, respecting each others decision, no coercion, a relationship of trust and respect and frequency of mutually agreed sex. They were asked to rate themselves in a score of 1-10 with regard to the factors described above. A score of above 5 was considered as "Satisfactory". "Refusal for sex" referred to refusal at any time and was not act specific.

Results & Discussion

Of the 170 men (mean 33 yr) and women (mean 27 yr) were married at sometime, widowed, separated or divorced. Fifty three per cent of the women and 9 per cent of the men were 18 yr or less at the time of marriage ($P<0.001$) (Table I). Culturally, in India as in many other parts of the developing nations, a girl is ready for marriage when she attains puberty. Early marriages are recommended for girls as it is felt that once married, a girl would have some security and

Table I. Marital and details of sexual behaviour of respondents

Details of marriage	Women (n=100) N (%)	Men (n=77) N (%)	*P* value
Age at marriage (yr):			
≤ 8	53 (53)	7 (9)	<0.001
>18	47 (47)	70 (91)	
Duration of marriage (yr):			
0-5	35 (35)	21 (27)	
6-10	40 (40)	27 (35)	0.31
11-14	9 (9)	9 (12)	
≥ 15	16 (16)	20 (26)	
Description of marriage:			
Satisfactory	45 (45)	51 (66)	<0.01
Unsatisfactory	55 (55)	26 (34)	
Frequency of sex:			
Often (≥15 times a month)	65 (65)	61 (79)	0.04
Sometimes (5-14 times/ month)	23 (23)	14 (18)	
Rarely (<5 times a month)	12 (12)	2 (3)	
Description of sexual relationship with spouse:			
Satisfactory	47 (47)	59 (77)	<0.001
Unsatisfactory	53 (53)	18 (23)	
Refused sex with spouse:			
Yes	54 (54)	12 (16)	<0.001
No	46 (46)	65 (84)	

safety for her future, in that she would be cared for both emotionally and financially by her husband. However, young married girls are more exposed to risk especially when the spouse is infected with HIV and the girl is unaware of his status. A study from sub-Saharan Africa concludes that early marriages increase coital frequency, decreases condom use and virtually eliminates girl's ability to abstain from sex[12]. Of the women, 35 (35%) were married for less than five years as compared to 21 (27%) of the men, before the diagnosis of HIV was made. More women (47%) as compared to men (33%) had heard of HIV only after their diagnosis of HIV and 65 per cent of the women and 10 per cent of the men were tested for HIV on account of their spouse testing positive. It seems therefore that the women were exposed to HIV from their husbands. Other studies from India have also demonstrated that simply being married increases women to risk of HIV[13,14]. Studies in Asia and Africa have shown that many married women contract HIV from their one and only sex partner, their husband[15,16]. It is therefore not surprising that more than half (55%) of the women respondents expressed dissatisfaction in their marriage as compared to 34 per cent of the men, the difference being statistically significant (P<0.01) (Table I).

Sexual behaviour: More men (71%) (48 married men and 24 never married men) than women (13%) (11 married and 2 never married) reported to having had premarital sexual relationships (P<0.001). Among the married respondents, 5 per cent of the women and 29 per cent of the men confessed to extramarital sexual relationships (P<0.001).Women reported that their sexual partner was an employer or a colleague and among the men, the sexual partner was usually a commercial sex worker. More than one-third of the women and 5 per cent of the men were aware that their spouses were having extramarital sexual relationships (P<0.001). In India, the women are expected to have only one sexual partner. Further, men's behaviour is tolerated and even accepted even if women are exposed to risk[17].

The reasons for risky sexual behaviour reported by the male respondents included "for fun, curiosity, friendship and under the influence of alcohol". Machismo and patriarchal authority characterize male roles in many cultures and the negative aspects of machismo resulting in heavy drinking and sexual risk has been reported[18]. Among the women, there is a feeling of helplessness and inability to refuse the premarital sexual relationship as the partner is usually their fiancé who promised them marriage or an employer who they were forced to oblige. The powerlessness of women to negotiate safe sexual practices has also been reported in other studies in sub Saharan Africa and Thailand[19].

It is worrisome that more than 80 per cent of the men and all the women reported that they did not use condoms during risky sexual practices both premarital and extramarital sex (Table II). This is similar to the findings of another study in rural India where 18 per cent married and 4 per cent unmarried adolescents reported ever use of condoms[20].

Fifty three per cent of the women described the sexual relationship with their spouse as 'Unsatisfactory' compared to 23 per cent of the men (P<0.001) (Table I). Sexual dissatisfaction with their spouses seem to be largely reported by women as reported in other studies[21,22]. Being seropositive with the associated health problems, and anger of being

Table II. Premarital and extramarital sexual experience

Premarital sexual history	Women (n=13) N (%)*	Men (n=72) N (%)
Use of protection during premarital sex:		
Yes	-	14 (19.4)
No	13	58 (80.6)
Premarital sexual partner:		
Fiancée, casual acquaintance, friend, relative	7 (53.8)	23 (31.9)
Commercial sex worker	-	42 (58.3)
Employer/ colleague	6 (46.2)	7 (9.7)
Reason for premarital sex(Multiple responses)*:		
Curiosity, friendship, love	7 (53.8)	48 (66.7)
Forced, threatened	6 (46.2)	-
Fun, peer pressure	-	62 (86.1)
Alcohol	-	12 (16.7)
Extramarital sexual history	Women (n=5) N (%)*	Men (n=22) N (%)*
Extramarital sexual partner:		
Fiancée, casual acquaintance, friend, relative	1 (20)	8 (36.4)
Commercial sex worker	-	13 (59.1)
Employer/ colleague	4 (80)	1 (4.5)
Reason for extramarital sex:		
Curiosity, friendship, love	2 (40)	3 (13.6)
Forced, threatened	3 (60)	1 (4.5)
Fun, peer pressure	-	8 (36.4)
Alcohol	-	8 (36.4)
Dissatisfaction with spouse	-	2 (9.1)

*Denominator for percentage less than 25

infected by their partners could also be some of the reasons for this sexual dissatisfaction. Thirty two of the 54 women who refused sex said that their spouses reacted violently to their refusal. Other studies from India found that violence was a barrier in discussing fidelity and refusing sex[23], and that economic dependence and social pressures limit women's response to violence from their partners[24]. The characterization of women as being unable to change situations or of complying with male demands results in women being dependant on their male partners and prevents them from asserting themselves in sexual relationships[7].

Our study was clinic based, cross-sectional and being a non probability sample, the findings could not be generalized. Another limitation was interpreting findings among currently married and other groups (widowed, divorced, separated) together.

In conclusion, our findings emphasized the need for health providers to understand the sexual behaviour patterns among HIV positive individuals which is influenced by gender disparities. The need for marital counselling among those living with HIV especially addressing concerns with regard to sexual marital decisions, behaviour, decisions in marriage and sex among people living with HIV/AIDS could help gain insight into these concerns and evolve intervention strategies which could enable them to a better quality of life.

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